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**P1**

**STANDARDIZATION OF NEW ONCOLOGY PATIENT EDUCATION USING TEACHING BINDERS**

Emily Albanese, BSN, RN, The Johns Hopkins Hospital, Baltimore, MD; Ashlynn Jones, BSN, RN, Johns Hopkins, Baltimore, MD; Erica Lilly, MSN, RN, Johns Hopkins Hospital, Baltimore, MD; Sandradee McKay, RN, BSN, OCN, Johns Hopkins Hospital, Baltimore, MD; Jessica Aquino, BSN, RN, Johns Hopkins Hospital, Baltimore, MD

**Patient Education and Safety**

On an inpatient hematologic malignancy unit at this National Comprehensive Cancer Center, nursing staff of varying experience levels do not perceive the process of new oncology patient education to be standardized. Some nurses also report low personal confidence in their ability to teach patients. Further, nurse inconsistency in documenting education in the EMR can be a barrier for tracking, continuity of care and effective patient-centered learning. Current literature supports that thorough education provides patients with autonomy and empowerment while navigating a new diagnosis. Streamlining the overall process using standardized educational materials allows for consistency of teaching among staff and improves nursing confidence in their teaching ability. Purpose: The purpose of this quality improvement project is to standardize patient education resources and to improve continuity of care, communication between staff, and staff confidence in teaching for new oncology patients. Intervention: A unique folder was created within the online institutional education portal and all oncology patient education materials were reviewed and approved. A standard workflow was established providing newly diagnosed oncology patients with an empty binder upon admission. As nurses educate patients according to a standard teaching plan guideline provided, the approved printed resources are added to the binder. This strategy allows for slow and purposeful dissemination of education to minimize the chance of overwhelming the patient and caregivers. The completion of education was documented in the patient education flowsheet in the EMR for tracking purposes. Evaluation: A survey was sent to nursing staff to determine perception of how effective and standardized the current process of patient education was before the intervention. We will compare pre-intervention survey results with a post-intervention survey administered three months after the project is implemented. Nursing staff compliance audits will be performed weekly to ensure patients are receiving the binders and resources and that the teaching and response to teaching is documented in the EMR. Discussion: Quantitative data analysis from comparison of the survey results regarding nurse perception of the process and statistical significance of findings will be discussed. Qualitative data will be considered to augment findings and capture staff attitudes of new education intervention. Conclusion: Success of the intervention in attaining a more standardized educational process as portrayed by post-survey nurse responses will be discussed here. Implications for new nurse training and future directions to be included.

**P2**

**ADVANCED PRACTICE PROVIDER DEVELOPED VIRTUAL CLINIC-HARNESING ARTIFICIAL INTELLIGENCE FOR OPTIMIZATION OF PROSTATE CANCER CARE.**

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**Coordination of Care**

Prostate cancer is the most common cancer among men in the United States. Monitoring patients closely after treatment is essential to detect recurrence and toxicities. Dana-Farber-Brigham Cancer Center (DF-BCC) Virtual Prostate Cancer clinic uses an AI-based platform to monitor post-treatment patients—42% of 2096 encounters were asynchronous from 01/10/22 to 8/22/23. In FY 21, AI-optimized workflow led to 38.8% improved access, 21.6% more patients treated, and a more than 20% rise in radiation department revenue. Technological advances are necessary to improve surveillance and patient experience. DF/BCC and Cancer Insights (CI) have received NCI funding to pilot advanced technology to support surveillance of prostate cancer patients throughout their journey. The CI oncology data platform will ingest and curate medical record data from prostate cancer patients seen at DF-BCC between 2016-2022. The
platform will identify primary and derived variables to classify patients into treatment states (active surveillance, treatment, or post-treatment surveillance) and to identify transitions from one state to another. A user interface will be built utilizing patient-level variables to triage by acuity levels (1-relapse, 2-no relapse-significant symptoms, 3-no relapse or symptoms). The platform automates initial communication with level-3 patients via the patient portal with an individualized patient status summary. Treatment state classification and transitions will underpin the technology, which will integrate with the EMR to monitor patient data continuously, flag patients by acuity, alert providers as well as the patient when a patient has missed surveillance activity, and if recent tests indicate further evaluation is needed to assess for recurrence. The tool will support remote care management, saving patients time and cost, promoting clinical efficiency, decreasing administrative and clinical burdens, improving communication between patients and providers, and streamlining care coordination between oncologic specialties.

With an NCI-funded grant, DF/BCC is partnering with Cancer Insights to build first-of-a-kind software that can provide an up-to-date status of prostate cancer patients throughout their journey, recommend the level of follow-up contact (synchronous vs. asynchronous) based on acuity level or are past due for their disease surveillance. The framework will be easily extendable to other cancers or conditions that require regular surveillance, monitoring and survivorship care.

**P3**

**THERAPEUTIC TOUCH FOR PATIENTS IN AN AMBULATORY PALLIATIVE ONCOLOGY CLINIC**

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**Symptom Management and Palliative Care**

Nearly, 16.3 million people worldwide will die from cancer each year by 2060. Uncontrolled pain, anxiety, fatigue, and depression are more prevalent in people with advanced cancers. Pharmacology therapies alone are not the best choice for symptom management. Therapeutic Touch (TT) is research supported non-pharmacologic integrative therapy that helps a variety of symptoms such as pain and anxiety. Despite the research, TT is not routinely provided for patients who may benefit. This evidence-based practice project focuses on awareness and implementation of TT for palliative care oncology patients. The objectives are to determine the change in likelihood a nurse or provider would recommend TT, to evaluate perceptions of TT, evaluate confidence in understanding TT, and evaluate the number of patients who agreed to have a TT treatment. The project includes a pre and post intervention survey, a TT educational offering and TT treatments. An informal survey was emailed to palliative clinic nurses, nurse practitioners and physicians. The TT education included evidence-based content on TT background, benefits, the treatment process, and the protocol implementation plan. An option for TT treatment was offered to people with pain and/or anxiety who have not received TT in the previous six months. TT treatment was provided for five to ten minutes. To determine the likelihood a nurse and provider would recommend TT, perception, and confidence in understanding TT, pre and post intervention survey frequencies will be compared. To evaluate the number of patients who agreed to have a TT treatment, patient’s anecdotal comments after the treatment are recorded. Pre-intervention results reveal the majority of providers and nurses lack confidence in their understanding of TT and are neutral in their likelihood to recommend TT to patients. Midway through project implementation, 25 patients agreed to and received TT after recommended by their provider or nurse. Patient and provider comments are positive. Complete results including comparison of pre- and post-intervention scores are forthcoming. Oncology centers across the globe are incorporating integrative therapies into services for patients. Symptom management for palliative oncology patients is often complex with limitations for improvement with pharmacologic therapies alone. TT as an innovative modality offers an opportunity to provide more holistic care for this patient population.

**P4**

**ELASTOMERIC AMBULATORY CHEMOTHERAPY PUMP CONVERSION ACROSS THE HEALTH SYSTEM**

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**Coordination of Care**
In early 2022, this NCI-designated cancer program learned that the infusion center workload was going to observe future impact: home infusion nurses would no longer be reimbursed for services initiated in ambulatory infusion centers, such as ambulatory chemotherapy infusion pumps for home administration. In addition, there has been a recognized shortage of home health nurses trained to perform chemotherapy services. Therefore, nurses in the infusion centers would need to initiate this service. The purpose was to standardize home infusion therapy processes across the health system’s 5 infusion centers. Realizing that no health system systematic process existed and great variability in home infusion pump systems were being used, an interprofessional team was led by a Clinical Nurse Specialist (CNS) and included the director of oncology pharmacy. After review of all infusion systems and documented complaints (leaks, connection issues, etc.), the director of oncology pharmacy recommended trialing a new elastomeric pump. The product representative provided 20-minute training sessions with nursing and pharmacy staff. The process included: standardizing pharmacy-initiated chemotherapy preparation; the CNS developed a competency document for nursing and pump education for patients; process for nurses to connect pumps to patients; and surveys for staff and patients to complete. It was anticipated that trial outcomes would be shared with oncology leadership for health system implementation. The elastomeric pump trial was conducted from 12/2022-1/2023. 45 nursing/pharmacy staff were trained across 5 sessions. The trial involved 129 patients with evaluations indicating successful implementation. The feedback from end users, both staff and patients, were positive and illustrated minimal workflow impact and no patient delays in receiving essential therapy. Clinically significant observations included reduced time for hospital pharmacy to prepare and deliver drug and reduced time for infusion nurse to connect patients to pumps. While chair time was not measured prior to the pilot, delays for drug delivery from the home infusion pharmacy and the home infusion nurse services to connect patients were eliminated. The pump trial pilot has been deemed a successful implementation and was adopted across the health system. As the majority of patients still receive their pump take-down by the home infusion nurse, a next step is to move forward with identifying appropriate patients/families to educate and train for self-take down processes. This innovative process can be replicated in any infusion clinic.

## P5

### CARCINOID HEART DISEASE: A TEAM APPROACH

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#### Coordination of Care

Carcinoid heart disease is a rare cardiac complication that occurs most commonly in patients with advanced neuroendocrine tumors and is a known sequela of carcinoid syndrome. Neuroendocrine tumors most associated with carcinoid heart disease include tumors in the small bowel (4%), followed by lung (4%), large bowel (4%), pancreatic (1%), appendiceal (1%) and ovarian neoplasms (1-2%). Care involves a collaborative team including cardiology, oncology and anesthesia. Care may also include hepatobiliary and cardiovascular surgeons, endocrinologists, and gastroenterologists. The purpose of this collaborative literature review was to define a team approach to the diagnosis and the management of carcinoid heart disease. The goal of this translational research was to create a team-based approach to the management and diagnosis of carcinoid heart disease addressing the known pathophysiology of the disease, the potential sequelae, and the current standards of care. The literature search included peer reviewed articles obtained from Ovid Medline and CINAHL databases. The search terms used included carcinoid heart disease, carcinoid crisis, carcinoid syndrome, neuroendocrine tumor, right heart failure, tricuspid valve, tricuspid valve replacement, pulmonary valve replacement, valve in valve replacement, percutaneous valve replacement, bio-prosthetic valves, anesthesia management, vasoactive peptides, fibrogenesis, vasoactive mediator release, octreotide, phenylephrine, and vasopressin. Knowledge of the pathophysiological patterns associated with and the subsequent sequelae of carcinoid heart disease are key to the collaborative management. Management of carcinoid heart disease is often challenging as patients can present late with rapidly progressing disease. Therefore, disease management of these patients requires close collaboration among various specialties to quantify disease burden, delay the progression of valvular disease, and determine most effective surgical and/or medical management strategies depending on the cardiac
manifestations to improve quality of life and reduce mortality. Future research is needed to define the best therapeutic options more clearly.

**P6**

TECHNOLOGY AS AN ALLY TO PROMOTE A MORE ASSERTIVE ADVANCED CARE PLAN FOR PATIENTS WITH GASTROINTESTINAL TUMORS

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Oncology Nursing Practice

Technology is increasingly inserted in the healthcare area for various purposes and, thanks for that, the symptoms management of cancer patients can be done in real time by skilled oncology nurses. Gastrointestinal tumors are one of the most common types of tumors worldwide, affecting men and women of different ages. Knowing the profile of patients and the most reported side effects can anticipate advanced care measures and, thus, make the advanced care plan for cancer patients more assertive. Purpose: To find out which side effects are most reported by oncology patients diagnosed with gastrointestinal tumors according to the most used antineoplastic protocols in the largest group of private hospitals in Brazil. Interventions: Patients undergoing treatment have access to an institutional mobile APP that can report their symptoms. Depending on the degree of symptom reported, a specialized nursing team will call them to perform correct management. In this study, we have 3 years of data only from patients diagnosed with gastrointestinal tumors. There were 2,997 symptoms reported from 410 patients, 177 women and 233 men. The most reported symptoms in both sexes were tiredness, pain, diarrhea, nausea, and anorexia. More women reported alopecia, while more men reported constipation. Among the most common protocols, we had FOLFOX, FOLFIRINOX, XELOX (or CAPOX) and FOLFIRI + Bevacizumab. Discussion: Drawing up an advanced care plan is essential for patient treatment and wellness. Once we can obtain data about the most common symptoms reported by patients in our institution and the protocols commonly used, in addition to providing more assertive actions, it favors preventive measures that involve the entire multidisciplinary team. In this way, technology, once again, demonstrates that, when used in a well-structured way, it is an excellent ally in the treatment of cancer patients.

**P7**

PRODUCTIVITY METRICS FOR ONCOLOGY ADVANCED PRACTICE PROVIDERS: JUSTIFYING OUR WORTH

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Professional Development

The Oncology APP workforce has significantly increased over the past decade and an integral part of the oncology care team. In our large academic/comprehensive cancer center, we have over 130 APPs in the inpatient and ambulatory settings. Much emphasis is placed on productivity for financial justification as well as obtaining approval for incremental APP positions with oncology program growth. The purpose was to develop productivity metrics of billable and non-billable APP services. Standard APP metrics are already established and include monthly and fiscal year RVUs (relative value units), number of visits, and fill rates. RVUs determine volume of work based upon CPT codes. Non-RVU generating services are more difficult to track. Meeting scheduled with Information Technology (IT) specialists to discuss development of metrics for number of notes written and number of orders placed by APP. In addition, EPIC smartphrases were developed for APP documentation and analysis of telephone triaging and insurance authorization procedures. APP Dashboard developed to track monthly activity of the above. Continual monthly analysis of APP metrics with RVUs and non-billable activities. Oncology APP role is not solely evaluating and managing patients but coordination of care and partnering with other team members to ensure quality oncology care is being delivered. Non-RVU generating activities may account for up to 25% of the APP’s time based upon institutional survey. Innovative: The development of productivity metrics is crucial in the growth and maturation of the APP role in oncology. As Oncology APPs, we can also be more innovative in our care delivery and revenue generating through APP driven clinics such as long term follow-up, palliative care, urgent care, and survivorship care.

**P8**

DEVELOPMENT OF A STANDARD TRAINING AND EDUCATION PROGRAM: DETERMINING APP COMPETENCY IN BONE MARROW BIOPSY AND ASPIRATE FOR A COMMUNITY HEALTH CARE SYSTEM

WWW.ONS.ORG/ONF
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Bone marrow biopsies (BMBx) and aspirate are diagnostic tools utilized in hematology/oncology. They can be performed by trained advanced practice providers (APPs) in the ambulatory setting. Presently there are limited guidelines for training and competency. Several studies outline formal training methodology, which has shown to be effective for increasing competency after completing the training program. Certain skills must be demonstrated prior to undertaking essential invasive medical procedures. The debate regarding the minimal number of procedures under direct supervision to establish competency is ongoing. However, Accreditation Council for Graduate Medical Education substantiates that performing a minimum of 10 bone marrow biopsies and 10 bone marrow aspirates under direct supervision is the necessary for establishing competency. The Journal of Advanced Practitioner in Oncology has proposed a guideline for procedural training and competency testing in their September/October 2022 issue which includes written, and video didactic with direct observation and supervision of procedure. There was no formal competency and training program for BMBx and aspirate at a community cancer system. Four out of 27 APPs were currently performing these procedures. The majority of the APPs had less than five years’ experience in hematology/oncology. Treatment delays were occurring as there were a limited number of credentialed providers to perform these procedures. In the fall of 2022, a formal, evidence-based, didactic and skills validation program was developed to train APPs to establish competency and obtain privileges to perform BMBx. A BMBx and aspirate procedure protocol, training curriculum and competency evaluation checklist was developed. The standardized checklist ensured uniform methodology for training and established competency to decrease potential complications, and yield better quality and diagnostic specimens with improved patient outcomes. From March to May 2023, two didactic classes were held followed by a simulated skill validation. Post simulation, participants collaborated with their physician partners for the clinical validation. From May to August 2023, one APP has completed the complete training program and the remaining 10 are in the process of completing this. APPs reported increased practice confidence, rating themselves confident to very confident. As participants complete this process, more data is expected to further study how this training and competency program impacts patient access, experience and time to treatment. A follow up questionnaire is planned for Winter 2023 to assess for continued competency.

P9
AVAPRITINIB USE IN PATIENT WITH D842V-MUTANT GIST AND DESMOID TUMOR, A CASE STUDY

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Oncology Nursing Practice

Desmoid tumors (DT) and gastrointestinal stromal tumor (GIST) are both rare soft tissue tumors. DT is a rare, locally aggressive tumor of the fibroblastic connective tissue with an annual incidence of 2-4 per million population annually while GIST has an annual incidence of 15 per million population annually. It is the most prevalent soft tissue sarcoma (STS) of the gastrointestinal (GI) tract and fourth most common STS in general. Although GIST can occur anywhere along the GI tract, it is most common in the stomach (60%) or small intestine (30%). GIST is typically driven by alterations in tyrosine kinase genes, most frequently in KIT (~80%) or PDGFRA (5-10%, including exon 18 D842V), though other driving mutations can be seen as well. Until recently, surgical resection was the standard primary treatment for both DT and GIST, but with recurrence rates around 40% in DT and up to 50% with GIST. However, with the advent of tyrosine kinase inhibitors (TKIs), there has been an increasing role for systemic therapies in management of these tumors. After reviewing this poster, the learner should be able to describe incidence, diagnosis, and common treatment options for desmoid tumors and gastrointestinal stromal tumor (GIST). This is a case study describing a patient who was diagnosed with D842V mutant GIST which was surgically resected followed by surveillance. The patient subsequently developed a rapidly enlarging pelvic mass suspicious for metastatic GIST and was started on avapritinib with partial response followed by resection. Final pathology revealed the pelvic mass was actually desmoid tumor, showing that avapritinib may be effective in treating desmoid tumor as well as GIST. The advent of avapritinib has opened new treatment opportunities for patients with exon 18 mutant GIST who historically had poorer prognosis due to imatinib resistance mechanisms. Based on this case study, it seems avapritinib may have some activity in desmoid tumor as well though this has never been formally investigated. There is an opportunity for further research.
P10
ADOLESCENT AND YOUNG ADULT (AYA) ADVANCED PRACTICE PROVIDER (APP) COLLABORATIVE
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Survivorship
Advanced practice providers (APPs; nurse practitioners and physician assistants) practice in various settings including oncology. Adolescents and young adults (AYAs; diagnosed between 15-39 years) are an age-defined cohort with unique challenges and needs in cancer care. Often these AYAs are cared for by APPs in oncology care settings, who are left to navigate the AYA through cancer survivorship and balance oncology and primary care delivery. Given the need for more support for the unique AYA APP role, a group of these providers were brought together in a formal collaborative. The purpose was to present the conception and evolution of the AYA APP Collaborative. The AYA APP Collaborative was launched in July 2021 to begin collaborating around practice issues in AYA care. The Collaborative is an international group of roughly 15 APPs (masters or doctorally-prepared providers) passionate about bringing AYA education to all oncology APPs. The collaborative’s vision is to gather a geographically diverse group of AYA APPs to share common clinical and institutional challenges in providing AYA care as well as present and publish on the APP role in AYA care. Meetings are held quarterly via Zoom, and there are no formal dues. Membership was offered by word of mouth. Various organizations have sought the AYA APP Collaborative for content related to the psychosocial aspects of AYA care. Collaborative members have presented at various national and international conferences, including ASPHO, Global AYA Congress, ONS Congress. Specific needs identified at a recent meeting will help inform current efforts to create and develop an AYA educational module for community practitioners. Use attendee response data from this presentation to highlight unmet needs for education in this area and propose additional AYA programs. APPs are well-positioned to provide care to, and conduct research with, AYAs diagnosed with cancer. A collaborative, international group of these APPs have been brought together and future offerings will include networking/communication opportunities for publishing and speaking, and possible identification as a special interest group under the umbrella of the AYACC (Adolescent and Young Adult Cancer Coalition). Our goal has been to present, publish and educate on AYAs, while highlighting the unique role advanced practice providers can play in the care of this special population.

P11
IMPROVING ACCESS TO CARE: AN ADVANCED PRACTICE PROVIDER (APP)-LED CANCER DIAGNOSTIC CLINIC
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Coordination of Care
According to the American Cancer Society, there were a projected 1.9 million new cancer diagnoses in the United States. In 2022, there were over 600,000 (projected) cancer-related deaths. Cancer is the 2nd most common cause of death in the United States. Barriers to diagnosis include access to care, healthcare bias, and significant delays in care. Care delays can be influenced by numerous issues such as time from diagnosis to referral to an oncology appointment. This process can take weeks to months and often requires evidence of a tissue diagnosis. The COVID-19 pandemic negatively impacted cancer screenings, resulting in delayed diagnosis and treatment. The impact of COVID-19 on cancer survival, particularly among vulnerable populations, will be felt for the foreseeable future. There is evidence associating care delays with increased morbidity, mortality, and negative patient satisfaction with care. This project explores an intervention to serve the community by mitigating delays in care through a rapid access cancer diagnostic clinic that provides expedited evaluation of signs and symptoms suspicious for an underlying malignancy. In June 2020, a rapid access cancer diagnostic clinic model was implemented in a comprehensive cancer center. The clinic is led by oncology certified advanced practice providers (APP) and oncology nurses. The clinic provides same day diagnostic testing, collaboration with multidisciplinary providers across the health system and personalized follow up until the workup is complete. The clinic accepts referrals from internal and external providers and self-referrals from patients concerned their symptoms may be caused by cancer. Since its opening in June 2020, the rapid access cancer diagnostic center has seen over 1,800 new patients. The average lag time from referral to the initial cancer diagnostic center visit is 2-4 days. Innovative models such as a rapid access cancer diagnostic center provide a valuable opportunity for APPs.
to mitigate delays in care. Rapid access and diagnosis have implications for improved patient outcomes and satisfaction. Future directions include expanding the clinic to additional ambulatory sites, adding APP and RN staff, and improving internal turnaround time for scheduling, expediting imaging, biopsies, and referrals to disease-specific oncology treatment teams.

P12 IMPLEMENTATION OF PATIENT-REPORTED OUTCOME MEASURES HAS CONTRIBUTED TO COMPREHENSIVE CANCER CARE AT THE INSTITUTE OF ONCOLOGY LJUBLJANA, SLOVENIA

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Coordination of Care

Patient-Reported Outcome Measures (PROMs) are invaluable tools for identifying patient needs and improving the quality of care in cancer care settings. Patients often experience many symptoms during cancer treatment, some of which are not immediately apparent to healthcare professionals. The PROMs criteria provide a structured way for patients to report their symptoms and needs, allowing them to communicate more fully about their experiences. The coordinator cancer nurse plays an important role in systematically monitoring the patient’s psychophysical and social well-being and quality of life, enabling doctors and nurses to gain insight into patients’ needs and engage them in supportive care in a timely manner. The purpose of implementing PROMs is to improve the patient’s quality of life, alleviate symptoms and improve the general well-being of cancer patients at different stages of their journey. Interventions: PROMs data collected for patients accessing care at the Oncology Institute of Ljubljana will be retrospectively analysed from December 2022 to December 2023. Data will be collected using the standardized EORTC QLQ C30 questionnaire. The interpretation of the results will be a comparison between different types of cancer and demographic data. The results will be used to identify trends, significant differences or associations between variables and quality of life outcomes in different stages of patients’ journey. Perceived risks, barriers and facilitators of PROMS use will be presented. This study will demonstrate the benefits of using systematic PROMs monitoring and follow-up to screen patients’ needs and provide holistic approach for cancer patients. By regularly assessing patients’ self-reported data, healthcare teams can identify deteriorations or emerging issues earlier, allowing for timely interventions. It will also highlight opportunities, barriers and facilitators to PROMs implementation occur.

P13 TRACKING PATIENTS WITH METASTATIC PROSTATE CANCER FOR GENETIC TESTING: AN ONCOLOGY NURSE PRACTITIONER NAVIGATION PROJECT

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Coordination of Care

Evidenced based guidelines recommend somatic and germline testing for patients with metastatic prostate cancer. These provide guidance for risk assessment and promote a tailored prescription for treatment with targeted therapies. Lack of timely navigation that supports patients so that they complete somatic and germline testing can hinder both outcomes, as well as impede proactive preventative care for families. This quality assurance initiative evaluated the Oncology Nurse Practitioner Navigator (ONPN) effectiveness in the coordination of a mPC pretreatment genomic testing protocol and to increase genetic testing documentation in the patient’s medical record. This was a secondary analysis of two genetic databases and medical records for a sample of patients. Prior to and after the Oncology Nurse Practitioner Navigator (ONPN) coordinated genetic testing, data was analyzed for the number of patients with documented germline and somatic testing and documentation in patient medical records that confirmed testing, from July 1, 2022, through May 18, 2023. This VA quality assurance initiative established that before the ONPN care coordination, 197 patients needed germline and 250 needed somatic testing. Oncology nurses are responsible for ensuring that the care of our patients is evidenced based. This study demonstrated the effectiveness of an ONPN in organizing a streamlined approach for consolidating patient results and ensuring that patients obtain testing according to evidenced based standards. Additionally, it is important that documentation of results is centrally located. This study identified the templated note as one method of standardizing results for ease of view. This study outlined an initial protocol for practice that can be built upon through further research. It sets the groundwork for the development of a navigation tool that can be utilized for the organization of testing as well as a handy resource for expediting patient care. Further research is indicated as noted that will further refine the navigation tool.
LONG TERM FOLLOW UP POST ALLOGENEIC STEM CELL TRANSPLANT

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Survivorship

Follow up for allogeneic stem cell transplant is crucial for early detection and appropriate management of complications. Currently, it is estimated that there are 100,000 HSCT survivors nationwide. Survivors face considerable risk for long-term physical and psychosocial effects, such as cardiovascular diseases, pulmonary diseases, and anxiety. These effects can cause substantial morbidity, impair quality of life, and contribute to late mortality. Although, many late complications could be prevented or reduced if detected and treated early. The purpose of this project was to establish, implement, and evaluate an advance practice provider (APP) driven survivorship intervention for adult allogeneic transplant patients and assess the effects it will have on patients’ complication prevention and management. A template was developed based off of the ASTCT (2012) guidelines. The template was inserted into cellular therapy Advanced Practice Provider (APP) note template in the electronic medical record (EMR.). The APPs perform the screenings/test and utilize the note template to document and track recommended screenings and outcomes. Chart reviews were performed to review the results or findings of the preventative screenings performed. Patients’ diagnosis, conditioning regimen, were also tracked to help identify additional findings, outliers, or correlations. Feedback that standards are outdated. Physicians practice differences; two physicians primarily see their own patients in ambulatory. Based on internal discussions with some of the transplant physicians, expressed concern that certain recommendations may not be current practice. Did not note many PFT/EKGs being done. Need consistency with tool being completed to identify interventions performed. The utilization of the guideline note template demonstrated a positive transition handoff process for patients from the Day Hospital to the infusion clinic. There is not a consensus among physicians that our practice should follow the 2012 guidelines as outdated. There were also many patient variables that excluded the patient for a specific time point screening secondary to earlier than anticipated complications. It was also important to note that a BMT unit with cardiac monitoring would be beneficial to patient outcomes and experience. The success of this project will allow the APP role to be the lead in achieving patient survivorship in this population.

THE DEVELOPMENT OF A PRACTICE MODEL TO IDENTIFY UNMET HEALTH-RELATED SOCIAL NEEDS: ENHANCING THE PATIENT EXPERIENCE OF INDIVIDUALS DIAGNOSED WITH ADVANCED CANCER

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Psychosocial Dimensions of Care

Patients diagnosed with an advanced stage of cancer are living longer due to innovations in cancer therapies and increased access to supportive care resources. However, the lived patient experience may still be negatively impacted by factors outside the health care delivery model. Health-related social needs (HRSN) are the social conditions that contribute to disparities in cancer care and ultimately poor clinical outcomes. Patients living with advanced cancer are coping with the uncertainty of their diagnosis and the challenges associated with long-term cancer treatment. They may be unaware of the resources available to address their unmet social needs. The cancer care team at an academic medical center recognized the importance of looking beyond the status of disease as the primary indicator of patient well-being. A comprehensive method of screening allows the cancer care team to identify unmet HRSN that may be a source of significant distress for the patient and their caregivers. A screening process has been incorporated into the scheduled follow up to treatment and surveillance appointments. During the visit providers engage in a structured screening process that includes open-ended questions and the review of a brief patient survey completed prior to the visit. A list of common social factors that may impact quality of life serves as a guide for the discussion. Each visit is an opportunity to establish or maintain an open network of communication that prioritizes the needs of the patient and normalizes the discussion of patient and caregiver concerns with the cancer care team. The ultimate goal of this new screening process is to increase the recognition of HRSN in the advanced cancer patient population and provide timely referrals to resources within the health care system and the community. Early intervention allows patients to access the resources they need to overcome potential barriers that may limit their ability to participate in their established plan of care. Patients and caregivers will also be more likely to actively seek out assistance in the future as their HRSN change during their cancer experience.
care experience. The evaluation of the patient experience and HRSN can be utilized as a guide for quality improvement in the delivery of cancer care. Comprehensive screenings are key to enhance quality of life and promote long-term cancer survivorship in the advanced cancer patient population.

P16 EMERGENCY EVACUATION OF AN OUTPATIENT ONCOLOGY CENTER
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Professional Development

Any crisis or disaster can have a major impact on the normal operational function of a healthcare facility. Safety is threatened when disasters occur in any healthcare setting, and administrators have an obligation to be prepared to respond to those they serve. According to literature, cancer patients have unique needs due to their physical and emotional status, impaired immunologic and neurologic function, and complex treatment strategies necessitating alternative planning compared with well populations. With the increase in natural and manmade disasters worldwide, clinical providers must be equipped to deal with emergency events in their work environment. The objective of this study was to develop an outpatient emergency evacuation training program utilizing a combination of audiovisual and hands-on exercises to increase nursing staff knowledge of their role and enhance skills for disaster preparedness. A 12-minute webinar presentation was created and shown to a single free-standing outpatient oncology clinic. Approximately 75 employees attended the session, with a voluntary population of 52 nursing personnel who completed a pre-test and post-test survey. This was a quasi-experimental design with a non-randomized convenience sample. Results of the two-tailed Wilcoxon signed rank test were significant based on an alpha value of .05, \( V = 0.00, z = -5.75, p < .001 \), indicating that the differences between pre-test and post-test total scores are not likely due to random variation. Emergency management and disaster preparedness is a fundamental issue that all companies face. We live in an unpredictable world with increasing violence, varying weather patterns and more accidents that have forced workplace administrators to review response protocols. The occurrence of a disaster can be tragic, causing great loss to an organization in revenue, but more concerning is the impact on the ability to provide essential patient care. Disasters require organizations to have established plans but being able to effectively disseminate information remains a challenge.

A literature review demonstrates various programs and methods for skills drills and training techniques. This project combined the essential elements of multiple programs, and the webinar format proved to be an effective, flexible modality for educating staff and caused no interruption to providing essential patient care activities. The opportunity to participate in hands-on skills was greatly desired and successful. Staff verbalized increased understanding of emergency evacuation procedures and their role in site evacuation procedures after the completion of this program.

P17 IMPROVING HEALTH EDUCATION THROUGH A PATIENT-CLINICIAN PARTNERED INTERVENTION IN THE PATIENT WITH GENITOURINARY CANCER
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Patient Education and Safety

Health literacy is associated with health equity, acts as a cornerstone in optimizing patient care and is associated with improved quality of life. The objective of this project is to improve health literacy in patients with genitourinary cancer through a patient-clinician-partnered education intervention. Utilization of a targeted education program delivered in-person using voice instruction demonstrated the greatest significant effect on health-related quality of life; the additional of illustration and text further improved this metric. Optimal health related quality of life is associated with greater comprehension of disease and adherence to treatment plan, heightened self-efficacy, and improvement in patient-provider communication. The intervention is a patient-clinician-partnered written form used in conjunction with verbal instruction. The patient documents reasons for the visit and primary concerns to be addressed prior to the provider encounter during the visit. The “Action Plan” then records the treatment plan and next steps discussed during the visit. A “Confidence Ruler” acts as a visual representation of patient confidence in the plan of care, acting as a prompt to the provider to ensure adequate information transfer at conclusion of the visit. The patient then retains the written form highlighting the care discussion for reference and recall as needed. A five-point Likert test will measure change pre/post intervention; data will be analyzed in a cohort looking at improvement in overall mean. The HRQOL-14 and the CHLT-6 modified will be used to assess baseline health related quality of life and health literacy respectively followed by cohort analysis of the means to determine efficacy. The primary
outcome is to improve health literacy in all patients within a genitourinary oncology clinic population using a written tool in concurrence with verbal instruction with secondary focus on improving health-related quality of life in the same population. Health literacy must be assessed each visit to optimize patient care outcomes and quality of life. Targeted health education must be patient specific and titrated to individual health literacy needs.

P18
ADVANCES IN SOLID TUMOR TREATMENT AND MANAGEMENT FOR APP’S
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Oncology Nursing Practice
It is estimated that more than 18 million cancer survivors live in the United States today secondary to early detection of cancer and emerging treatments such as Selpercatinib (Retevmo). This novel agent selectively binds to and targets RET mutations and RET-containing fusion products, which interferes with cell growth and proliferation. On September 21, 2022, the Federal Drug Administration granted accelerated approval of Selpercatinib for adult patients with locally advanced or metastatic solid tumors (thyroid, colorectal, breast, lung, and salivary gland cancers) who have RET (re-ranged during transfection) fusion or mutation.

The purpose was to increase knowledge and management skills of APRNs to manage possible side effects of Selpercatinib treatment and to maximize the clinical benefits of patients in the community. Generally, twenty-five percent of patients on Selpercatinib will experience common adverse effects (AEs) such as edema, diarrhea, fatigue, dry mouth, hypertension, abdominal pain, constipation, rash, nausea, and headache. It is essential that APRNs have a basic knowledge of Selpercatinib and its mechanism of action in order to manage common AEs. Mild toxicities can be managed by dose reduction, treatment interruption or supplementary measures to enhance tolerability and improve patient’s quality of life. Treatment should be discontinued for unrelenting, severe, or life-threatening AEs with Selpercatinib. APRNs should be educated to manage patients on selective RET inhibitors in a wide range of solid tumors to prevent or treat possible AEs and to avoid compromising outcomes with treatment cessation. Given that there will be an increase usage of Selpercatinib across multiple tumor types it is important to disseminate the information regarding the management of these patients to APRNs whose role may involve monitor, recognizing, and managing AEs associated with Selpercatinib. Precision oncology in the treatment of RET-dependent cancer is evolving with promising outcomes with the development and approval of selective RET inhibitors and the APPs must be included in disseminating the information regarding the management of these patients and in the delivery of high-quality care. APRNs in the community can monitor the safety of patients being treated with selective RET inhibitors with early interventions to manage potential AEs.

P19
NURSE PRACTITIONER INTEGRATION IN A MULTIDISCIPLINARY TEAM CARING FOR PATIENTS WITH CANCER AND ADDICTION
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Professional Development
Little information exists on addressing substance use in people with cancer, although this has definitely increased over the past 5 years, with more attention focused on addiction in people with cancer. Several challenges exist in caring for this population in the outpatient setting. Historically, palliative medicine would not care for people with cancer-related pain and substance use. The Palliative Harm Reduction and Resilience (PHRR) clinic first started in 2020. This full day/half day clinic occurred weekly and included a physician, pharmacist and licensed chemical dependency counselor. As patient volumes increased, a palliative nurse practitioner joined the multidisciplinary team in 2022. Little has been published about the nurse practitioner role in an ambulatory palliative clinic working with patients who have cancer and addiction. The purpose was to describe the integration of a palliative nurse practitioner into a clinic specializing in palliative care for patients with cancer related pain and substance use. PHRR patients include a variety of cancer diagnoses, such as head and neck, GI, lung, gynecologic and breast. These patients may have active substance use, may be in recovery or are considered high risk. Patients are initially evaluated by the physician, this visit may also involve meeting with the pharmacist and a referral to the chemical dependency counselor. The PHRR nurse practitioner position is full time providing continuity for patients and staff. The nurse practitioner
independently completes follow up visits, assess and treats complex symptom management incorporating harm reduction strategies. The use of Buprenorphine products are typically used for opioid use disorder but can also be used effectively for cancer related pain. This role collaborates with other interdisciplinary team members including social work, oncology, addiction medicine, psychiatry and the inpatient palliative service. Palliative nurse practitioners can positively impact the outcomes for patients with cancer and substance use. However, not much literature exists when the diagnosis includes substance use. This model for the nurse practitioner presents a way of bridging this gap. The PHRR nurse practitioner provides comprehensive palliative care for patients with cancer who also have substance use disorder. Educational gaps identified early on, such as specialized addiction medicine and psychiatry knowledge, were met through personalized training, mentoring and relationship building. Little is known about role development and the outcomes that a PHRR nurse practitioner has on patients with cancer and substance use disorder.

**P20**

**A SHOT AT SAVING LIVES: VACCINES IN THE POST TRANSPLANT SETTING**

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**Survivorship**

The importance of vaccines in preventing disease and associated morbidity and mortality is well appreciated in the medical field. With the COVID-19 pandemic, the role of vaccines in preventing severe disease, particularly in vulnerable populations, has become even more clear. A key vulnerable population with regard to vaccine-preventable diseases are those who are immunocompromised. Yet, research on effectiveness of vaccine administration and response in these populations is lacking. Many centers do not have programs that allow for long-term survivorship care and follow up. Frequently, patients care becomes fragmented and difficult to track. Pneumococcus, measles, influenza, covid, and HPV are the start of preventable illnesses we could ensure our patients are vaccinated against. Immunosuppressed patients are at a high risk for vaccine preventable illnesses. This includes patients who have recently transplanted as well as undergoing chemotherapy and immunotherapy. Because these patients are seen by many specialists it is difficult to accurately track vaccine administration and immune reconstitution to assess readiness for vaccine administration. APP’s should be at the forefront vaccine administration. Over the past two years I have trialed several different ways to track vaccine administration and readiness. Communication amongst providers is at the forefront of importance, but utilizing one document that can be easily read by patients and providers is extremely important. Providing documentation about vaccines with education can also help patients who may be vaccine hesitant. Guidelines may not be in place for vaccines like COVID-19, RSV, and HPV. If there are no guidelines in place it is important that APP’s be up to date on the most recent updates and science behind administering these vaccines to immunocompromised patients. What has worked for our center? What has not worked? Have we had any patients lost to vaccine preventable illness? What is the most recent data on vaccine administration for newer vaccines? What kind of adverse events are we seeing related to these vaccines in immunocompromised patients? The APP must be at the forefront of vaccine administration and tracking. Putting into place a system that is easy to follow for providers and patients must be prioritized in order to ensure vaccine preventable illnesses are avoided in immunosuppressed patients. We must put into place standards for newer vaccines that are less studied but still as important.

**P21**

**IMPLEMENTATION OF THE DISTRESS THERMOMETER IN ONCOLOGY PATIENTS: EVIDENCE-BASED PRACTICE PROJECT**

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**Psychosocial Dimensions of Care**

During the journey of oncological treatment, patients experience various emotions, including distress. According to the National Comprehensive Cancer Network® (NCCN) definition, distress is “an unpleasant mental, physical, social, or spiritual experience. It can affect the way you think, feel, or act. Distress can make it harder to cope with cancer, its symptoms, or its treatment.” For individualized and patient-centered care, their needs must be assessed and met. Identifying
distress in oncology patients is a recommended best practice by national and international organizations. The purpose was to report the team’s experience in conducting and developing an evidence-based practice (EBP) project, based on the problem of the lack of objective assessment and management of distress in oncology patients. Methods: This is an experience report. The Johns Hopkins Nursing model was used to conduct the EBP project, which aims to support the clinical team through all phases of the EBP process, from formulating a question based on a practice problem to critically evaluating literature, making recommendations, and implementing them in practice. Results: The initial question was “What is the best available evidence in the literature for assessing distress in oncology patients?” A comprehensive literature review was conducted in the PubMed and CINAHL databases, as well as manual searches. A total of 74 full-text articles were retrieved, and 15 articles were included for final critical analysis. The Distress Thermometer was recommended for practice as part of the patient’s psychosocial assessment. The PDSA tool was used for testing with the aim of adjusting and improving implementation performance. The test involved applying it in practice to a small sample of patients. Based on the patient’s self-reported score, considering a cutoff score of 4 or higher, the nurse in charge of the EBP project referred the patient to the nurse navigator, and after clinical discussion, the patient was then referred for evaluation, intervention, and follow-up with the psychology team. Discussion: Actions based on the best available scientific evidence were recommended. Disseminating strategies used by healthcare institutions related to evidence-based practices is important to encourage other nurses. Evaluating individual distress through the Distress Thermometer can be considered yet another important patient-centered care strategy.

P22
LOOKING TOWARDS HOPE WHEN YOU HAVE A PREDISPOSITION TO CANCER
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Screening, Early Detection, and Genetic Risk
A NCI accredited institute in central New Jersey determined that there was a need to better serve patients with a predisposition to breast and gynecological cancers either due to family history or genetic mutation. Lifetime risk for breast cancer with the average woman is 1 in 8 or roughly 12.83%. The lifetime risk goes up when a person has certain risk factors such as one or more first degree relatives with breast cancer and previous breast biopsies with atypical cells. It can be determined who is at increased risk for breast cancer using algorithms such as Tyrer-Cuzick Risk Assessment Calculator. Gynecological cancers encompass many different types but two-uterine and ovarian can be linked with genetic predisposition. Ovarian cancer affects 11.5 per 100,000 women and uterine affects 26.82 per 100,000. A need was determined at our institute to better serve our patients by providing better screening, guidance and monitoring; thereby providing expedited prophylactic or cancer treatment to our patients. The high-risk program was set up using a collaborative approach- Oncologists, Surgeons, Plastic surgeons, Nurse practitioner with a cancer genetic risk assessment certification, genetic counselors, social workers, dietitian and research clinical nurses. Referrals are obtained from primary care and gynecologists, direct patient referrals and genetic counselors. Marketing along with community outreach was done to inform both the public and other providers regarding the importance of a high-risk clinic along with the availability. Patients calling through the oncology access center (OAC) are scheduled correctly utilizing a scheduling algorithm. Referrals from genetics are scheduled by their administrative assistant. We anticipate that provider and patient awareness of the importance of monitoring high risk individuals will increase. Earlier detection of cancer along with earlier treatment, provided efficiently. Improved education and communication. These interventions will be evaluated by patient survey. We hope to prove that a high-risk program promotes awareness of varying degrees of risk, allows for personalized risk determination, personalized treatment plans, furthers prevention with healthy lifestyle and diet, and increases community awareness of the need for better screening. A team approach allows for earlier detection and treatment with faster results. A high-risk clinic is appropriate for a well-trained oncology nurse practitioner to run under the guidance of a medical oncologist. Taking the burden off of busy surgeons and oncologists while still providing optimum care.

P23
CANCER CLINICAL TRIAL TUMOR BOARD – A METHOD TO INCREASE TRIAL ENROLLMENTS
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Coordination of Care
Clinical trials are pivotal for advancing cancer knowledge and therapies. Yet, limited awareness and
complex enrollment processes create barriers. Clinical trials provide advanced treatment options and drive cancer prevention, diagnosis, and treatment research. To tackle these challenges, a Louisiana health system established the Cancer Clinical Trial Tumor Board (CCTTB), embracing a multidisciplinary approach led by an oncology advanced practice registered nurse (APRN). The CCTTB was launched in July 2020 with a dual mission: to boost trial enrollments and offer second opinions for complex cases. Recognizing that the existing referral system hindered patient reviews for clinical trials, an integrated referral process was developed in March 2023. The aim was to centralize and simplify referrals, easing healthcare providers’ ability to refer patients for evaluation and ultimately increasing patient referrals and trial enrollments. The CCTTB convenes weekly to review patient cases for clinical trials. The integrated referral process embedded within the health system’s EMR allows any provider caring for a cancer patient to request a trial review. Referring providers input essential patient information, including diagnosis, stage, treatment history, performance status, and more, directly into the EMR. This data is reviewed daily by the APRN CCTTB coordinator and presented during CCTTB meetings. Before CCTTB (2017-2019), 233 patients participated in clinical trials. Following its establishment, enrollments surged by 158% over three years. The introduction of the integrated referral process in March 2023 further increased reviewed patients by 64%. CCTTB’s success is evident through its consistent increase in clinical trial enrollments. The integrated referral process demonstrated its efficacy by expanding the pool of potential trial candidates. This initiative highlights the pivotal role of oncology APRNs in facilitating the care of prospective research candidates and showcasing a promising avenue for improving cancer research and treatment.

P24 ENHANCING ONCOLOGY CLINICAL TRIAL COMPETENCIES: A PILOT PROGRAM FOR CLINICAL TRIAL ADVANCED PRACTICE PROVIDERS (CTAPP) AT AN ACADeMIC CANCER CENTER

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Professional Development

Oncology clinical trials are critical in advancing cancer care, and the contributions of Clinical Trial Advanced Practice Providers (CTAPPs) with specialized expertise are instrumental for their effective execution. However, a notable gap exists in structured education for CTAPPs, which is needed given the complexity and evolving nature of this role. This pilot program aimed to address the deficiency in clinical research education, focusing on CTAPPs with less than two years of experience in the role. This program aimed to equip CTAPPs with knowledge and skills necessary to actively participate in clinical research, contributing to the advancement of the oncology clinical trial landscape. The two-day program featured expert speakers covering nine core competencies such as scientific concepts and research designs, ethical and safety considerations, medicine development and regulations, trial operations and data management, vulnerable populations, and leadership and professional development. The program incorporated lectures, interactive sessions, case studies, and discussions. The program was evaluated through a program evaluation and a post-knowledge assessment. Feedback from the pilot program of nine participants, each with less than two years of experience, was overwhelmingly positive. They unanimously agreed (100%) that the program was informative, engaging, relevant to practice, and effectively met the objectives. Additionally, 89% strongly agreed or agreed that the program was well organized, with 11% undecided. Knowledge assessments revealed strengths and growth areas. The mean overall score was 10.1 out of 15 questions, with a standard deviation of 1.8 and a range of 8-13 correct answers. High-performing content categories were Study, Site & Data Management and Clinical Trial Operations. Questions using a “Select all that Apply” format posed challenges, particularly in statistics (with limited on-the-job exposure) and recent FDA guidance (without prior education). The program's success underscores its significance in equipping CTAPPs with specialized knowledge in oncology clinical trials at an academic cancer center. While attendance and completion rates indicate immediate impact, questions related to statistics and recent FDA guidance highlighted areas for improvement. Despite limitations, like a small sample size and end-of-day evaluations, the program demonstrated potential to enhance practice and stimulate interest in further education. The goal is to integrate this program into CTAPPs onboarding, ensuring newcomers receive essential education and training in oncology clinical trials. Continuous refinements will amplify its impact, ultimately benefiting oncology patients and advancing clinical research endeavors.
P25
ADVANCED PRACTICE PROVIDER MEDICAL ONCOLOGY MANAGEMENT OF THE HEAD AND NECK CANCER PATIENT AT A COMPREHENSIVE CANCER CENTER.
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Oncology Nursing Practice

The purpose was to describe the beneficial utilization of the Advanced Practice Nurse within the ambulatory infusion center. Head and Neck cancer is among the 7th most common cancer. It is estimated that 66,920 cases have been reported in the United States for 2023. The treatment of Head and Neck Cancer can involve single or multi-modality treatments involving individual or combined use of surgery, radiation and/or chemotherapy. The toxic side effects from these treatments makes this group of patients high risk for readmission. Purpose: To demonstrate a decrease in the Emergency Room visit rates in Head and Neck Cancer patient population when Medical Oncology APPs are utilized in the infusion setting. Surgical, medical and radiation oncology teams are utilized in the management of head and neck cancer care. Additionally, multi-disciplinary tumor board, dietitians, nurses, speech therapists, dental services, and social work collaboration help us provide a comprehensive approach. Medical Oncology APPs independently manage toxic effects from the bedside while patients receive infusions. Thus, aiding in acute management of CRT related toxicities decreasing the severity of toxic effects that could potentially cause admission to ER or hospital. Currently, our readmission rate is 10.8%. The hospital has set a goal for 12%. In a Canadian study in 2018, it was found that 28-55% of patients with Head and Neck SCC had at least one ER visit or unplanned hospitalization within a 90-day period of receiving treatment (regardless of treatment modality). In our infusion unit, Medical Oncology APPs see approximately 100 Head and Neck Cancer patients per week. Our readmission rates to ER within 30 days of receiving chemotherapy are one of the lowest among all oncology teams at The James, 10.8%. The medical oncology team also has one of the lowest readmission rates to the hospital. Independent APP management of treatment side effects at each infusion appointment can decrease readmission rates. Independent APP visits during patients’ infusion appointments allow APPs to function at their highest level of care in real time and in person and provide timely and quality care to patients.

CLINICAL PRACTICE

P26
PROSTATE CANCER
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Screening, Early Detection, and Genetic Risk

Bone health impairment is a recurring detrimental outcome of prostate cancer cells’ high bone tropism. The impairment is further exacerbated by administering androgen deprivation therapy (ADT), one of the current gold standards of care in treating advanced prostate cancer. Androgen deprivation therapy causes bone mineral density (BMD) loss, risk of osteopenia, and osteoporosis, leading to poor quality of life. Cancer treatment-induced bone loss is well known, but greater awareness of the risks and preventive measures is required. The aim is to improve providers’ adherence to bone health screening on prostate cancer patients receiving ADT in compliance with National Comprehensive Cancer Network (NCCN) guidelines, utilizing an electronic medical record (EMR) standardized order set for screening. This evaluated providers’ compliance with screening patients for bone health and patient knowledge about bone health as measured by the Osteoporosis Knowledge Assessment Questionnaire (OKAT). The pre-treatment bone health screening helped to identify at-risk patients for bone loss, osteopenia, and osteoporosis. Thirty high-risk prostate cancer men aged 50 to 90 participated in the project. A new bone health policy and patient education were developed. A standardized bone health screening order set was built and used to screen all high-risk prostate cancer patients for bone health prior to initiation of ADT. All providers and nurses were provided with an educational session on navigating the EMR order set. Lastly, the pre-and-post-osteoporosis knowledge questionnaire was provided to eligible patients to test their osteoporosis knowledge. System-generated data revealed that 30 out of 30 patients (100%) were screened for bone health utilizing the standardized bone health order set post-implementation compared to one out of 30.
patients’ pre-implementation (3%). 30 out of 30 charts reviewed post-implementation have documentation of bone health screening ordered. Patient knowledge of osteoporosis with the use of questionnaires increased from 8.4 to 13.6 questions answered correctly post-implementation, overall increase of an average of 5.2. The use of a standardized order set to screen high-risk prostate cancer patients for bone health before initiating ADT proved effective. All ACPs and other providers are required to perform bone health screening before ADT treatment. This increased compliance with the NCCN standard of care and best clinical practice for high-risk prostate cancer patients. Bone health screening prevents bone disease and increases the quality of life for the already vulnerable patient population.

P27 INFUSION UNIT NURSES’ RATINGS OF RISK FACTORS FOR DIFFICULT INTRAVENOUS ACCESS (DIVA) DIFFER BASED ON PATIENTS’ TYPE OF CANCER
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Oncology Nursing Practice

Multiple times a day, oncology nurses who work in infusion units need to recognize which patients are at increased risk for difficult intravenous access (DIVA). However, little is known about oncology nurses’ ratings of patient characteristics (i.e., risk factors) that predict DIVA. In addition, no studies have reported on whether the patients’ cancer diagnosis (i.e., hematologic versus solid tumor) influences nurses’ ratings of risk factors for DIVA. The purpose was to evaluate for differences in nurses’ ratings of risk factors for DIVA between patients with hematologic malignancies versus solid tumors. A total of 152 nurses, who cared for patients with hematologic malignancies and solid tumors were reported a higher first attempt intravenous insertion success rate. Of the 53 risk factors, compared to nurses who cared for patients with solid tumors, those who cared for patients with hematologic malignancies were older and reported a higher first attempt intravenous insertion success rate. Of the 53 risk factors, compared to nurses who cared for patients with solid tumors, those who cared for patients with hematologic malignancies rated four risk factors as more predictive of DIVA, namely: patient is overweight, patient is obese, patient exhibits psychomotor agitation, patient has a needle phobia or generalized anxiety. Patient receiving an anticoagulant was rated as less predictive of difficult venous access by the nurses who cared for patients with hematologic malignancies. Study is the first to describe differences in nurses’ perceptions of risk factors for DIVA based on the patients’ type of cancer.

P28 MINI SATELLITE INFUSION UNIT
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Oncology Nursing Practice

Breast cancer clinic not utilized adequately due to lack of nurses competence, specifically in chemotherapy administration, CVC management and the other procedural and treatment requirements. Thus, whenever patients need any sort of treatment, they are referred to the infusion center or the emergency room to get their prescribed treatment. As the infusion unit and/or the emergency room are always fully occupied, our patients have to wait a longer time until being called for treatment. The purpose was to decrease waiting time of cancer patients who require treatment or central venous catheter management by utilizing the procedure room in the breast cancer clinic. Thus, we asked the following question to guide our project process. “Will cross training of oncology clinic nurses help in better utilization of the ambulatory procedure room and decrease the waiting time of cancer patients in the
ambulatory setting?” The unit manager met with the unit instructor and the head nurse of the infusion unit and discussed the situation. After reviewing the literature, there was no conclusive best practice regarding the planned project, then the team decided to conduct a quality improvement project. Thirteen clinical nurses cross-trained in the infusion unit for twelve weeks in total. Each staff nurse went for two days and work with a preceptor from the infusion unit. The clinical nurse had an opportunity to refresh their skills and then were checked-off by their unit instructor. Thirteen staff nurses were cross-trained in the infusion unit with preceptor guidance and supervised by their instructor. Chemotherapy administration, blood transfusion, usage of smart pump, cannulation, and central venous catheter including Porta-Cath management were the core competencies that nurses were trained on. After completing the cross training, the treatment room in the breast cancer unit opened and staffed with two nurses. Set of accepting criteria were agreed up on with the medical team (Table#1). Equipping the outpatient clinic nurses with the necessary skills and knowledge impacted gratefully on patients and nurses satisfaction as well as it decreased the patient’s waiting time.

P29
IMPROVING NURSING DOCUMENTATION OF INTAKE AND OUTPUT IN ONCOLOGY PATIENTS UTILIZING VISUAL AIDS, CHART AUDITS, AND TARGETED STAFF EDUCATION

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Oncology Nursing Practice

Accurate fluid monitoring in patients on a hematology oncology unit has been an integral part of care to ensure fluid balance and to monitor for renal or cardiac function. Inaccurate documentation can impact fluid balance related interventions leading to unnecessary fluid repletion or cause delays in treatment of fluid overload. Overhydration can cause complications in patients receiving chemotherapy, patients with heart failure, or kidney disease. Poor documentation can then cause delays in treatment. On the other hand, failure to document negative fluid balance can delay the treatment of dehydration which can result in unnecessary complications or lead to extended hospitalization. Proper and accurate documentation of intake and output is highly reliant on staff accuracy and compliance. There are many staff perceived or actual barriers preventing consistent documentation of intake/output in the EHR of hospitalized patients on the 26 bed hematology oncology unit. Audits performed allowed for identification of areas that needed improvement including frequently missed areas of documentation, which in turn allowed for more focused staff education. Charts were given a ‘pass’ or ‘fail’ based on documentation of oral intake, IV fluid intake, and documentation of voided output. Prior to intervention, 37% of charts audited received a ‘pass.’ In order to improve accurate documentation rates, first an educational presentation was provided by an oncology nurse practitioner, then one on one education was provided to nurses and nurse assistants. In addition, visual cues for documentation reminders were posted throughout the unit. Visual aids posted throughout the unit included fluid values for commonly consumed products such as a water bottle, juice box, or bowl of soup. The charge and resource nurses for each shift were then tasked with providing reminders on documentation to staff and chart reviews were performed at the end of each shift to ensure compliance. A chart review was performed 12 weeks post education resulting in 68.7% of charts receiving a pass, a 31.7% increase in documentation of intake and output compared to the pre-education chart review. Findings demonstrate that education of the importance of maintaining proper fluid balance was crucial for staff compliance. Visual aids served as reminders for staff to document and proved to be a cost effective educational tool.

P30
A MULTIDISCIPLINARY APPROACH TO NURSING MANAGEMENT OF HYPERSENSITIVITY REACTIONS: PRACTICE AND GUIDELINE UPDATE

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Oncology Nursing Practice

Immunotherapy agents are an important component of treatment with oncology patients often receiving them on phase I studies. A high incidence of infusion reactions occurs in patients receiving novel immunotherapy agents and steroid use is often
contraindicated. At this National Cancer Institute designated cancer center, agents associated with infusion/hypersensitivity reactions have orders with emergency medications embedded in the treatment plan, allowing the nurse to treat symptoms as they arise based on an algorithm. It was identified through the institution’s error reporting system that methylprednisolone was being utilized in the management of these reactions. This presentation will describe the development, standardization, and implementation of updated hypersensitivity guidelines for both adult and pediatric patients receiving chemotherapy/biotherapy in the outpatient and inpatient setting. This guideline includes an algorithm for the nursing staff to follow when a patient is suspected of having a reaction. A multidisciplinary team of nurses, clinical nurse specialists, an oncologist, allergist, and pharmacists convened to revise and update the current hypersensitivity guidelines and algorithm. Changes included clear criterion on using epinephrine for anaphylaxis, criterion on when to use methylprednisolone, avoiding its use during immunotherapy reactions, and drawing a serum tryptase to confirm anaphylaxis. Once changes were finalized, institution-wide education was developed and implemented using didactic lectures, case studies, and simulations for the infusion nurses across all settings. Updates were made to electronic orders, guidelines and policies. Lastly, a supplemental online module was developed to educate all nursing staff about anaphylaxis. Data was collected at baseline prior to implementation.

After implementation, there was an increase of 28% in epinephrine use, a 14% decrease in methylprednisolone use, and a 16% increase in obtaining serum tryptase levels. Hypersensitivity reactions can be severe and life-threatening, rapid interventions are necessary to manage these. With education and support, nurses can initiate management and have a significant impact on the care of these patients. Nurses should feel empowered and safe to manage these types of events. Creating and standardizing guidelines can be instituted in any oncology setting to give nurses autonomy and clear criteria for management. Collaboration with the multidisciplinary team is key to ensuring safe and current treatment of hypersensitivity reactions.

As more chemotherapy is being administered in the outpatient setting, there are fewer opportunities for inpatient chemotherapy nurses to maintain high levels of competence within their practice. With the traditional didactic chemotherapy course, transitioning to a self-paced online course, facilities need to assure that staff maintain a high level of competence with a diminishing inpatient chemotherapy experience. To standardize the care across the hospital, all day shift chemotherapy trained RNs would be assigned an 8-hours shift in the outpatient cancer center once a quarter. Each nurse was assigned on a Monday to allow for ease in planning. This allowed for a more unified experience for the chemotherapy nurses and allowed for real-time hands-on approach to education. Each quarter they would focus on a different topic that was identified as a low volume high risk concern ( Extravasation, Hypersensitivity, Spill Management and Charting/Teaching). Each Monday the nurse was met by either the oncology director or an experienced nurse navigator/educator to look at their patient assignment and review a protocol regimen, review math checks, and to look at their education topic for the quarter. Staff were asked to answer questions, show where charting occurs, and locate policy and procedures. When applicable hands-on practice was available. Paper resources were provided each quarter for staff to use if needed when giving chemotherapy on the inpatient unit. Time was allotted for 30-45 minutes for the education to occur, before their first patient arrived. Topics rotated so not every nurse completed the same education that quarter. The nurse mentor was able to identify areas that staff commonly questioned or struggled to answer. The post survey showed that the nurses are more confident in managing the topics reviewed. The additional question on the post survey that asked what information was new to them today and what they would like to focus on the next time has been helpful. We have identified common themes that the nurses want to learn more about including labs, clinical trials, and disease progression treatment management. A few nurses were hesitant with the rotation plan. They have voiced that it has helped them feel more comfortable with inpatient chemotherapy administration. The plan is to keep the same process next year. We have also started working with night shift nurses on a yearly rotation.

P31 QUARTERLY ROTATION FOR INPATIENT NURSES TO THE INFUSION CENTER
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Oncology Nursing Practice

P32 OPTIMIZING AMBULATORY NURSE TRIAGE FOR CLASSICAL HEMATOLOGY PATIENTS
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Coordination of Care

Classical Hematology (CH) patients comprise a substantial portion of the ambulatory population at our academic institution. CH is an umbrella term used to describe hematologic conditions that are non-malignant. Immune thrombocytopenia, venous thromboembolism, Von Willebrand disease and varying types of anemia are a few of the diagnoses that make up this complex patient demographic. In order to properly monitor counts and stability of disease, CH patients require frequent blood draws in between clinic visits and as needed based on symptomatology. Standing lab orders frequently expire without patient or provider knowledge, causing a delay in care and an increase in patient dissatisfaction. The nurse is currently unable to facilitate prompt lab order placement without MD signature. Given the acuity, volume, and variation in patient care needs, the purpose of this project was to improve the nurse triage process for CH patients in the ambulatory setting and to facilitate work up and timely patient assessment and treatment. Nine of the most common CH conditions were identified. Standing order sets were then created for each condition in collaboration with an attending physician and supporting literature. Each order set is supported by at least two peer reviewed articles and includes the most relevant lab orders needed to appropriately triage and treat CH patients diagnosed with one of the nine included conditions. Each standing order set includes a pre-selected diagnosis code to avoid processing errors. These standing order sets are intended for RN use during the triage process and would become immediately available for patient use once entered. The project was presented to both nursing and MD leadership in July 2023 and feedback was very positive overall. Presently, the CH standing order sets have received final approval. The plan is to first trial them in our main CH ambulatory site for 12 weeks to ensure efficacy and to identify any potential concerns. Focused education sessions to the remaining 14 ambulatory sites will follow. CH standing orders were created in response to a recognized gap in workflow. Staff and leadership agreed that the process of real-time lab order entry is in need of improvement across our ambulatory sites. Implementing the CH standing order sets system-wide would promote consistency in practice while allowing RN’s to work at the top of their licensure.

P33

CRUSIN’ THROUGH NAVIGATION WITH A NEW LIFELINE

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Coordination of Care

The growing incidence of cancer created a need for oncology nurse navigators (ONN) to assist patients in navigating through multidisciplinary specialties for timely access to care. An increasing volume of patients to track poses challenges to efficient navigation and identifies the need for tools to standardize and centralize data collection for improved care coordination across all disease-oriented teams (DOTs). The purpose was to share one institution’s approach to creating a centralized data tool to streamline care coordination. With Epic’s collaboration, the ONN has an “Onc RN Navigation” tab in the EMR where an “Episode” is created and titled with the cancer diagnosis. The Episode is a pivotal component as it stores pertinent information which leads to navigation activities. This central location contains an ONN flowsheet, social determinants of health, patient goals, oncology history, treatment summaries, time spent navigating, MyChart messaging, and a task list with the capability of setting due dates for reminders. Task examples are obtaining outside records, ONN follow-up, social referrals, review research studies, treatment plan, and patient education, to name a few. The ONN flowsheet and MyChart messaging capability is exclusive to an active Encounter while the other components can be documented anytime. The flowsheet choices adapt with the patient along their journey from diagnosis through survivorship to end-of-life. The ability for the ONN to access information from a central location while assisting patients through the cancer continuum has filled the gap by streamlining collection of valuable information for the ONN such as documentation, data collection, task reminders etc, no matter the DOT. ONNs have found this tool to be very helpful while adapting it into their daily workflow, increasing efficiency of their time while completing navigation tasks. Some ONNs identified the need to have the ability to customize tasks based on their DOT needs. Confusion was expressed when the patient had multiple “Episodes” such as “Palliative Care” and “Pancreatic Cancer”, where navigation tasks overlapped. Management can use this tool to collect data on various metrics to improve care coordination, track productivity and identify any gaps. This tool continues to be a work in progress as we adapt and refine it.
P34
INSTITUTING A HIGH RISK SCREENING AND FOLLOW UP PROGRAM IN A MULTI-SITE ONCOLOGY PRACTICE
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Oncology Nursing Practice
Work involving geriatric assessment and interventions has demonstrated that the use of an assessment tool with intervention based on identified needs decreases the incidence of grade 3/4 chemotherapy related toxicities. No significant decreases in hospitalizations or re-hospitalizations were described. Researchers noted that the use of risk assessments and interventions resulted in an increased number of advanced directives being completed. High risk screening can be performed by nurses with follow up symptom/side effect management falling within the scope of nursing practice. To provide proactive identification, documentation and intervention for the at-risk population, meeting the program goals of decreasing ED visits, identification of individuals requiring supportive/palliative care, advanced care planning and goals of care discussions. Other goals include decreasing the percentage of individuals who die while receiving cancer directed therapies within the last fourteen days of life and increasing hospice length of stay to greater than three days. Nursing leaders from three sites met with the CNO to develop this nurse guided program. A tool was identified, and with physician input, we developed an adapted version of the G-8 Questionnaire using Oncology specific measures such as complexity of chemotherapy regimen, number of co-morbidities, social support and hospitalizations as well as food intake, weight loss, mobility and age. The tool was entered into the electronic medical record and scoring is reflected on the treatment plan. We then identified appropriate points of risk evaluation/re-evaluation including treatment initiation, treatment change, disease progression, assessment changes and post hospitalization. Risk follow up phone call frequency is based on the score, twice weekly for the high-risk group, weekly for those at moderate risk and monthly for low-risk patients. Services offered include social work, nutritional counseling, a physical therapy/exercise program and counseling regarding side effect/symptom management. Chart reviews are used to assess compliance with the performance of the risk assessments and documentation of follow-up interventions on the Risk Follow Up Form. Nursing is documenting the at-risk population targeting interventions designed to decrease toxicities of treatment, though it is too early to tell whether we will be able to decrease ED visits. We are incorporating Advanced Care Planning into all interventions. The development of the Risk Stratification and Advanced Care Planning programs in Oncology Private Practice demonstrates an arena for innovation and nursing excellence.

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ADMINISTRATION OF TECLISTAMAB SHORTLY AFTER FOOD AND DRUG ADMINISTRATION APPROVAL IN A COMMUNITY HOSPITAL SYSTEM
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Treatment Modalities
Since 2022, the Food and Drug Administration (FDA) has approved six Bispecific T-Cell Engagers (BiTEs) for hematological malignancies. These BiTEs vary in indications, mechanisms of action, administration methods, side effects, and participation in Risk Evaluation and Mitigation Strategies (REMs) programs. In a regional community healthcare system, three designated sites, including an acute-care facility and a clinic, were chosen to introduce these medications. Notably, Teclistamab was the first BiTE introduced since prior use of Blinatumomab. The aim was to ensure the standardization and safe administration of Teclistamab at the selected institutions, encompassing both acute-care and clinic settings. Secondary objectives included tracking the time from the onset of cytokine release syndrome (CRS) and/or immune effector-cell-associated neurotoxicity (ICANS) to protocol intervention. The interventions were comprehensive and interdisciplinary. Initially, literature was reviewed to assess best practices with BiTEs administrations. Once a plan was in place, other interventions included collaborating with pharmacy partners to ensure REMs certification for all necessary staff. Hematologist-oncologists contributed to protocol development for managing CRS and ICANS. Educational programs were created to educate nurses across the continuum of care. Standardization of patient follow-up was assured utilizing a smart-phrase, in the electronic medical record, and through
the role of the advanced practice providers (APPs) in clinics. Continuity was prioritized to facilitate patient transitions between care settings with the assistance of case managers. To date, Tocilizumab has been administered to five patients across the three institutions. Among these, two patients experienced Grade 1 CRS, with a timely administration of Tocilizumab within 90 minutes. One patient experienced Grade 1 ICANS, with administration of Levetiracetam within 120 minutes. As the approval of BiTEs for hematological malignancies expands and their use extends to solid tumors, standardized and collaborative practices are essential for safe patient administration and monitoring. The various interventions allowed for seamless communication between physicians, pharmacy, nursing, APPs, and the pharmaceutical company for REMS needed side-effect reporting. In this initiative, three community institutions within a regional center successfully collaborated on education, protocol development, and implementation. This collaborative model serves as a valuable template for future BiTE administration in community healthcare settings.

ART VIEW:

P36
ART JOURNEY: TRANSFORMING CHALLENGES INTO HEALING EXPERIENCES FROM A PATIENT’S POINT OF VIEW.
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Psychosocial Dimensions of Care

Art therapy has proven to be a valuable form of supportive therapy for adult and pediatric patients facing the challenges of leukemia or lymphoma diagnosis, treatment, and recovery. This presentation explores the inspiring journey of a patient who leveraged her artistic talents to transform difficult situations into positive and healing experiences. This project seeks to highlight the remarkable story of a patient who used her artistic talents to navigate the complexities of leukemia and lymphoma treatment. Her purpose is threefold: (a) Inspirational Sharing: The patient wishes to share her artistic creations, which whimsically convert challenging situations into positive and healing experiences historically via mandalas, and whimsically; (b) Motivational: By sharing her journey and artwork, the patient aims to inspire fellow patients, to explore their own artistic capabilities as a means of coping and self-expression; (c) Hospital-Wide Impact: The artist has consent for her artwork to be used within the hospital and for professional organizations. The artwork will be integrated into various initiatives to promote art therapy within the Adult and Pediatric Cancer Services: (a) Album for Patients: An album will allow patients to select a drawing to be placed on their hospital room door to serve as a source of inspiration and hope for patients undergoing treatment; (b) Hospital Art Show and Artist Interview/video: In the planning phase: a hospital-based art show coinciding with cancer awareness months in 2024. This exhibit will showcase the patient’s artwork along with the stories behind each piece. This video will be accessible to patients and healthcare providers, providing insight into the therapeutic benefits of art therapy. The artist’s whimsical work and positive intentions have encouraged other patients to use art and are requesting selected pieces for their hospital rooms.

This program highlights the transformative power of art therapy in the context of leukemia and lymphoma treatment. The patient’s artistic journey, characterized by her use of the mandala art technique and personal imagery, serves as an inspirational example of how creativity can be harnessed to navigate challenging medical experiences.

P37
INNOVATIVE NURSING INTERVENTIONS IN CHALLENGING SKIN CONDITIONS
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Oncology Nursing Practice

Advancements in medication and diagnostic techniques have introduced new challenges in wound care, particularly concerning skin injuries and exacerbating skin conditions. In these cases, the role of nurses becomes crucial in finding innovative and ingenious solutions to address these complex issues effectively. The purpose is to showcase the creative problem-solving skills of a Registered Nurse (RN) who devised inventive solutions to manage challenging skin conditions. This article presents two case studies, highlighting the RN’s engineering ingenuity and resourcefulness in delivering patient-centered care. Case Study 1: The resourceful RN devised a solution by utilizing a multipurpose tubular retainer net. They ingeniously designed and crafted a custom vest to securely hold the central venous catheter dressing in place. This innovative approach not only prevented the dressing from shifting but also reduced friction and potential skin damage, contributing to the patient’s overall comfort and healing. Case Study 2: Anasarca and Lymph Node Dissection Wound. Case number 2 features a patient who developed anasarca, a condition characterized by severe generalized edema,
in addition to a complicated wound resulting from a lymph node dissection. This wound exhibited excessive weeping and hematoma formation, posing significant challenges in wound management, and dressing stabilization. Drawing upon her engineering ingenuity, the RN tackled this complex scenario by devising a creative solution. She developed a specialized wound management strategy that combined innovative dressing materials and a tailored compression technique. This approach effectively controlled the weeping and hematoma, facilitating wound healing and mitigating complications associated with anasarca. Both patients did not have any further wound exacerbation based on skin dressing injuries. Both designs we easy for RN colleagues to replicate for these patients. These case studies demonstrate the invaluable role of nursing professionals in adapting and inventing solutions to meet the unique challenges posed by evolving medical conditions and treatments. The RN’s engineering ingenuity, as showcased in these interventions, underscores the importance of fostering creativity and resourcefulness within the healthcare community. By sharing such innovative practices, healthcare providers can inspire others to think outside the box and ultimately enhance patient outcomes in the face of complex skin conditions and wound management challenges.

P38
NEUTROPENIA, CLABSI PREVENTION AND FOOD SAFETY: PATIENT AND FAMILY EDUCATION
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Patient Education and Safety

In the community setting, neutropenic diets are no longer standard practice for neutropenic patient. At present, current literature reviews do not produce results recommending dietary precautions. However, there are requests for information on dietary precautions when a patient is undergoing cancer treatments. Research centers have developed neutropenic or low microbial-bacteria diet guidelines for a very narrow group of patients in the Bone Marrow Transplant arena. Recently, a patient had CLABSI and the involved bacteria was Bacillus Cereus that is often associated with outside diets with left over rice. During the CLABSI root cause analysis, it was found that the patient’s friend brought in food with left over rice that she ate. Consequently, this has led to the concept of food safety education. Collaborating with the oncology registered dietician and infection prevention consult, a standardized education tool was developed for staff and patients that addresses the following:

- Foods that are allowed and those to be avoided in the following food groups: breads and grains; milk and dairy products; meat, chicken, port, fish, and substitutes; fruits and vegetables; beverages and drinks; condiments; desserts
- Ordering food in
- Leftovers
- Food preparation
- Safe internal heating temperatures
- Food storage tips

Neutropenia, CLABSI Prevention and Food Safety was tested on patients and staff, and content was revised and/or added. The materials are now added to new patient admissions materials along with the ACS Nutrition Guide and to the new hire unit onboarding. This is also provided for patients with central venous catheters. The patient survey indicates that it is well-received and very practical. Staff indicate that it is very useful especially when patient’s food has been sitting for hours or days in their rooms. This topic is ever-evolving especially with the complexity of patient’s medical status and the use of central lines. Perhaps there needs to be a food safety component added to CLABSI prevention bundles.

P39
CHEMOTHERAPY NAVIGATION FROM ADMISSION TO DISCHARGE BY UNIT-BASED RNS IN A COMMUNITY HOSPITAL ACUTE CARE SETTING: AN RN IV AND III PROJECT
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Oncology Nursing Practice

In the 2020’s, the concept of population-specific navigations gained immense popularity, leading to the establishment of practice standards, competencies, certifications, and defined job descriptions. Initially, navigators were primarily associated with the ambulatory settings, but their role has extended into the acute care settings. Surprisingly, there is a lack of literature addressing the concept of an acute care nursing team guiding patients through the entire chemotherapy administration process, spanning preadmission, admission, hospitalization, and discharge. This intricate journey is a collaborative effort involving medicine, pharmacy, dietary, social services, Palliative Care, Advanced practitioners (eg. NP, CNS), Case managers,
P40
ADOPTING PHOT DOCUMENTATION TO THE CLABSI PREVENTION BUNDLE: A NOVEL CONCEPT IN BENCHMARKING
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Oncology Nursing Practice

In 2019, an analysis of nine CLABSIs was performed. CLABSI best practices were in place starting in 2016 and the biopatch was added in 2019. Nursing documentation chart review, found that insertion site assessments were performed per policy. Bedside rounding provided further understanding that the actual nursing assessment was limited due to the dressing and biopatch obscuring the insertion. The Intravenous Nursing Society assessment standards described the necessity for daily visual assessments. Additionally, oncology patients transferred from multiple locations (e.g. home, clinic, other facilities, etc.) There was a significant difference in the quality of the dressing. However, in every situation, standard documentation of “Within normal limits” did not capture the true site assessment. The benchmarking technique was identified photodocumentation to document the inconsistencies of dressing compliance, and then, the status of the insertion site. Historically, nursing considered the CVC insertion site a puncture, not a wound. The actual placement technique results in the presence of a wound. Unlike the Wound and Ostomy Guidelines that have scoring and assessment tools for skin wounds, this is missing from the vascular access literature. Of note, the assessment uses subjective descriptors (e.g. swelling, erythema). In the absence of such tools, and scoring standardization, photo documentation seems to be an obvious option for benchmarking and assisting in CLABSI prevention. The purpose of this presentation is to show how the integration of photodocumentation into the CLABSI prevention bundle provides consistency in insertion site assessment and benchmarking to improve patient outcomes. A 2-step process was identified using an iPhone with eMR software access and uploading capabilities. Step one, photograph the dressing on admission, and Step 2, with dressing removal, allows for insertion site visualization. Rolled out in huddles, Oncology Skills cinematation to document the inconsistencies of dressing and standardization, benchmarking and assisting in CLABSI prevention. The success of our navigation process hinges on the stability of our oncology staffing and leadership. Since 2020, we have encountered a significant turnover of staff and management, which has presented unique challenges to sustaining the vital process.

P41
ONCOLOGY DISCHARGE COORDINATION
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Symptom Management and Palliative Care
Significance and Background:
- High readmission rates and ED utilization for cancer patients on active treatment.
Oncology patients transitioning from inpatient to outpatient settings need Transition of Care (ToC) interventions to reduce the risk of complications. Decreasing the length of time between discharge and follow-up appointment is an essential component to this transition.

**Purpose:**
- Develop workflows to ensure continuity of care between inpatient, ambulatory, and other care settings, thus decreasing ED visits and readmissions.

**Interventions:**
- Development of Discharge Coordinator workflows with the GI Med Onc pilot team, Triage RNs, and leadership.
- Development of Epic order and Tip Sheets for referral to Oncology Transitions of Care (OToC) work queue in collaboration with hospitalists and ED physicians, leadership, IS, and Discharge Coordination project team.
- Development of Epic report identifying established oncology patients (seen by cancer services faculty in last 6 months) from hospital or ED in last 2 days.

**Pilot launch:**
- Triage RN, using scripted workflow, contacts patient to review discharge instructions and schedule an appointment for them within 7 days.
- During this call, Triage RN assesses the patient’s understanding of each of the following topics and uses the teach-back method to educate/reinforce: discharge diagnosis, post-discharge instructions, medication reconciliation, including pick up, utilization of meds and/or any barriers, equipment or supplies at discharge, including patient knowledge of how to obtain more if needed, home health services established.
- Wellbeing and Symptom Management: symptoms since discharge, worries or concerns, able to verbalize how they will follow up if any issues arise, including how to contact oncology team during business hours or after hours.
- Follow up appointment with oncology team (MD or APP):
  - If patient has existing appointment within 7 day window, any barriers to attending?
  - If patient does not have appointment, Triage RN schedules an appointment for them with review of date and time.
- Anything else the patient would like to communicate with the team?

**Evaluation:**
- Decrease in ED visits and readmissions decreased for pilot and control GI Med Onc providers.
- Decrease in days from discharge to outpatient clinic visit for pilot providers.

**Discussion:**
- Expansion of Discharge Coordination workflows to all medical oncology teams planned for October 2023 with continued tracking of metrics.

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**P42 ONCOLOGY CLINIC RN PRACTICE AND DOCUMENTATION STANDARDS DEVELOPMENT**

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**Oncology Nursing Practice**

**Significance and Background:**
- Rapid team growth across multiple sites and lack of a dedicated clinical nurse educator since 2020 led to significant drift in oncology clinic RN competence and consistency in documentation of nursing practice, including critical screenings, assessment, interventions, and outcomes.
- Variation in RN practice and documentation standards create significant risks for patient safety and healthcare team communication.

**Purpose:**
- Establish nursing practice and documentation standards for all new and return patient visits to improve continuity of care, decrease patient safety risk, and enhance healthcare team communication.

**Interventions:**
- Multi-disciplinary team, led by clinical nurse educator and composed of clinic RNs, social work, registered dietitians, quality leadership, and IS.
- Conducted gap analysis across all sites.
- Review of existing oncology RN practice and documentation standards through ONS.
- Creation of standard note template (Epic smart phrase and smart text functionality) integrating essential practice components, including: fall risk, malnutrition risk, advance care planning, wellbeing screening, oral cancer-directed therapy, etc.
assessment including pain and symptoms/toxicities, plan of care, evaluation of care, patient/family education

- RN and healthcare team education on role of oncology clinic RN in care coordination, including background in national standards and best practices - key to change management
- Designation of super users for pilot and successive roll outs, with continuous improvement based on staff discussion and feedback, including ability to add additional assessment requirements based on disease site
- Integration into New Competency-Based Orientation and Annual Education updates
- Development of measures of success, including Epic compliance reports and manual review by nurse leaders and super users

**Evaluation:**

- Positive feedback from RNs and multi-disciplinary team overall
- Continuing to refine compliance reports to ensure accuracy for tracking/trending
- Individual coaching with RNs needing additional EMR assistance

**Discussion:**

- Dedicated clinical nurse educator with 1:1 and small group rounding for planning, implementation and feedback truly key to success
- Essential to focus on value and importance of oncology clinic RN and importance of consistent, evidence-based practice standards in guiding patient and family through care continuum, in collaboration with entire healthcare team

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**P43 EMBRACING AI: ASSESSING THE KNOWLEDGE AND COMFORT OF ONCOLOGY NURSING STUDENTS WITH ARTIFICIAL INTELLIGENCE**

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Patient Education and Safety

Artificial Intelligence (AI) has immense potential for transforming healthcare delivery, but its responsible use is crucial. To investigate this, we assessed the knowledge and comfort of oncology nursing students with AI. Despite its widespread use in other healthcare fields, AI has been underutilized in nursing. The objective of this project was to bridge the knowledge gap and potential apprehension among oncology nursing students concerning AI by incorporating it into a course curriculum. We sought to establish their baseline understanding of AI resources, with the goal of enhancing it, preparing them for the modern medical landscape, and fostering innovation in nursing practice. For the intervention, 35 students in an introductory oncology nursing course were given the educational intervention and assigned an AI-related project that used a “Persona” prompt created by course instructor. “Persona” prompts refer to cues or questions tailored to elicit specific character-based responses, guiding an AI in understanding a particular role. Students were instructed to use AI to generate information on an oncologic disease of their choice, and then compared the AI-generated data with information from scholarly sources by evaluating the accuracy, appropriateness of health literacy level, and comprehensiveness of the AI-generated information. Students completed a Qualtrics survey assessing their knowledge and attitudes about AI pre- and post- educational intervention. The study was exempted after review by the Institutional Review Board (IRB). Prior to our intervention, 73% of students had limited understanding of AI’s practical application in nursing. Following the intervention, we found an increase of the students had an increase in both knowledge and comfort levels. After the intervention, 93% of students had a positive change in perception of AI’s practical application in healthcare. Many students expressed that their initial apprehension had evolved into an interest in integrating AI into their future nursing practice. With AI poised to alter patient care, it is important to ensure that the next generation of nurses is well-acquainted with AI. Novel educational interventions like ours are needed to enhance nursing students’ skills and use of AI. Embracing AI early in nursing curricula may ensure that future nurses can harness AI’s full potential in enhancing patient care.

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**P44 RESEARCH TEAMS PURSuing BEST ONCOLOGY CARE IN EARLY PHASE CLINICAL TRIALS**

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Oncology Nursing Practice

In a large NCI designated Ambulatory Cancer Center a Phase I unit devoted to early phase clinical trials. Clinic volumes fluctuate as enrollment on early phase trials occurs. Medical providers which include 13 Investigators, and 5 nurses who serve an average of 40 patients across 17 active protocols. The Clinical Nurse Coordinator, (CNC) oversees the assessment of the patients (n=40) during pre-screening and administration of protocol. In an ongoing review of clinical processes unanticipated gaps in communication, patient education, physical assessment, symptom management and care transition facilitation were identified as opportunities to improve clinical trials implementation and patient care. The purpose was to establish standardized communication and practice activities to assure best research care and patient study outcomes. A collaborative team of medical investigators, nurse leadership, research coordinators (RC) and the CNCs did an assessment of Phase I program barriers. Communication across the interdisciplinary roles was identified as a crucial component in assuring consistency in the trajectory of relevant time points: consent, end of treatment and acute episodic event management for toxicity and disease evaluations. An expected and documented workflow for patient clinical communication for visits with CNC, medical providers, and RCs, was initiated. Workflow encompassing attendance of team (CNC, providers, RCs) has resulted in increased recognition of toxicities, early engagement in symptom management, improved patient satisfaction, and increased job satisfaction for staff. A primary metric in this work is increasing patient safety while participation in early phase studies provides potential opportunities for essential data in implementation of innovative therapies for cancer treatment. Early Phase clinical research is rapidly expanding endeavor and is pivotal to improving oncology patients’ outcomes. State of the science research mandates inclusive intentional staff participation with documented workflow interpreting and facilitating protocols, coordinating implications for patient enrollment and treatment with these new modalities.

P45

CENTRAL LINE, FAMILY EDUCATION EBP AND QI PROJECT LEADS TO DECREASE IN

CLABSI ON PEDIATRIC INPATIENT UNIT

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Oncology Nursing Practice

Background:
Central Line Associated Blood Stream Infections (CLABSI)
- Major source of hospital acquired infection in the pediatric population
- Prolongs hospital stay
- Increases morbidity
- Raises mortality by 12-25%
- Center for Disease Control (CDC) estimates attributable CLABSI cost $48,000/episode
- An estimated 250,000 bloodstream infections occur annually, and most are related to the presence of intravascular devices.

Significance:
- CLABSI rate on pediatric oncology unit 1.2/1000 Central Venous Catheters (CVC) days
- Among the pediatric patients on CHAM 9 with CVC’s, will providing education and central line swag bags, improve infection rates and lead to better patient outcomes?

Design/Methodology:
- Target Population: Pediatric patients on in-patient unit CHAM 9, with a CVC. (Broviac, porta-cath, PICC, Apheresis Power Flow Port, dialysis catheter)
- Measure: Rate of central line blood stream infection rate over time. Rate per one thousand central line days.

Intervention:
- Based on presence of CVC, clinical expert provided education, assigned specific Get Well Network (GWN) education videos pertaining to CVC and provided a backpack that included chlorhexidine wipe instruction sheet, lidocaine cream with occlusive dressing, port-a-cath access information, CVC securement vest (Gus Gear) and patient specific line maintenance education.
- Unit secretary entered patient specific line days into the hospital electronic occurrence system (Midas).
- Weekly bedside compliance with best practice bundle elements audited and results submitted to CHAM Quality Management
- Microbiology notified attending of service and RN of lab confirmed blood stream infections
- Infection Preventionist (IP) performed root cause analysis (RCA) along with CHAM CLABSI committee to confirm if positive culture was the result.
of a central line related blood stream infection and if there were any contributing factors.

Evaluation:
- After implementation of GWN videos, in person hands on education, and CVC backpacks that include line specific equipment and literature, CLABSI rate (without mucosal barrier injury) went from 1.2 in 2020, to 0.3 in 2021. A significant decrease.
- Compliance with assigned videos viewed was 17%. Average reliability of bundle elements in 2021, was 59.5%, and 64.3 % in 2021.
- Despite low viewing rate of digital offerings, infection rates were significantly reduced. Our results suggest in person bundle auditing, patient education and review of CVC equipment have greater effects on CLABSI rate reduction.
- CLABSI rate (without mucosal barrier injury) went from 1.2 in 2020, to 0.3 in 2021, a 75% decrease.

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CERTIFIED NURSING ASSISTANTS IN ONCOLOGY: AN IMPORTANT PIECE OF THE PUZZLE
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Oncology nurses typically receive numerous educational opportunities during orientation and annually related to the care of oncology patients. Formal oncology specific education was not being provided to unlicensed assistive personnel (UAP), such as Certified Nursing Assistants (CNAs). CNAs play a vital role in delivering care to oncology patients, as such these individuals should be presented with educational opportunities that provide foundational information for caring for oncology patients, as well as explaining the rationale of the care we provide. The purpose was to provide foundational and ongoing oncology education to UAP, particularly CNAs, to enhance their understanding of the care of oncology patients in the acute care setting of an academic medical center. Newly hired CNAs and CNAs new to the oncology division were required to attend the Oncology CNA Academy during their orientation period. Current oncology CNAs were required to attend the Oncology Divisional CNA Annual Education yearly. Information was presented utilizing various methods, such as didactic, simulation, interactive gaming, and pre/posttests. Specific objectives were focused on infection prevention and management, fall prevention, pressure injury prevention, documentation, and emergency management of oncology patients. The organization’s learning management system was utilized to evaluate participant’s response to learning, increase in knowledge, and gain feedback for class improvements. The Oncology CNA Academy had 26 participants in 2022 and 23 participants in 2023 (year-to-date). Evaluation results revealed that 100% of participants noted an increase in knowledge related to the care of oncology patients. The Oncology Divisional CNA Annual Education had 34 participants in 2022 and 29 participants in 2023. Evaluation results revealed that 98% of participants noted the educational offering was effective in improving their knowledge related to the care of oncology patients. The Oncology CNA Academy and Oncology Divisional CNA Annual Education provided CNAs with information to increase their knowledge of oncology patients, their care, and the rationale for that care. By offering these educational opportunities to CNAs they felt included and recognized that they are an important piece in providing safe and effective care to oncology patients. It is vital to exercise inclusion and ensure that all those who provide care to oncology patients, including CNAs, have a foundational understanding of how to appropriately care for this special population. This in turn, will improve overall patient care and outcomes.

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CRITICAL IMPORTANCE OF THE VERIFICATION NURSE ROLE IN THE SAFE DELIVERY OF HIGH-RISK MEDICATIONS
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Chemotherapy/biotherapy administration is a high-risk nursing practice in oncology with potentially fatal results if errors occur, the most famous of which occurred in 1994. A unique nursing role, the Verification Nurse (VN), was developed to facilitate identifying and resolving treatment errors before reaching the patient. The VN is the first safety check in the order review process. The role contributes to improving patient safety, quality of care, patient wait times, and reducing drug waste by catching prescribing errors, avoiding delays in treatment, and promoting advance mixing of treatments. This project’s purpose was to refine and standardize the existing role/responsibilities of the VN...
across all care settings in a large comprehensive cancer center after variations in practice were identified. In addition, we sought to demonstrate and quantify the importance of the VN in patient care and the institution’s culture of safety. A VN representative from each site formed a taskforce that carried out a comprehensive literature review. From there, nursing policy, site specific workflows and annual competencies focusing on low volume/high-risk situations were reviewed and updated. Through this work, variations in practice were identified, which led to the creation of an orientation pathway and task checklist. Event reporting education was developed to address the underreporting of errors. A VN practice council was formed to continue the work of role standardization, prevent practice drift and to report activities within the department of nursing’s shared governance structure. Evaluation of event reporting data showed trends in prescribing errors, care delivery and protocol violations. Event reporting education was implemented in Q4 2018. Data was reviewed before and after implementation and demonstrated a significant increase in the number of prescribing errors identified by VNs prior to pharmacy verification and drug preparation. Adding an additional layer of safety with this unique nursing role helps ensure patient safety in addition to the well-established independent double check at the bed/chairs. Executive leadership at this large comprehensive cancer center centralized the outpatient adult VNs under one nurse leader as an additional initiative to ensure the continued work of role standardization. Institutions that do not have this role should consider implementing it based on patient safety and risk reduction in errors reaching patient.

P48
DECREASING CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION (CLABSI) AND STANDARDIZED INFECTION RATIO (SIR) IN AN INPATIENT MEDICAL ONCOLOGY UNIT BY USE OF A STERILE TABLE
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Oncology Nursing Practice
The Inpatient Medical Oncology Unit continued to have high Central Line-associated Bloodstream Infection (CLABSI) rate and Standardized Infection Ratio (SIR). The sterile procedures including central line dressing changes, port access, and blood culture collection involved use of the bedside table. The bedside table is a non idealistic surface due to high risk of contamination by the placement of patient’s personal daily items. Utilization of a sterile table was recommended by a bedside nurse and implemented to perform sterile procedures. The implementation of a sterile table for sterile procedures allows nurses to perform these tasks on an aseptic surface that minimizes opportunities for contamination to decrease CLABSI rate and SIR. An implementation of a sterile table required education to the unit staff regarding the process of using, disinfecting, and storing. Training was conducted by the Nurse Manager and Clinical Nurse Educators. Nurses transport the sterile table to the patient’s room when preparing for a sterile procedure. The sterile table is to be wiped down before and after use with appropriate sanitation wipes, leaving the nurse with an aseptic surface to prepare a sterile field. The sterile table remains stored in a secure location draped with a plastic cover when not in use. The use of the sterile table was implemented in September 2022 (Q4 – 22). As shown in Table 1, the CLABSI rate and SIR decreased to 0 for the 4th quarter. For the three quarters prior to the implementation, there were 8 CLABSIs. The three quarters following had 5 CLABSIs, a decrease of 37.5%.
Discussion: The addition of a sterile table, as shown in Figure 1, can improve patient outcomes with the decrease in CLABSI rates. The easy to disinfect and sterile table allows nurses to perform sterile procedures on a frequently cleaned and less trafficked surface decreasing the risk for contamination.

P49
NUMBER OF INTRAVENOUS INSERTIONS PER WEEK DOES NOT INFLUENCE INFUSION UNIT NURSES’ RATINGS OF RISK FACTORS FOR DIFFICULT INTRAVENOUS ACCESS (DIVA)
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Oncology Nursing Practice
The initiation of intravenous access is a task that...
oncology nurses perform multiple times a day. As part of this process nurses need to assess each patient for risk factors that increase their risk for DIVA. However, little is known about oncology nurses’ ratings of patient characteristics (i.e., risk factors) that predict DIVA. In addition, no studies have reported on whether the number of insertions that nurses do per week influence their ratings of risk factors for DIVA. The purpose was to evaluate for differences in nurses’ ratings of risk factors for DIVA between nurses who perform <10 compared to >10 insertions per week. A total of 152 infusion unit nurses received an email with an explanation of the study and a link to a Qualtrics survey. Completion of the survey indicated the provision of informed consent. Nurses complete a revised version of the “Survey on Nurses” perceived DIVA factors that contained a list of 93 risk factors. Nurses rated the extent to which each factor was perceived as a risk factor for DIVA, based on their experience, using a scale that ranged from 0 (not at all predictive) to 10 (extremely predictive). In addition, nurses provided information on demographic characteristics and clinical experience. Differences in nurses’ ratings of risk factors for DIVA between those who performed <10 compared to >10 insertions per week were evaluated using parametric and nonparametric tests. Of the 81 nurses (53.2% overall response rate) who completed the survey, 55.5% and 44.5% performed <10 versus >10 insertions per week, respectively. No differences were found between the two groups on age, gender, education, and years of experience in nursing or infusion nursing. Compared to nurses who performed <10 insertions per week, those who performed >10 rated one risk factors as more predictive of DIVA, namely: patient has a history of cirrhosis. The risk factors with the highest prediction scores for DIVA (i.e., >7) were: current or past history of intravenous drug use, occurrence of dehydration, history of multiple sticks during previous visits, and multiple intravenous attempts on the day of treatment. Study is the first to describe differences in infusion nurses’ perceptions of risk factors for DIVA based the number of needle insertions performed per week.

P50
REATING PATIENT EDUCATION RESOURCES FOR STEROID-INDUCED HYPERGLYCEMIA
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Patient Education and Safety
Uncontrolled steroid-induced hyperglycemia is a common, often insidious problem, within oncology care that can lead to numerous complications and increased morbidity and mortality. While patient education materials for diabetes are plentiful, there is a lack of health literacy-friendly patient education content for steroid-induced hyperglycemia due to cancer treatment. Oncology nurses play a pivotal role in providing quality patient education and the use of comprehensive, yet concise written materials can help promote health literacy and engagement among patients and family members. The purpose was to create standardized and health-literacy friendly steroid-induced hyperglycemia patient education materials for an APRN-led quality improvement initiative within a stem cell transplant program. The cancer center’s office of patient education collaborated with content experts from endocrinology and the stem cell transplant team to create a detailed education packet for patients with steroid-induced hyperglycemia. The primary information resource was a newly created booklet called Starting Insulin Therapy. Additional items included glucose tracking logs, resources for initiating continuous glucose monitoring, a nutrition handout and a Steroids and high glucose education checklist for tracking topics taught by team members. Each piece was evaluated using health literacy guidelines for print communication and the group engaged members of the patient and family advisory council for feedback about the booklet prior to implementation. Results from the Patient Education Materials Assessment Tool for Printable Materials (PEMAT-P) will be shared, along with discussion of readability assessments, design and implementation challenges and suggestions for creating and evaluating patient education materials that align with health literacy guidelines. The specialized nature of cancer care may require creating custom patient and family education content to fill gaps in available resources. Clinicians often want to provide thorough, easy-to-understand items, but they may lack the time and training to evaluate or develop them. Working with colleagues who have training in health literacy and plain language can help ensure that providers are delivering consistent messages that align with patient education and health literacy best practices.

P51
PLANNING FOR SUCCESS: A NEW

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MARCH 2024, VOL. 51, NO. 2 ONCOLOGY NURSING FORUM 33
APPROACH IN CLINICAL CARE TO ENHANCE PATIENT EDUCATION
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Patient Education and Safety

The complexity of chemotherapy regimens coupled with the stress accompanying a new cancer diagnosis requires the oncology nurse to be creative with education planning. Currently, pre-chemotherapy education takes place at the clinic visit during the consent process and again at the first infusion. The opening of a new satellite facility combined with leadership support presented an opportunity for nursing to enhance patient education and overall experience by implementing a formal pre-treatment education session. Education for patients prior to their first scheduled infusion appointment is crucial to ensure safety and a clear understanding of the process. Emphasis on side effects, symptom management, and reporting of any treatment related issues was a priority. The pre-treatment education session allows the patient and their family time to meet the multidisciplinary team reviewing their treatment plan, ask questions, and understand their role in the process. The implementation of this project focused on the development of a unit-based committee comprised of chemotherapy certified nurses and leadership. Committee members identified gaps with the current education practices and conducted a needs assessment based on the specifics of the satellite facility. Core chemotherapy teaching was scheduled in-person or virtually, allowing patients time to identify the family or support person assisting them in processing the vast amount of information. Nursing staff compiled a pre-chemotherapy checklist, ensuring each educational session included all necessary components regardless of the teacher. A key component driving this initiative was the care coordination to ensure labs were collected forty-eight hours prior to treatment. Discussion on supportive care, community resources, nutrition, intravenous access and advanced directives were included. Ongoing evaluation via survey from the front-line team and patients continues to drive this process improvement project. Evidence based research supports a standardized workflow for patient education. This is a unique opportunity for staff and patients to work collaboratively with local resources, building a supportive oncology community together, in a growing satellite infusion center. Identification of key stakeholders was vital in structuring this standardized workflow. Next steps are to share and educate our peers across the ambulatory care network.

P52 IMPLEMENTING THE ROLE OF AN RN (REGISTERED NURSE) PHARMACOKINETIC (PK) SHEET REVIEWER FOR INPATIENT PROTOCOLS
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Oncology Nursing Practice

Clinical trials are innovative, complex treatments requiring extensive coordination for safe administration and positive patient outcomes. An important element to ensure accurate documentation, compliance and safety is the use of a Pharmacokinetic (PK) Sheet. The PK Sheet is derived from the protocol and provides a roadmap for the treating RN. A 43-bed inpatient hematology and clinical trials unit at a comprehensive National Cancer Institute (NCI) designated institution identified trends associated with protocol deviations due to inconsistent or incorrect information on the PK Sheet. To combat this issue, the inpatient nursing team collaborated with the nursing clinical trials team to establish an Inpatient PK Sheet Review Role. The purpose was to demonstrate how the establishment of an Inpatient PK Sheet Review Role ensures feasibility and reduces deviations. The Inpatient PK Sheet Reviewer evaluates and approves PK Sheets for feasibility prior to enrollment of patients into a clinical trial. The PK Sheet Reviewer is an experienced clinical nurse with vast knowledge caring for patients on protocols. This nurse reviews the draft of all new PK sheets, created by a research assistant. Issues identified during the review, such as timing of labs, vitals, EKGs, and assessments are brought back to the research team for clarification. Adjustments would be made to the PK Sheet prior to the patient’s admission to ensure accurate documentation of protocol needs. Approval by the PK Sheet Reviewer is required prior to patient enrollment. The success of this role is measured by issues reported through the Reporting to Improve Safety and Quality (RISQ) system. Prior to implementation, nursing time was misspent identifying the appropriate personnel to reach out to...
for clarification. Since implementation, RISQ reports of missing, inconsistent, and incorrect information on PK Sheets decreased. Anecdotally, nurses report less time spent seeking clarification on PK Sheets and report feeling more confident treating protocol patients. If any issues on the PK sheet are identified after the review process, the PK Sheet Reviewer is contacted, and adjustments are made accordingly. Multidisciplinary collaboration allows for addressing concerns and in a cohesive manner. The implementation of the PK Sheet Reviewer has allowed for errors to be corrected before reaching the patient’s bedside. Information on the PK Sheet has been proactively reviewed to ensure accuracy of the protocol and safety of the patient.

P53 EXPANDING USE OF THE MODIFIED ADULT DIFFICULT INTRAVENOUS ACCESS SCALE PRIOR TO INITIAL TREATMENT OF BREAST CANCER PATIENTS
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Oncology Nursing Practice
The Modified Adult Difficult Venous Access (A-DIVA) scale is a standardized venous assessment scale used to determine adequate venous access for safe administration of chemotherapy. It was first implemented in UChicago Medicine’s outpatient Infusion Therapy Department in 2021, and it resulted in a 79% reduction in venous events. The next step was to expand its use to the hospital’s Hematology Oncology (HemOnc) Breast Cancer program clinic, where patients are seen for consultation prior to treatment initiation. The Breast Cancer program was chosen because many of their regimens include vesicants, which are chemotherapy medications with a high risk of causing serious tissue injury. Early assessment will provide an opportunity for central line placement before initial treatment, thus reducing venous events and treatment delays. The purpose is to identify the need for port placement prior to initial treatment of the scheduled breast regimen by completing a venous site assessment. The Intravenous Therapy (IVTH) Unit Based Council (UBC) nurses educated breast cancer nurse navigators on the venous assessment process in HemOnc clinic via Zoom and email. Three additional IVTH nurses were trained on the consultation process. Upon patient’s initial consultation, the nurse navigator contacted the IVTH charge nurse who assigned an IVTH nurse to perform venous assessment in the HemOnc clinic. Once the IVTH nurse is done, results and recommendations were communicated to the nurse navigator or provider. A-DIVA score and nursing notes were documented in EPIC by the IVTH nurse under the HemOnc encounter. From November 2022 to May 2023, 16 breast cancer patients were seen by IVTH nurses in HemOnc clinic. Among these patients, 9 had central line recommendations and 78% of them had a port placed prior to initial scheduled treatment. Of the 9 patients, 5 were deemed high risk and 4 had ports placed, and 4 patients were moderate risk and 3 had ports placed. Preliminary data from this pilot suggest an earlier venous assessment in HemOnc prior to initial treatment has the potential to reduce adverse venous events and treatment delays. Next steps are to expand this project to other programs in the HemOnc department before treatment initiation.

P54 TALQUETAMAB SKIN TOXICITIES: PRESENTATION AND MANAGEMENT GUIDELINES
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Symptom Management and Palliative Care
Talquetamab is a T-cell redirecting bispecific antibody that targets a novel antigen, GPRC5D, on myeloma cells and CD3 on T cells. Talquetamab is approved for patients with relapsed/refractory multiple myeloma (RRMM) and has shown to have overall response rates >71%. Talquetamab is associated with a distinct group of GPRC5D-related adverse events (AEs) including dermatologic (skin and nail) AEs. Here we describe a single center’s experience with the presentation and management of dermatologic AEs. Weekly interdisciplinary meetings which included nursing, dermatology, and the primary care teams were held to discuss the presentation and management of patients with skin toxicities receiving talquetamab on the MonumenTAL-1 clinical trial. Best practices and care plans were discussed. Here we discuss the management of a cohort of patients who received subcutaneous talquetamab at the recommended phase 2 doses (RP2Ds) of 0.4 mg/kg weekly or 0.8 mg/kg every other week. Dermatologic AEs in MonumenTAL-1 included skin (dry skin, exfoliation), rash, and nail (thinning, peeling) AEs. Among N=24 patients receiving the talquetamab RP2Ds, 87.5% had skin (grade [Gr] 3, 4.2%), 45.8% had rash (Gr 3, 33.3%), and 58.3% had nail (Gr 3, 0%) AEs.
Median time to onset of dermatologic AEs was ~4-15 weeks following first talquetamab dose. Most dermatologic AEs resolved, except nail AEs: only 28.6% of events resolved, with a median time to resolution of ~16 weeks. Management of dermatologic AEs included use of a heavy moisturizer for general dryness; ammonium lactate 12% lotion twice daily (BID) for hand and foot peeling; loratadine 10-mg oral tablet daily for 3-5 days post-dose and triamcinolone 0.1% cream BID for pruritus, injection site reaction, and rash; and use of nail hardeners, topical vitamin E oil, and triamcinolone 0.025% ointment for nail thinning and peeling. Methylprednisolone taper and betamethasone 0.05% cream BID may be considered for grade 3 rash. Other approaches for mitigating grade 3 dermatologic AEs included dose holds. Patients were encouraged to take short, lukewarm showers, use a heavy lotion or moisturizer throughout the day on skin and cuticles, and keep nails short and clean. No patient from our center discontinued the study due to dermatologic AEs. Skin and nail AEs are common but primarily low grade with no discontinuations. Appropriate management, education, and supportive care ensures patients can stay on treatment to receive optimal benefit from talquetamab.

P55
DESIGNING A REFERRAL PROCESS IN A LARGE ADULT HEALTH SYSTEM TO ADDRESS THE NEEDS OF ADOLESCENT AND YOUNG ADULT (AYA) PATIENTS WITH CANCER
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Survivorship
Patients with cancer can experience unmet needs that may impede medical care and treatment uptake. Addressing these needs often begins with a measure of a patient’s level of distress at diagnosis and continues throughout the care trajectory (NCCN, 2022). For adolescents and young adults (AYA) with cancer, a simple distress assessment may not fully capture their unique needs. Much different than the older adult with cancer, AYAs with cancer are often in the early stages of relationships, beginning careers, completing education, and starting family planning. A holistic approach to the more specific needs of the AYAs with cancer in an adult population and implementation of a targeted referral process could lead to improved physical and mental wellbeing, willingness to adhere to the prescribed treatment, increased patient satisfaction, and potentially decreases in cancer morbidity. A multidisciplinary team was established to design a study to address these concerns. Institutional Review Board and nursing governance approval was obtained. The purposes of the study were to: 1) describe the development of a referral system for assessing AYA needs and referring AYAs to appropriate resources. 2) evaluate the implementation and effectiveness of the screening and referral process from a provider and patient perspective. The study was observational in design to describe the creation and implementation process of a patient referral system, and quantitative and qualitative to measure of the extent and effectiveness in serving the AYAs with cancer. After consenting, AYA needs were first assessed using a distress assessment through the patient portal. Then, based on self-identified concerns of the AYA, additional scales focused on spiritual distress, personal relationships, survivorship concerns, practical needs, and body image were sent to the AYA. Next, those results were sent to chaplains, social workers, and nurse navigators through the EMR. AYAs were then contacted by the team to provide assistance with the AYA self-identified concerns. AYAs who completed the study and team members were interviewed about their experience, satisfaction, and sense of control when using the referral system. At 9 months, over 100 AYAs have been screened and 25 have been consented. Initial barriers identified by the team include managing the referral work mailbox, language, coordination of appointments for consenting, and lack of response to multiple portal messages. Initial interview results include high satisfaction of the referral process by AYAs participants and team members.

P56
UPDATED CLABSI INTERVENTIONS FOR MEDICAL ONCOLOGY
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Oncology Nursing Practice
Central lines are routinely utilized in delivery of hazardous drugs, blood products, parenteral nutrition, and antibiotics in the medical oncology population. A variety of microorganisms can lead to a central line bloodstream infection (CLABSI). CLABSI is the leading healthcare associated infection. AHRQ estimates as many as 28,000 individuals die annually from CLABSI. Bacteria that reside on the skin or in the mucosa without causing harm to the individual are known as common commensals. In the neutropenic patient, these organisms can lead to an increased length of stay and mortality. Bathing with 4% chlorhexidine (CHG) has been shown to reduce skin contamination and thereby reduce the risk of CLABSI. Between July and
December 2022, the unit experienced an increase in the number of CLABSI events. Of the 3 events, 2 cultures grew Staphylococcus epidermidis, a common commensal. The goal of this project was to decrease CLABSI events and eliminate potential Staphylococcus epidermidis culture contamination. The team explored opportunities for additional prevention strategies. Unit leaders met with the hospital team. In addition to the existing CLABSI prevention bundle, an additional intervention implemented was cleansing the arm with CHG prior to drawing peripheral cultures. An education document was developed to provide direction to nursing staff. Lab was invited to participate and utilized a blood diversion device with peripheral draws. Signage was posted on patient doors to alert lab to contact nursing prior to drawing cultures. An additional find was inconsistent reaplication of tissue adhesive (TA) during dressing changes. TA has antimicrobial properties. Leadership emphasized the importance of the product during daily huddles. One intervention to increase compliance with use was to tape the product to dressing change kits. Later, the product was relocated directly above the kits. Tools were developed for monitoring compliance with the new initiatives. In the 7 months post implementation, January through July 2023, the unit experienced 1 CLABSI event which was not a common commensal (a decrease from 3 events in 6 months prior to project implementation). Discussion: The unit continues to utilize CHG cleansing and use of a blood diversion device prior to drawing peripheral blood cultures. Since the implementation of the plan, there has been staff turnover and the unit is currently providing an education refresh for new and existing staff.

**P57**

**EVALUATING THE IMPACT OF PRE-CHECK MEDICATION RECONCILIATION TOOL FOR NURSES AND PATIENTS**

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**Patient Education and Safety**

Patients at their radiation appointments are asked to update their current medications. Most patients do not remember all the medications and dosages of medications they are taking, and the appointment may be delayed or extended for medication questions. The pre-check medication reconciliation tool aims to reduce the time nurses and physicians would need to spend updating current medications while allowing the patients sufficient time to review their medications without pressure. The tool would allow greater ease and patient satisfaction while still maintaining safe medication reconciliation practices. The medication reconciliation tool was evaluated by a series of two online surveys for staff nurses to complete. The initial survey was multiple-choice followed by an open-ended second survey. 22 nurses participated in the initial survey. 91% of nurses reported that the tool was helpful when completed by patients. 71% of nurses wanted the tool to continue to be implemented to patients at check-in. In the follow-up survey, 11 nurses submitted responses. Many nurses shared that the tool decreases the total time spent reviewing medications and that it was helpful for patients to see the medication names on paper for easier identification. The tool’s impact demonstrates a smoother and safer process for medication reconciliation. Nurses found the tool useful, and its continued use has been agreed upon. It is important to note that the tool does not replace verification by clinical staff which is still required by policy. Patients should be educated that double checks are necessary to avoid medication errors that could potentially be harmful.

**P58**

**ONLINE/ZOOM TEACHING INCREASES NUMBER OF TRANSITIONS TO SELF-ADMINISTERED SUBCUTANEOUS INJECTIONS IMPROVING ACCESS TO CARE FOR PATIENTS IN A HEMOPHILIA TREATMENT CENTER.**

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**Oncology Nursing Practice**

Emicizumab (Hemlibra) is a monoclonal antibody prescribed for hemophilia A patients with or without inhibitors. Consistent use of emicizumab has been proven to decrease bleeding episodes in hemophilia A patients. It is administered as a subcutaneous (SQ) injection weekly, biweekly, or monthly at home. Prior to in-home use, the SQ administration of emicizumab is taught to patients in clinic. Many patients live in remote areas and some patients are unable to come into clinic due to inflexible work schedules. An online teaching tool was developed to improve access to emicizumab in hemophilia A patients by remote/online teaching on self-administration via zoom. Patient was emailed a link to emicizumab administration video (from manufacturer’s website) and a checklist of supplies to have ready before the zoom appointment. During an online live teaching session a nurse reviewed a powerpoint presentation with the patient which included: a) mechanism of how emicizumab works b)
route of administration c) areas appropriate for subcutaneous injections d) a short video recorded by the nurse in advance of emicizumab administration as a refresher e) a 5 week calendar noting the weekly dosing up until the transition to maintenance dose. An email was sent to the patient immediately after the teaching session with a pdf of the presentation and a copy of the customized calendar. Weekly check in calls for the first 5 weeks was made to make sure the patient did not have any questions or issues. 13 patients underwent self-administration teaching via zoom.10 patients had congenital hemophilia without inhibitor and 2 patients had acquired hemophilia.12 patients were men and 1 a woman with an average age of 45 years old (range 28 to 81). All 13 patients were able to successfully complete the weekly emicizumab loading dosing and transitioned to maintenance dosing. No doses were missed. One patient needed help from her son during the teach for administration. Another patient had trouble with internet and had to get help at their local primary care physician’s office for the first dose before successfully self-administering subsequent doses. In conclusion, selecting patients who have prior experience with administering injections to self or to a family member and having access to zoom either on phone or laptop/computer is crucial to success of teaching self-administration via online session.

P59 DEVELOPMENT OF A CLABSI PREVENTION BUNDLE TO REDUCE CENTRAL LINE ASSOCIATED BLOOD STREAM INFECTIONS ON A HEMATOLOGY ONCOLOGY UNIT
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Oncology Nursing Practice

Central lines are an essential part of the care provided for patients on a Hematologic Oncology Unit. However, other aspects of these patients including immunosuppression, need for cytotoxic chemotherapy regimens, and increased number of catheterization days puts this population at a higher risk for central line blood stream infections (CLABSIs). Literature has shown that CLABSIs are associated with prolonged hospital stays, increased hospital costs and unnecessary exposure to antibiotics. Thus, reducing CLABSIs rates is crucial in the supportive care provided by hematology oncology nurses. Purpose/PICOT question: In hematology oncology patients, how does the use of an evidence based CLABSI prevention bundle, compared to current practices, impact the rates of CLABSI during hospitalization? An evidence based CLABSI prevention bundle was created to include:
- Pre-intervention survey to identify gaps in central line knowledge and assess educational needs of staff nurses.
- Central Line Maintenance education/policies handouts attached to assignment sheets for float nurses
- Double sided laminated graphics hung on all IV poles to remind nurses to label and update IV tubing per institutional policies.
- Unit wide standardized competency check off on central line dressings and blood sample/blood culture sampling from central lines. This included a nurse made practice board and reusable practice dressing to reduce waste.
- Creation of in-depth and realistic video demonstration of dressing changes and blood draws to encourage standardized practice and to assist in education of new onboarding nurses
- Re-education and implementation of institution’s evidence based central line maintenance policies
- Creation of unit CLABSI Champions to round on all central line patients

Post intervention assessments will include a new survey to assess impact of educational interventions. Additionally, unit CLABSI rates will be compared pre and post intervention of the CLABSI prevention bundle. This nurse led CLABSI prevention bundle will strive to sustainably standardize central line practices on a newly formed hematology oncology unit with increased onboarding of new nurses to support patient safety and improve patient outcomes.

P60 NURSE NAVIGATION: BRIDGING THE GAP IN A VIRTUAL ENVIRONMENT
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Coordination of Care

Oncology Nurse Navigation is a trusted field that supports patients by providing them with education and resources to overcome barriers to care. Iris by OncoHealth supports patients by providing access to 24/7 nursing support and an interdisciplinary care team through a digital platform. Building a therapeutic
relationship and patient trust in the digital environment can be challenging. The Iris nursing team aims to bridge this gap by leveraging oncology nurse navigators as the cornerstone in the patient's experience by connecting them with support specific to their individual needs. The goal of this project is to evaluate if assigning a nurse navigator to each patient in a digital health setting has a positive impact on patient-nurse rapport and utilization of interdisciplinary services. If we can improve patient engagement, connecting them to the resources they need, research suggests this can lead to better outcomes. Recent studies have shown that the implementation of nurse navigation programs can have positive outcomes on readmission rates, survival rates, and overall patient QOL. Patients are assigned a nurse navigator upon enrollment in Iris and provided a personalized introduction to their navigator and the program. The goal is to personalize the patient’s experience by providing a one-on-one relationship with the navigator who can coordinate any needs throughout the interdisciplinary team. Evaluation of this project is ongoing with the goal of increasing nurse to patient engagements, successful referrals to mental health therapy, nutrition services, resource navigation, and personalized symptom monitoring. Early data does suggest that nurse navigator support in the remote setting does promote a positive relationship, which in turn leads to early multidisciplinary interventions, increased quality of life, and potential decrease in Emergency Department visits. Connecting with an assigned nurse navigator can help build trust with patients when interacting in a digital setting. Patients who engage with their nurse navigator were more likely to utilize nutrition and mental health teams, as well as utilize self-service tools available through the app. Our goal and hypothesis within Iris are that as we continue to build strong, nurse-patient relationships, this coupled with the resulting use of interdisciplinary support, will result in decreased emergency room visits and hospital admissions amongst the population that we serve.

P61
BALANCING TOOL AN ACUITY-BASED TEMPLATE: CELEBRATING 5 YEARS OF SUSTAINING EXTRAORDINARY INNOVATION ON AN AMBULATORY INFUSION UNIT
Erin Clark, RN, MSN, OCN, Mayo Clinic, Phoenix, AZ Coordination of Care
In early 2019, a team of oncology nurses developed and implemented an innovative allocation template known as the Balancing Tool (BT) for an ambulatory infusion unit. Encouraging this practice change was prompted after a unit survey revealed a need for a standardized practice to equally distribute complex patient care assignments. Nurses were passionate about designing an evidence-based tool that would improve the process of evaluating and assigning patient care loads across small nursing teams more efficiently. Nearly five years after its launch, the BT continues to receive praise and recognition for its positive impact on the unit, has sparked other ambulatory infusion units to implement its process, and has ignited extraordinary innovation. The purpose of implementing the BT template was to develop a more efficient and easier workflow to guide nurses with the goal of creating a safer care environment. The BT was designed after reviewing evidence-based literature on outpatient acuity guidelines and researching how other ambulatory infusion units were coping and handling the same problem. It took four months to format a customized template which balanced patient care loads efficiently and user friendly. A unique benefit of the BT is using a color-coding technique to act as a guideline when evaluating and distributing patient acuity levels, while simultaneously computing a summary of those care loads amongst small nursing teams. Making this process more proficient, faster and easy for nurses to master. Since the implementation of the BT, the process of distributing patient assignments has shown to have a positive impact on multiple ambulatory infusion units who have adopted its process. Unit survey results showed 95% of nurses reported a clear and easy understanding of the BT process, and 100% support in sustaining and continuing its workflow resulting in increased unit satisfaction scores. The BT is continually evolving and being refined based on practice changes, unit growth, and staff feedback. The team routinely updates and reviews the template to ensure it stays current on new medication regimens and ease of use. During the past 5 years, the BT has demonstrated extraordinary innovation by increasing the unit’s workflow efficiency, empowered nursing autonomy, increased unit satisfaction scores and created a safer care environment which is crucial for all ambulatory infusion units.

P62
STICK EM UP: USING STICKERS TO REDUCE PATIENTS LEAVING FACILITY WITH CHEST PORT NEEDLES IN
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Many patients receive their antineoplastic medications through chest ports (IVAD) at our Comprehensive
Cancer Center. A barrier to safe needle removal is human error - the patient leaving too early, or staff not seeing the IVAD due to bulky clothing, etc. Patients leaving the facility with their IVAD needle in (accessed) is an infection risk, safety risk and patient dissatisfier. This step can be easily overlooked by patients and staff. Accessed IVADs are not always easily visualized, and in the wake of receiving news, good or bad, the patient may not remember their IVAD is accessed. Removing a port needle is a clean procedure and the patient would need to come back to the facility or go to an ER to have it safely removed. The purpose was too reduce the occurrence of patients leaving the facility with an accessed IVAD using stickers. In 2021, the gynecology clinic began putting 1-inch yellow circle stickers on patients’ shirts who had an accessed IVAD to serve as a visual queue for the patient and staff. Providers notified the charge nurse of any patient not receiving treatment so the patient’s needle could be removed. The clinic schedulers, responsible for checking patients out, notified the charge nurse should any patient have a sticker but not be receiving treatment when checking out. Following the use of stickers in the gynecology clinic, the chemo infusion clinic began placing 2-inch white circle stickers with ‘port accessed’ on patient’s clothing. Due to the success of the white sticker, the pilot stickers were changed to standardize among the units. Two patients left accessed from the ambulatory center and neither were wearing stickers. Since 2021 this pilot has shown promising results. Expanding the utilization of stickers throughout all patient care settings would improve communication between departments, increase the visibility of IVAD needles and reduce the number of patients leaving with an IVAD accessed unintentionally.

**P63 THERAPEUTIC PHLEBOTOMY: SAFE USE OF CENTRAL VASCULAR ACCESS DEVICE**

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**Treatment Modalities**

Therapeutic phlebotomy is a procedure performed to remove a prescribed amount of circulating blood volume from a patient. In patients with polycythemia vera, therapeutic phlebotomy decreases red blood cell mass. In patients with iron overload syndromes, the procedure is used to decrease iron stores. Therapeutic phlebotomy is a treatment, not a cure; patients undergo the procedure whenever symptoms appear. Peripheral venipuncture is the most common method of access for removal of the ordered volume of blood and standard procedures guiding practice are available. However, in patients requiring multiple phlebotomies, use of a central vascular access device (CVAD) may be necessary. Currently, there are no established standards for using a CVAD for the procedure. As a result, it was found that between 20-25 syringes may be used to manually withdraw the ordered volume of blood, depending on the ordered withdrawal volume (usually no more than 500 mL). The purpose of this initiative was to develop a closed-system transfer method when performing therapeutic phlebotomy from a CVAD. Implementing the use of a 3-way stopcock was found to be safe and effective for maintaining a closed transfer system when using a CVAD for performing therapeutic phlebotomy. At our facility, the blood collection bags used for therapeutic phlebotomy are individually packaged. The bag tubing is directly attached to the stopcock, which is attached to the CVAD lumen. Blood flow direction is controlled with the stopcock. One 20 mL syringe is used to extract the blood from the CVAD, which is then diverted into the blood collection bag. The process is repeated until the ordered volume of blood is obtained. Following the procedure, the CVAD is flushed with 20 mL of 0.9% normal saline flush to maintain patency. Use of a 3-way stopcock to create a closed-system method when using a CVAD for therapeutic phlebotomy eliminates the need for multiple syringes and reduces risks associated with blood and catheter manipulation. The process has been successfully standardized throughout the hospital system. Although patients requiring therapeutic phlebotomy often receive treatment by oncology nurses in ambulatory infusion centers, hospitalized patients may also require treatment. Most recently, an educational video demonstrating the procedure was developed in collaboration with the educational team as an additional resource.

**P64 RAPID RESPONSE PAGING SYSTEM IN AN OUTPATIENT ONCOLOGY CLINIC SETTING**

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**Patient Education and Safety**

In a community-based oncology and hematology practice that includes 34 clinics, the largest site located in the greater Nashville area, can see over 200 patients per day and is open 5 days a week. Due to the size of the clinics floor plan, the treatment room nurses are far from the lobby and lab. When front office staff urgently need clinical assistance, a desk phone intercom system is used to broadcast “code blue and location” to
each phone. This can cause nurses, medical assistants, nurse practitioners, and doctors to urgently respond, thinking that someone was experiencing a cardiac and/or pulmonary arrest. When staff respond to the scene, they could find a conscious patient/family member experiencing a fall, chest pain, fainting, or shortness of breath instead. The need for an alternative call system as well as front office medical emergency education was identified by staff and leadership. On 12/13/21, The clinic began piloting a Rapid Response Paging System, a way for different areas of the clinic to call for nursing assistance without causing unnecessary interruption in other areas. Front office and lab staff were educated on different types of medical emergencies and when to activate the paging device. A rapid response paging device was placed at check-in, check-out, and in the lab. When the rapid response paging device was activated, two designated nurses were alerted to respond to the corresponding area numbered on the device. The two nurses responding, assessed the situation, assessed the patient, and called for additional assistance if needed. The number of code blue calls decreased to zero during the pilot period from 12/13/21-3/31/22, while the Rapid Response Paging System was used at least once weekly. Though there were technical issues keeping the pagers and call devices connected and charged, response times were less than 30 seconds, patients’ safety was maintained as the priority, and the clinic experienced fewer unnecessary interruptions. Front office, lab, and nursing staff expressed an increase in preparedness, confidence, and knowledge for handling medical emergencies. The Rapid Response Paging System is still in use at the clinic and continues to provide excellent care for symptomatic patients. The organization plans to implement the Rapid Response Paging System across the enterprise.

**P65**

**BENEFITS OF INPATIENT ONCOLOGY PALLIATIVE CARE NURSES LEARNING REIKI**

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Symptom Management and Palliative Care

Whether from advanced disease or complications of treatment, oncology patients experience multiple symptoms which can negatively impact their quality of life. These symptoms include pain, emotional stress, depression, anxiety, insomnia, and fatigue. Reiki is an energy healing technique that promotes relaxation, reduces stress and anxiety through gentle touch. Multiple studies have demonstrated the benefit of Reiki in relieving symptoms such as fatigue, pain, emotional stress, and anxiety. The purpose of our project was to teach oncology palliative care nurses the benefits of Reiki for symptom management and to help nurses become proficient in providing Reiki to their patients. Nurses achieved Reiki level 1 certification at the end of the class following their demonstration of the technique. At a major medical center in Boston, two Reiki level 3 nurses offered a 4-hour Reiki class for nurses who worked on the Intensive Palliative Care Unit (IPCU). The class was voluntary, and nurses were paid for their participation by their nursing department. Two identical classes were offered to accommodate nurses’ schedules and to increase opportunities for nurses to attend the class. To receive their level 1 certificate nurses had to demonstrate the Reiki technique at the end of the class. There was a great deal of interest from nurses who wished to attend the class. Though many nurses wished to attend the class, not all nurses could attend due to unit scheduling issues and personal scheduling conflicts. Thirteen nurses attended the class. Feedback from the nurses was excellent. The nurses reported that they had very limited experience with Reiki prior to the class. Immediately following the class nurses reported they were eager to begin to use Reiki on their patients to help with symptom management. Nurses reported they were happy to have another “tool” at their disposal to help patients with symptom management. One year post Reiki certification, we will explore with nurses how they have used Reiki in their practice in the oncology setting.

**P66**

**BRIDGING GAPS IN PATIENT CARE THROUGH NURSE-DRIVEN ULTRASOUND GUIDED IVS**

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**Oncology Nursing Practice**

Historically, there has been avoidance of the use of ultrasound guided IVs (USGIVs) in the chemotherapy infusion setting; however, Radiology would place US-GIV’s in patients who had an order until operational constraints shut down this service. Losing this service
left our patients vulnerable to being sent home without treatment and our department at risk for decreased patient satisfaction. In an effort to increase patient centric practice, our institution decided to take a more liberalized approach to the use of these lines. USGIVs are a bridge for patients to avoid the incidence of missed treatments until central line placement. Our leadership team started by reviewing the literature. When there was no strong evidence to support or dispute the use of USGIVs, we benchmarked other similar sized infusion centers. We referenced our institutions venipuncture policy to ensure alignment. Knowing that our infusion staff are expert in peripheral IV placement, we developed the standard of practice for USGIVs to be a Nurse-Driven practice, that started with vein assessments prior to the start of treatment and would continue with the assessment of a patient’s veins throughout the duration of treatment. USGIVs, would bridge a patient through their treatment, if appropriate, until a central line could be placed, but would not be a long-term solution. After three months of placing USGIVs, 166 patients, only 4 patients were sent home without treatment when we were unable to obtain access. We consider this a positive, given the abrupt shift in practice and need to quickly adopt this within our department. We remain challenged with balancing safe practice with patient preferences, expectations and provider buy in for central lines. Our nursing staff is doing a great job educating patients and providers and providing recommendations based on nursing assessment. We learned that with appropriate treatments, these lines are a great alternative for patients until a long-term solution is available. We learned that the skill of placing an ultrasound guided IV is entirely different than placing a traditional peripheral IV and a difficult task to master, even for the most skilled of nurses. The ongoing training for this skill and maintaining competency remains challenging, given varying volumes of patients requiring this service. In the future, we would adjust our training methods to accommodate different learning styles and experience mixes of nurses.

**P67**

**PROSTATE CANCER PATIENTS WITH PERSONAL AND FAMILY HISTORY OF MAJOR ADVERSE CARDIOVASCULAR EVENTS (MACE) HAVE HIGHER RISK OF MACE AFTER BEGINNING ANDROGEN DEPRIVATION THERAPY**

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Screening, Early Detection, and Genetic Risk

Prostate cancer (PCa) is the leading cancer and the second leading cause of cancer death in US men. Androgen deprivation therapy (ADT) is the gold standard in the treatment of early and late stage disease. Many men on ADT experience major adverse cardiovascular events (MACE). There is evidence that certain PCa patients may have high, uncontrolled cardiovascular risk before starting ADT. History of cardiovascular (CV) events is a risk factor; an analysis found that each new CV event increased the probability of a future event 1.2 to 1.9-fold. Nurses play an intricate role in the management of patient care, education and recommendations for patients receiving ADT. This study evaluates MACE risk after ADT initiation for patients with and without personal and family MACE history using real-world data. Medical records (2010-2020) of PCa patients (n=43,320) receiving LHRH agonist/antagonist injections were used to evaluate the impact of personal and family history of MACE on MACE-free survival. MACE was defined as myocardial infarction, stroke, and mortality from any cause. Exclusion criteria included lack of ADT initiation date or MACE within six months prior to ADT initiation. Kaplan-Meier event-free survival curves were constructed, and Cox regression was used to compare the CV event/MACE hazard rates between patients with and without MACE history. Overall, MACE incidence was 3.9% and 19.6% for the cohort at one year and four years after ADT initiation, respectively. MACE risk following ADT initiation was higher for patients with a history of MACE (unadjusted: HR=2.76, 95% CI 2.49-3.06, p<0.05); (adjusted: HR=2.29, 95% CI 1.73-3.02, p<0.05). MACE risk was moderately higher for patients with a family history of MACE compared to those without (unadjusted: HR=1.14, 95% CI 1.04-1.25, p<0.05); (adjusted: HR=1.26, 95% CI 1.00-1.59, p<0.052). Current literature supports elevated CV risk following CV events, MACE risk following ADT initiation was higher for patients with MACE history. While personal and family history of MACE cannot be modified, nursing interventions may decrease risk. Nursing interventions may include measures such as providing recommendations for heart healthy diet, exercise, smoking cessation, and adherence to hypertensive and diabetes medications and follow up. Nurses can monitor PCa patients with MACE history and provide education on lifestyle factors that may impact treatment outcomes, quality of life and adherence.
The STAT RN is an established role in the acute care setting, providing a high level of clinical expertise and critical thinking while supporting nursing staff and responding to emergent situations. In an NCI designated ambulatory center, the STAT RN role was initiated and is key to the identification and episodic management of complex, high acuity patients. Consultation across the ambulatory care system is frequently initiated as patients are experiencing acute symptoms, oncologic emergencies or toxicities. The purpose was to describe the implementation, utilization, and ongoing evaluation of the STAT RN role following a 6-month implementation. A STAT nurse is staffed 5 days per week during peak hours and is a mandatory role for daily staffing. STAT RNs are a member of the Rapid Response team (n=23 events per month). STAT nurses are immediately accessible via phone or in person. STAT RN rounding in patient care areas involves an informal huddle with charge RNs for each unit for assessment of nursing care needs. Managing hypersensitivity reactions, oncologic emergencies, and time-sensitive interventions such as sepsis protocols are essential STAT RN expertise (n=45 events per month). STAT RNs assist with specialty skills requiring additional training including difficult vascular access, troubleshooting and removal of central lines, urinary catheter placement, wound care, bladder scanning, blood glucose checks (n=40 per month). Prompt care coordination and appropriate resource utilization has been crucial for patients. Expert STAT RN assessment facilitates decision making with clinical providers and promotes “fast tracking” of timely interventions and appropriate disposition. Common dispositions include emergency room (15%), in house oncology urgent care (15%), clinic team or home. The role of a STAT RN has proven essential in the ambulatory cancer care setting. The utilization of the STAT RN continues to increase with front line staff. The greatest benefit has been reported by ancillary services, where there is limited access to oncology clinicians and nurses. A descriptive “STAT Report” at shift completion has served as a vital communication tool for the STAT RN group, ensuring shared best practices, identification of STAT team needs, and as a valuable tool for ongoing clinical learning. A tracking form captures metrics such as time utilization, categories for events and patient disposition. Ongoing evaluation is critical to the evolution and advancement of the STAT RN role.

Cancer infusional therapy requires specialized skills and nursing expertise that covers multiple disease states, treatments, and modes of administration. Due to shifts in staffing models, an increasing number of nurses without oncology experience were transitioning to this specialty. It was recognized that additional support was needed to aid in this transition beyond the traditional orientation model. The purpose was to support nurses’ transition to oncology infusion therapy, bi-weekly Clinical Nurse Specialist (CNS)-led clinical rounds were implemented in an academic ambulatory infusion center. Upon collaboration with peer CNSs, the unit nurse manager, and expert infusion nurses, the model for clinical rounds was developed. The manager allocates dedicated time for the nurses to leave the unit to attend Clinical Rounds (CRs). CRs involve the presentation of a short didactic topic that is then followed by employee-selected case presentations. The new nurse chooses a complex patient and presents to the group using a grand rounds style, where nurses discuss the patient’s disease and staging, current and past treatments, comorbidities, and nurse-sensitive indicators. This forum also promotes group discussion of shared ideas, practices, policy review, and peer collaboration. CRs have provided an opportunity to discuss specific patient plans, complicated patient situations, and applicable policies and procedures. Didactic topics included extravasation prevention and management, patient education, chemotherapy dual-verification practices, carboplatin calculations, and immunotherapy patient monitoring. While more than 25 nurses have participated in clinical rounds since its inception, attendance varies from two to twelve attendees at any given session. CRs have been well received by new staff on the unit with feedback indicating that the content is relevant to practice, the format fosters discussion, and the experience is recommended to all new employees. Based upon feedback, CRs frequency were updated to a monthly format along with a date change. CRs were successfully implemented in 2020 and continues.
monthly in this ambulatory academic infusion center. Flexibility with scheduling and leadership support has been crucial to its adoption. Additionally, allowing for nurses to select future topics for discussion fosters engagement. Due to the success of CRs, experienced nurses are requesting a similar model to support their ongoing learning needs. Expansion of a CR model is currently under exploration for experienced oncology nurse support.

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ASSESSMENT OF DISTRESS AMONG FEMALE BREAST CANCER SURVIVORS: A LONGITUDINAL ANALYSIS

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Survivorship

Breast cancer survivors often experience cancer- and treatment-related adverse events, which can impact on the prevalence of distress. This study aims to determine the prevalence of distress and problem-related distress among female breast cancer survivors at three time points. Additionally, we aim to explore the association between distress and clinical characteristics. This longitudinal study was conducted at a private cancer center located in São Paulo, Brazil, from 2021 to 2022. Patients were assessed at three months (T1), six months (T2) and nine months (T3) after the completion of surgical and clinical treatment (excluding endocrine therapy). The project received ethical approval from the committee (protocol number: 3.203.556/3.351.628). Data collection included a questionnaire to access clinical data and the Distress Thermometer, which consists of an 11-point scale (ranging from 0 indicating no distress to 10 indicating extreme distress), along with a problem list (PL) comprising 35 items distributed across five domains: practical, family, emotional, spiritual, and physical. Data analysis: Kruskal-Wallis test was used to determine the association between the outcomes (p ≤ 0.05). The study included 101 participants with an average age of 52.9 years (SD=9.9), of whom 65.3% were married. The majority reported moderate to severe distress (61.4%) at T1. At T2 and T3 the prevalence was 66.3% and 59.0%, respectively. The most commonly reported problems were emotional, spiritual, and physical. Older patients reported higher levels of distress at T1 and T3. At T2, lower levels of distress were associated with higher education, and at T3, lower level of distress were associated with elementary education compared to high school and higher education. Distress was significantly associated with problems-related distress at T1, particularly with depression (P=0.001). At T2, higher levels of distress was associated with housekeeping, financial concerns, partner-related issues, depression, loss of interest in daily activities, breathing, and eating (P<0.05), while at T3, they were associated with partner-related issues, nervousness, sadness, changes in urination, diarrhea, indigestion, dry or congested nose, sleep, dry and itchy skin (P<0.04). The majority of female breast cancer survivors reported emotional, spiritual, and physical problems over time. Distress levels were significantly correlated with age and education level. The qualified care of cancer survivors requires personalized and continuous assessment.

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HEALTH LITERACY OF PEOPLE WITH CANCER USING BRAZILIAN PUBLIC HEALTHCARE AND RECEIVING ORAL ANTINEOPLASTIC CHEMOTHERAPY: CORRELATIONAL STUDY

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Patient Education and Safety

The assessment of health literacy (HL) is related to health behaviors and assertive decision making. Scientific evidences indicate that HL has an impact on the appropriate management of oral therapy. The purpose was to characterize HL levels and correlate them with the sociodemographic and clinical characteristics of adults with cancer undergoing to oral therapy. Cross-sectional, correlational and quantitative study, carried out with patients treated in clinical oncology outpatient clinics of a university hospital in the city of São Paulo, São Paulo, Brazil, linked to the free public health system. Data collection took place between 2019 and 2021, with disruptions caused by the COVID-19 pandemic. Instruments: Questionnaire for sociodemographic and clinical characterization (age, sex, self-declared race, oncological diagnosis, pre-existing comorbidities, number of oral medications taken daily, years of education, work activity) and the Brazilian version of the European Health Literacy Survey.
(HLS-EU-BR), composed of 47 questions, distributed across four dimensions of information processing: access, understanding, evaluation and use of information in decision-making. The final score indicates the following levels of HL: inadequate (0 to 25), problematic (>25-33), sufficient (>33-42) or excellent (>42-50). Ethical research precepts were respected. Data analysis: Spearman correlation test; Student’s t test, univariate variance test and the Kruskal-Wallis H test. Sample composed of 100 participants, 68% aged 51 or over and diagnosed with breast cancer (46%), chronic myeloid leukemia (45%) and multiple myeloma (9%). The majority without comorbidities (52%) and using three or more medications per day (52%); 53% had 11 years of education or more; 49% were retired or had a medical certificate to leave work. The overall HLS-EU-BR revealed that 52.9% of the sample had an inadequate level of HL, 24.1% with problematic HL, 20.7% with sufficient HL and 23% with excellent HL. HL levels varied across the three races/ethnicities (black, mixed race and white) between inadequate and problematic, with no statistically significant difference. There was a statistically positive relationship between HL and education (p: 0.007) and a negative relationship between HL and frequency of medication administration (p: 0.024). Discussion: The HL of adults with cancer on oral therapy was characterized as inadequate or problematic. Respondents with higher education and less frequent use of drugs had higher levels of general HL. The results suggested that health education must be well designed and prioritize principles that promote HL.

**P72**

**EMPOWERING ONCOLOGY NURSES WITH THE LATEST RESEARCH ON WELLNESS TO STRENGTHEN CONVERSATIONS WITH THEIR PATIENTS.**

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Survivorship
Cancer care is evolving beyond mere treatment, emphasizing holistic well-being. The integration of wellness into oncology patient care has emerged as a transformative paradigm. Yet, with the information age bringing vast amounts of data to our fingertips, unraveling the complexities of cancer risk factors, treatments, and prevention within the context of wellness-centered healthcare can be challenging as new research emerges. These topics can also be conversations which oncology patients and survivors ask of their care team on a regular basis. The purpose was to provide participants with the latest research and applicable point of care information in the areas of modifiable risk factors, specifically tobacco use, alcohol meat and fiber intake, cancer survivor diet, physical activity, obesity/overweight, and meta-inflammation can lead to increased education and potential behavior modification of oncology survivors. The session will:

- Review and provide an electronic link list of lifestyle recommendations related to cancer from 14 national professional healthcare organizations.
- Report a recommendation ranking across the 14 national professional healthcare organizations of individual lifestyle interventions in the areas of diet, physical activity & cancer prevention.
- Describe the latest research in the area of direct connections emerging between modifiable risk factors and a cancer diagnosis from the perspective of a medical oncologist who is also a diplomat from the American Board of Lifestyle Medicine.
- Provide an evidence based point of care “tips list” that have been crafted in collaboration with professional organizations. This “tips list” is designed to assist oncology healthcare providers with a “script” for meaningful and effective dialogue regarding these important lifestyle topics while simultaneously honoring the recommendations of the cancer care team.
- Emphasize the usefulness of available cancer center and ONS lifestyle wellness resources.

The presentation will include role play scenarios demonstrating oncology patient questions use of the “tips list” alongside an ONS/likely cancer center resource for oncology nurses with time for discussion and feedback. Integrating wellness into oncology care is essential. Equipping healthcare providers with current research and tools empowers them to address modifiable risk factors and foster behavior change among cancer survivors which is a worthy patient centered endeavor. This shift is imperative for improving cancer care in the information age. Continued focus on this area can lead to exciting helpful holistic interventions for cancer patients and survivors.

**P73**

**BRIDGING THE GAP: INTEGRATING UP-SKILLED MEDICAL ASSISTANTS INTO THE AMBULATORY CLINIC SETTING**

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The healthcare industry is constantly evolving, demanding versatility and adaptability from its workforce. In response, medical assistants (MAs), traditionally confined to basic clinical tasks, are increasingly upskilled to meet the dynamic needs of ambulatory clinics. This plan of action explored the process of transitioning trained MAs into their enhanced roles within ambulatory clinics, emphasizing the critical importance of seamless integration. The transition process involved several key components. It necessitated comprehensive training programs to equip MAs with advanced skills and knowledge required in an ambulatory care setting. This program encompassed expanded clinical responsibilities, proficiency in electronic health records (EHR), and improved patient communication skills. Successful integration required a collaborative approach involving physicians, nurses, and other healthcare professionals. Establishing clear roles, responsibilities, and effective communication channels are vital for cohesive teamwork. Technology also played a pivotal role in this transition. Initiating new responsibilities in the EHR systems, patient outreach responsibilities, and participating in electronic patient management solutions were integral to streamlining workflows and enhancing patient care. A timeline, inclusive of both required technological and tangible tasks, was established for the transition of skills to evolve sequentially across each pre-determined milestone. The approach was multidisciplinary, involving members of the care team and supportive departments to achieve success. Working cohesively created a successful environment and allowed for seamless transition of this element of care coordination in our ambulatory redesign. In conclusion, the integration of upskilled MAs into ambulatory clinics is a promising development in healthcare, offering improved access to care and more efficient operations. To achieve successful integration, a multifaceted approach including education, collaboration, and technology adoption is vital. At this current time, there is a landscape into the MA roles in ambulatory care, emphasizing the importance of adapting to meet the changing needs of healthcare delivery. Resultant from a thorough evaluation of the current state of MA responsibilities and workload, the team mobilized into the transition, examining all the benefits and challenges revealed. Upskilled MAs enhance clinic efficiency, reduce physician workload, and improve patient satisfaction. Additional attention will be placed on providing ongoing education to close potential skill gaps and to mitigate potential resistance to change with communication to support to MAs.

P74 ENHANCING COMMUNICATION AND CARE COORDINATION: ELECTRONIC HUDDLES IN AMBULATORY CARE SETTINGS
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Coordination of Care
In ambulatory healthcare settings, the need for efficient communication and care coordination is paramount to ensure delivery of high-quality patient care. The concept of electronic huddles is a novel approach leveraging technology to facilitate real-time multidisciplinary communication among healthcare providers. Electronic huddles offer a virtual platform for clinicians to collaborate, share insights, and make informed decisions regarding patient care, regardless of physical proximity. This initiative examines the benefits, challenges, and implementation strategies associated with electronic huddles in ambulatory care. Highlights with their potential of huddles to enhance patient outcomes, streamline workflows, and improve overall healthcare delivery are deployed. Channels were created within the Teams SharePoint site affording each clinic location an ability to participate in the daily morning huddles. The care coordination teams in the ambulatory clinic joined a virtual Teams meeting prior to the start of the morning sessions. An electronic list, embedded in the channel, was utilized to document concerns, room utilization, special patient considerations, additional staff commitments such as meetings to be attended, tasks to be completed, or additional assignments for other stakeholder awareness and to facilitate coverage, if necessary. This adopted documentation identifies themes or challenges with potential process improvement initiatives in ambulatory care. The findings underscore the importance of integrating electronic huddles into ambulatory care settings, thereby fostering a more efficient and patient-centered approach to healthcare provision. This process demonstrated to be contributory for communicating across the geographic footprint of the organization, keeping staff informed and engaged with their teams. Improved communication, throughput, and efficiency with daily clinic flow was evident in all areas. After a thorough evaluation of current in-person huddles, a platform for electronic communication was created by administration. Due to the vastness of the clinic footprint, the in-person approach was not a
successful modality to advance this initiative as staff were unable to gather at a central location and travel to the huddle sites. With this new accentuated approach, staff were able to be present for the huddle and no longer needed to leave their workspace. Additionally, staff were readily available to efficiently begin the morning clinic sessions post huddle. Lastly, the documentation platform allowed administration to confirm that the huddles were occurring, and vital daily information was shared across the teams.

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REDESIGN OF THE ONCOLOGY NURSE RESIDENCY PROGRAM
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Professional Development
Nurse residency programs play a vital role in patient safety, retention and recruitment of staff, and successful transition into nursing practice. Nurse leaders and educators at a large magnet hospital in the Northeastern U.S. identified several gaps in the Oncology Nurse Residency Program (ONRP). The ONRP functions independently from the main hospital’s core residency creating gaps in scheduling, resources, and resident and program evaluation. These gaps in the ONRP limits the capability to effectively meet the needs of the residents leaving our residents without the experience, and confidence to provide quality care. The purpose was to share our experience on the redesign of the ONRP to create a streamlined oncology residency program with a competency-based curriculum and a dedicated residency coordinator. The nurse leaders and educators developed a team of experts to lead this redesign. A crosswalk was completed on the ONRP and the central nurse residency programs curriculums identifying content and programmatic gaps. Outcome based goals were created based on the Oncology Nurse Generalist Competencies. These materials provided a comprehensive approach to build the curriculum utilizing high impact learner-centered strategies integrating didactic content, simulation, and clinical experiences throughout the residency. Residents fill out evaluations after the residency identifying satisfaction in the residency program, identifying confidence in transition into practice. The evaluation of the old ONRP will be compared to the evaluation of the redesigned ONRP. Pre-implementation data on nurse retention was collected prior to implementation of the redesigned ONRP, this will be compared to post-implementation retention data. Interviews with nurse managers will be conducted to evaluate competence, confidence, and readiness for practice in the exiting residents after the redesign.

New graduates in oncology experience the emotional burden of cancer care as well as complex, evolving treatment plans and symptom management. Some of this burden can be ameliorated by ensuring a knowledgeable and competent healthcare workforce. The redesign of the ONRP and addition of a dedicated residency coordinator will increase retention, ensure nurse and patient safety, and support new oncology nurses in their transition to oncology nurses that are confident in their practice. This work embodies an essential commitment from the leadership at our Cancer Center to prepare nurses to provide safe, effective, and inclusive cancer care.

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UTILIZING VIDEO ANIMATION TO INCREASE KNOWLEDGE PRIOR TO INFUSION VISIT
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Patient Education and Safety
Utilizing videos for education has been shown to improve retention of information and can assist healthcare systems improve the patient experience by allowing patients to feel better prepared for upcoming procedures and assist in explaining complex medical topics while overcoming barriers with low health literacy. During the COVID-19 pandemic, visitors were not allowed in the outpatient infusion centers. This left patients and caregivers uneasy about what to expect during their course of treatment due to the substantial amount of information at initiation that can result in comprehension difficulties. The oncology service line identified a need to better inform our patients and caregivers about what to expect prior to arriving for their first chemotherapy treatment. A team of frontline oncology nurses developed content and created online educational modules for newly diagnosed oncology patients and caregivers to view prior to the first infusion visit. The content contained what to expect during the first visit, general terminology, common side effects, support services offered, and what to expect after treatment. Seven short videos were created utilizing animation that patients could access and share with their caregivers. A postcard with a QR code leading to the videos is handed out by oncologists who refer to the infusion center. The oncologist can also incorporate the QR code into the patient’s After Visit Summary.
through a smart phrase in EPIC. The videos are available in English and Spanish with the intent to add other languages in the future. An optional survey was added to the end of the modules asking patients/caregivers to identify which modules were viewed, rate their knowledge before and after viewing the videos and advise if the videos were helpful. Videos were launched September 2023 and initial data analysis will take place in December 2023. Final presentation will include a full report of the outcomes related to this intervention. Technology is shaping the future of patient education. It allows healthcare organizations to engage patients and caregivers prior to even stepping foot into the hospital. Utilizing animation allows videos to remain relevant in the ever-evolving world, are patient friendly, and promotes inclusion, empowerment, and a cultural understanding.

P77 HOME HAZARDOUS DRUG SPILL KITS AND PATIENT EDUCATION
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Patient Education and Safety
Oncology patients were sent home with hazardous drugs (HD) in elastomeric infusion pumps without a consistent system’s process for the provision of a home HD spill kit (HHDSK) and patient education on managing a leak or spill. ONS safe handling toolkit states, “Patients should be given a prepackaged spill kit with easy-to-follow instructions on how to clean themselves and their environment, how to dispose of contaminated materials, and to whom they should report the spill.” This project was designed to consistently meet this safety recommendation. Collaborated with value analysis team (VAT)-RN to source an HHDSK that included recommended items, a reliable manufacturer, and an affordable price. Selection was presented to the VAT for approval citing the need to follow ONS recommendations. Upon approval, the HHDSK was placed on formulary. A patient education leaflet, Home Chemotherapy Spill Instructions (HCSI), was developed with input from infusion clinic nurses (ICNs) and patients. The HCSI was translated into Spanish and both versions were evaluated for health literacy and comprehension. The HHDSK bundle (HHDSK with color copies and laminated versions of the HCSI leaflets) was rolled out to all infusion clinic sites. Implementation with all ICNs included a review of the HHDSK contents, the HCSI leaflet and expected workflow to occur at the first cycle of HD via elastomeric pump. The ICN provides the patient with the HHDSK and a copy of the HCSI, reviews the contents and instructions, and validates comprehension through teach back. The HHDSK bundle was successfully implemented with ICNs reporting increased satisfaction in the care they provided through the preparation of patients to care for themselves. However, a problem occurred when the ICNs attempted to place an HHDSK restock order. The original HHDSK was unavailable. The potential lack of access to the HHDSK was quickly reported. Fortunately, another appropriate HHDSK was quickly sourced by the VAT-RN and at a lower price-point than the original. Patients frequently have treatment-related anxiety which is compounded when chemotherapy is infused at home without healthcare personnel. Equipping patients with HCSI safety knowledge and appropriate supplies has the potential to ease some of those concerns, while achieving our safety goal and meeting ONS recommendations.

P78 ADDITION OF PLERIXAFOR ON DAY 4 OF MOBILIZATION WITH GRANULOCYTE-COLON Y STIMULATING FACTOR (G-CSF) IN AUTOLOGOUS DONORS UNDERGOING APERESIS STEM CELL COLLECTION
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Treatment Modalities
Autologous stem cell mobilization requires minimum of 3x10^6 CD34+ cells/kg to be collected of the donor before proceeding with the transplantation. The mobilization and collection of the CD34+ cells using apheresis of peripheral blood can be performed after chemotherapy or at distance of cytotoxic treatment by using G-CSF. For patients with poor or delayed mobilization, the addition of plerixafor to filgrastim has demonstrated a positive impact (Gupta et al, Transfu Apher Sci 2021), allowing more donors to meet goals of collection. In our institution, a large percentage of patients undergoing stem cell mobilization with a conventional regimen of 4 days of filgrastim were not ready to start apheresis by day 5 of their mobilization. In these patients, at least one dose of plerixafor was required starting at day 5 which increased the number of days of apheresis to reach goal or delaying collection to day 6 (leaving empty chairs in the apheresis unit on day 5).
Purpose: Our purpose was to optimize collections for autologous patients by systematically using filgrastim (10 mcg/kg/d for at least 4 days) and plerixafor (dosing per package insert starting on day 4) as a standard mobilization regimen in non-chemo mobilized patients to reduce number of days of collection to meet goal and to initiate collection sooner. The algorithm was modified such that all patients collecting peripherally will receive plerixafor in the evening of day 4 and start collection on day 5. Patients, requiring a central line follow the same process but only receive plerixafor and central line placement on day 4 if their CD34+ count is >2 cells/µL. Evaluation was done with real time data collection and monthly review of the data. The following data was collected: plerixafor received on day 4, CD34+ count on day 5, goal for collection, goal met, and how many days for goal to be met. Data showed an important decrease in days of collection for patients. The data collected from January to December 2022 was used as a comparator. The systematic addition of plerixafor in the mobilization regimen of patients undergoing autologous collection positively impacted patient care by reducing the number of days to reach collection goal. It also allowed for a more predictable schedule in the apheresis unit, allowing to accommodate more patients in the unit each week.

**P79**

**MANAGING CRS AND ICANS WITH CAR-T AND BI-SPECIFIC ANTIBODY THERAPY**

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Symptom Management and Palliative Care

Cytokine Release Syndrome (CRS) and Immune Effector Cell-Associated Neurotoxicity Syndrome (ICANS) are often seen as side effects of chimeric antigen receptor T-cell (CAR-T) therapy which can lead to extensive morbidity and mortality. They are also seen, sometimes to a lesser extent, with bi-specific antibody therapy. Early recognition of and intervention for these symptoms are imperative. In the early days of CAR-T, steroids and tocilizumab were used to treat more progressive symptoms, later in the course of these complications. Recent changes in management of CRS and ICANS trend toward use of these agents earlier and even as prophylaxis. The purpose of this presentation is to discuss assessment for and early identification of symptoms of CRS and ICANS, as well as newer management strategies to prevent or minimize their effects. We will discuss newer recommendations for management of CRS and ICANS. Earlier use of steroids, tocilizumab, and anakinra may prevent these effects or avoid higher grade toxicities. We will also discuss the psychosocial impact on patients experiencing CRS and ICANS and their caregivers, as well as strategies for mitigating these effects. The early use of steroids and tocilizumab, and the addition of anakinra, may produce better patient tolerance of CAR-T and bi-specific antibody therapies. This may decrease length of hospitalization, avoid or reduce intensive care stays, and improve tolerance of therapy. More study is needed to evaluate the effects of early steroid use, to determine if it impacts long-term outcomes of these therapies.

**P80**

**ONCOLOGY NURSES FOCUS ON THEIR OWN SAFETY: CREATING A CLOSED SYSTEM DURING INTRAVESICAL HAZARDOUS DRUG ADMINISTRATION TO REDUCE SPILLS AND STAFF EXPOSURE**

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Oncology Nursing Practice

As oncology nurses, we are often tasked with handling hazardous drugs (HDs) that are lifesaving for our patients but can pose health risks to staff. Minimizing the exposure of HDs to our staff is of great importance. In reviewing reports of HD spills and staff exposures, it was clear that the intravesical therapies were putting staff at risk. A baseline surface wipe study showed contamination of the environment with drugs used in this therapy. The purpose of this quality improvement project was to design a new process for the safe administration of intravesical HDs that allowed for accurate delivery of the drugs, reduced HD exposure for staff, and reduced environmental surface contamination by maintaining a closed system during HD delivery and draining. A work group was formed to brainstorm an alternative administration procedure for intravesical therapies. The goal was to develop a technique that would allow the nurses to keep the drainage bag and the catheter connected without having to break the manufacturer seal between the two pieces and to use the side port and closed system transfer devices (CSTDs) to administer the HDs. Mock intravesical therapies were completed to test the safety and to
verify the procedure prevented backflow during dwell time. Once the new procedure demonstrated consistent results in the mock trials, training and education was completed with nursing staff using competency and skill validation. The new administration procedure for intravesical therapies has been in place for 2 months. The nursing staff has verbalized feeling safer when using the new procedure because they are able to keep the CTSD in place and avoid any disconnects of the urinary catheter from the drainage bag during the installation of drugs. Environmental surface contamination monitoring results will be conducted 6 months post implementation to monitor success. Intravesical HD administration can be a high-risk procedure but there are steps that can be taken to reduce the potential for spills and staff exposure. Safe handling of HDs is vital to the health of everyone on the unit. It is imperative that we use all the safety mechanisms available to protect our staff and the environment.

P81
PALLIATIVE CARE, SERIOUSLY, WHY ARE YOU CALLING!? AM I DYING?
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Symptom Management and Palliative Care
Patients often are referred to Palliative Care when they are at end of life, but is that truly taking advantage of what can be offered to them? Palliative Care is often misconstrued that way from the lay person and the educated. Palliative care is meant to not only care for people, but engage, listen, and focus on what they as patients want. Pain, symptom management, psychosocial needs, quality of life, and most important, how they the patient want to proceed with their serious illness. This is meant to establish a relationship with patients at the initial conversation with Palliative Care via telephone. Taking the time to educate and understand and gain trust at the time of the initial conversation. To educate patients/people that being referred to Palliative Care does not mean one is giving up. Calling patients within 24-72 hours of receiving the referral. Introducing oneself at the beginning of the call, reiterating who the referring provider is, and why they are being referred. Assessing what is occurring from a physical/psychological standpoint (pain, symptom, psychosocial, quality of life, etc.). Plan is to evaluate 80% of all new referrals, conduct a survey with 4 questions to gain patients perception of what Palliative Care is, and what Palliative Care offers.

■ Prior to your initial conversation with the Palliative Care RN, was Palliative Care explained to you? Yes or No
■ Do you feel that after talking with the Palliative Care RN, you as a person/patient better understand what Palliative care has to offer? Yes or No
■ Do you feel that you can trust the Palliative Care team as part of your care while you are dealing with your disease? Yes or No
■ Do you feel that you trusted the Palliative RN that you spoke to after your initial conversation? Yes or No

The importance of understanding as a professional what Palliative Care is and having the knowledgebase to educate patients of what it has to offer. Understanding that we all offer Palliative Care in our nursing care. Establishing trust with all of our patients and hearing what their needs are.

P82
NORMAL SALINE VERSUS HEPARIN FLUSH IN IMPLANTED PORTS
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Oncology Nursing Practice
The use of heparin in ports is outdated. Recent studies show normal saline pulsatile flushing to be adequate to maintain port patency. There are risks associated with heparin, including heparin-induced thrombocytopenia. In addition, there is a cost savings opportunity with elimination of heparin flushes. One hospital’s translation of evidence into practice by addressing, “In adults, is normal saline flush, compared to heparin flush, adequate to maintain port patency?” The total Alteplase administrations each month was gathered for both the Reading Hospital Infusion Center (RHIC) and Reading Hospital (RH) to serve as a baseline for port occlusions. Approval was obtained from key stakeholders. Electronic learning module was developed and assigned to nurses with port competency. RH Nursing Administration Memorandum sent to all nursing units on February 15, 2023. Practice revision of ports being maintained with normal saline flush only prior to port de-access went into effect March 1, 2023. Total Alteplase administrations were reviewed in the three months following implementation to monitor port occlusion trends for the fiscal year (FY). A detailed usage report listed the lowest unit of measure for each department in the time measured. The average monthly product was then multiplied by the cost of a heparin flush ($0.35) to measure cost savings. In reviewing Alteplase utilization after the practice revision, there was no significant increase in
usage throughout RHIC or RH. In quarter 4 of FY 2023, this project demonstrated a cost savings of $1,149.75 for RH. Removal of heparin flush from port de-access protocol is safe and effective in maintaining patency and reduces healthcare associated costs in the adult population. More research is needed for the pediatric population. Normal saline flush needs to be at least 10 ml with a push and a pause after each ml given.

P83
DEVELOPING A STAFF LED SURVEY TO ASSESS TEAM SATISFACTION AND LEARNING NEEDS IN ENDOSCOPY
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Endoscopy procedures provide preventive, palliative, and curative interventions to cancer patients. Most of patients coming to cancer centers for endoscopic therapy are seeking diagnosis or on-going therapeutic intervention. In 2022 the endoscopy department at an NCI designated multi-center cancer facility doubled the clinical capacity for service, requiring an twofold increase in trained staff. The purpose of this project was to assess educational opportunities for staff, to obtain input regarding staff and patient safety, and to elicit feedback regarding staff concerns and satisfaction. The roadmap for this work followed the rich shared governance structure of the institution. The Practice Council created a questionnaire using a survey platform, REDCap, consisting of question on demographics, role satisfaction, safety concerns for patients and staff, and self-evaluation and peer-evaluation on the type of cases performed on our unit. The survey was distributed to all staff including Registered Nurses, Surgical technicians, and Surgical Assistants between February and April, 2023. 88% (n 37) of staff participated in the survey. The results were reviewed by the Practice Council in partnership with nursing leadership. Survey results identified strengths in role satisfaction (86% satisfied or highly satisfied) and patient safety measures including communication (86% satisfied or highly satisfied), infection control (86% satisfied or highly satisfied) and patient identification (91% satisfied or highly satisfied). Questions asked to assess competence and comfort with procedures were organized to scale learning needs and were used to drive content for In-services and educational presentations coordinated by the teams Clinical Nurse Specialist and delivered in weekly long in-services. The results of the survey indicated overall positive findings related to a culture of safety and desire to work as team to close gaps in knowledge. Future directions for this work include harnessing the passion identified in the Endoscopy staff to maintain rigorous safety standards and ignite the passion for education to move forward with novel therapies for endoscopic interventions for oncology patients. The council plans to administer the survey bi-annually to increase competency and identify areas of improvement.

P84
STANDARDIZED SYSTEMATIC NURSING ASSESSMENTS IN AN OUTPATIENT ONCOLOGY SETTING
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Standardized nursing assessments improve quality of care and patient outcomes by concisely collecting patient data resulting in improved care coordination (Alderdan & Cummins, 2016). A systematic assessment improves patient interventions and reduces patient emergency room visits (Graze, et al., 2014). Systemic criteria have a proven 40%+ satisfaction rate among nurses when piloted in an outpatient oncology clinical setting (Cunningham, et al., 2017). Widely inconsistent nursing assessments were noted across our community-based oncology practice with more than 30 locations scattered across two states. The purpose was an Evidence-Based Practice Project (EBPP) focused on reducing inconsistencies of treatment and “nurse only” visit assessments among the organization’s infusion center nursing staff. Nurse Residents (NR) at our practice must identify a need and complete an EBPP. Variation in nursing assessments was noted by the NR during clinical rotations and submitted for consideration. The project request was reviewed by a committee and approved. The NR completed a literature review on the significance and impact of standardized nursing assessments with focused attention on outpatient infusion centers. This included patient and nursing satisfaction. Other areas of the EBPP included standardized equipment needs versus equipment available and documentation best practices compared to nursing forms available. Recommendations for changes were submitted to committee during formal presentation of the EBPP that included details of assessment,
equipment, and documentation requirements. The EBPP was then presented to Executive Leadership Team for approval. Practice guidelines including timing, frequency and content were created for various visit types outlining head to toe and focused assessments. Assessment equipment standards were set for all infusion centers. Recommendations were made to modify the existing Nursing Progress Note adding a systems assessment tab to guide documentation. Macros that can be personalized to individual patient findings were recommended. Updates to CTCAE toxicity categories were needed to expand options for assessment findings. Phase II (implementation) of standardized nursing assessments is projected for early 2024. In Phase II, surveys would be conducted at defined intervals to measure nursing and patient satisfaction with assessments and determine any modifications needed. Nurse Residency EBPPs are a valuable tool for identifying gaps in care or service needs within a multi-location community practice. Creation and implementation of a standardized nursing assessment guideline will bring about consistent documentation, concise patient data, increase patient outcomes, and improve care coordination.

P85 PREVENTIVE SCREENING FOR CLOSTRIDIUM DIFFICILE TO REDUCE HOSPITAL-ACQUIRED INFECTIONS IN BMT PATIENTS
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Oncology Nursing Practice
Clostridioide difficile infection (CDI) is a critical issue in healthcare but has shown to substantially affect morbidity and mortality among bone marrow transplant (BMT) patients. CDI typically arises from antibiotic use, which disrupts the gut microbiome leading to critical conditions such as colitis and severe diarrhea. Due to the weakened immune system in the transplant population, CDI is more prevalent. This study is aimed to improve patient care quality within the BMT population by implementing a comprehensive screening protocol for CDI upon hospital admission. The protocol was designed to prevent hospital-acquired CDI (HA-CDI) among BMT patients at Temple University Hospital and to differentiate patients who acquired a CDI during their inpatient stay from patients who are colonized with C. diff. The pre-screening was implemented in November 2022 and is currently ongoing.

As part of the protocol, BMT patients are routinely screened for CDI using PCR and toxin tests. Testing was done irrespective of whether the sample is formed, unformed, or watery. All patients received prophylaxis with oral vancomycin regardless of test results. Additionally, patients testing positive for both PCR and toxin received the appropriate vancomycin treatment dose. A stringent infection control policy was implemented to minimize the spread and recurrence of the infection throughout the treatment process. To assess the interventions’ effectiveness, we thoroughly compared post-intervention CDI rates with those from a historical control group. Since the pre-screening protocol’s implementation, we observed lower-than-expected rates of HA-CDI. Only two cases of HA-CDI were observed in the first half of 2023, demonstrating the implemented measures’ significant effectiveness. Preliminary data suggest these interventions are associated with reduced rates of HA-CDI. The differentiation between patients with HA-CDI and those colonized prior to admission has further enhanced the understanding and management of CDI in BMT patients. The combination of early detection through comprehensive screening and prompt treatment initiation plays a critical role in minimizing CDI-related morbidity and mortality. This study seamlessly integrates routine CDI screening and targeted treatment within the BMT context. It emphasizes the paramount importance of not just managing, but proactively preventing infections in immunocompromised patients, thereby presenting a more effective approach in the realm of infection control within BMT.

P86 TECLISTAMAB EARLY DISCHARGE PROGRAM
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Oncology Nursing Practice
Teclistamab is a new bispecific T-cell engager (BiTE) being used to treat the multiple myeloma population. Initial administrations called for 11-day inpatient admission for step up dosing and monitoring for cytokine release syndrome (CRS) and immune effector cell-associated neurotoxicity (ICANS). We found we could escalate the dosing schedule to days 1/3/5 without increasing incidence of CRS and ICANS. Here at
our comprehensive cancer center, bed shortages are common. This often leads to delayed admissions for patients scheduled for more complex anti-cancer treatments or requiring those with oncologic emergencies to be boarded on non-oncology units. To mitigate the problem, we explored ideas of discharging patients earlier in the Tecristamab administration process and continuing the regimen in our outpatient myeloma clinic. The purpose was to create a Tecristamab early discharge program to free up hospital beds for critical oncology patients. The goal, at this time, is to discharge patients on day 6 to the outpatient clinic, where they will resume patient care. A program has been developed whereby the outpatient clinic tracks patients prior to admission, through admission and discharge. Admissions occur Wednesday-Saturday to ensure discharge day aligns with outpatient clinic schedules (open Mon-Fri). An electronic inpatient/outpatient flowsheet is used to transition care from inpatient unit to outpatient team. At this time, a select team of myeloma nurses are responsible for patient follow up calls on days 6 and 7. A home caregiver helps assess for late onset CRS/ICANS symptoms. To date, 2 patients have been a part of the early discharge program. One patient, 76 years of age, exhibited potential signs of CRS including headache and nausea. She was brought to clinic for supportive care and lab work and remained outpatient. The second patient had no reportable side effects. At this time, 3 additional patients are scheduled for the early discharge program. Patient results continue to be monitored with hopes of implementing a day 4 discharge with day 5 dose administration outpatient.

Discussion: Standardized assessment tools for CRS and ICANS provide the nurses toxicity grading and management algorithms. We have the ability, at our outpatient clinics, to administer Tocilizumab and Keppra to manage toxicities related to CRS and ICANS. The plan is safe, and we expect to continue to decrease length of stay for this regimen.

P87  
ANXIETY MANAGEMENT: A NON-PHARMACOLOGICAL APPROACH  
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Oncology Nursing Practice

As cancer survival rates improve, there’s a growing emphasis on enhancing quality of life for oncology patients (Allemani et al., 2019). Oncology patients experience various symptoms and emotional stressors, leading to stress and anxiety (Villoria & Lara, 2018). The purpose was to evaluate the impact of aromatherapy on emotional distress amongst hospitalized oncology patients. Implementation occurred over a two-month period from May to July 2023. To ensure consistent results, staff training was provided during staff huddles, monthly meetings, and through reading materials placed around the unit. During the admission process, nurses assessed their patients for any signs and symptoms of anxiety and/or checked the medical administration record (MAR) for any PRNs being used to manage anxiety. If deemed appropriate, nurses then scanned a QR code on a flyer located at bedside that redirected to a webpage questionnaire comprised of the HADS-A rating scale. The survey consisted of seven questions evaluating symptoms of emotional distress. Responses were graded on a scale indicating the amount of days per week the patient being evaluated experienced the symptoms described in each question. The responses ranged from zero to three, zero being not experiencing any symptoms and three indicating experiencing symptoms daily. Any score above 8 denotes a positive screening for anxiety. If a score of 8 and above on the questionnaire was indicated, patients were able to choose from lavender, peppermint, or lemon essential oils. Essential oils and educational information were placed at the nurses’ stations. Patients were re-screened upon discharge. The HADS was utilized to assess patients’ anxiety scores. The type of essential oil used was evaluated using a survey. The scores were measured upon admission and discharge of the patient. Collected data from Qualtrics on adult oncology patients revealed all three scents effectively reduced anxiety scores (Graph 1). The average anxiety score dropped about 7 points from 11.40 to 4.47 post-implementation, indicating anxiety levels below the positive screening threshold (Graph 2). Project findings suggest aromatherapy’s anxiety-reducing benefits in oncology patients, particularly lavender, which is consistent with the literature review. Future practice may benefit from adding a condensed HADS scale to CareConnect’s assessment section, providing patients an early, non-pharmacological treatment option. Staff compliance was limited due to the unit’s workload, and inadequate follow-up on staff education caused implementation challenges.

P88  
EVALUATING THE REACTION RATES CAUSED BY THE TITRATION OF PACLITAXEL AND DOCETAXEL
Across our infusion centers, the administration of first and second dose Paclitaxel and Docetaxel was not standardized. Some sites were titrating doses, while others were not. The proper way to administer the drug was unknown. There is no recommended standard practice from the drug manufacturer nor consistent evidence-based guidance to support titration for first and second doses of Paclitaxel and Docetaxel. The purpose was to identify the best process with the lowest reaction rate that will standardize the administration of first and second dose Taxanes for patient safety and consistency in nursing practice. A quality improvement project was begun starting with a current chart review citing reaction rates, grades of reaction, and completion of prescribed doses. This review looked at titrated doses over a three-month period from October to December across four infusion sites. Subsequently, a pilot study was conducted across three infusion sites, eliminating dose titrations in favor of flat rate administration over a three-month period from May to July. Across pilot sites, nurses reported a decrease in severity of reactions and unchanged occurrence of reactions. The decision was made to change to flat rate administration across all of the infusion centers. Initial data collected using the Common Terminology Criteria for Adverse Events (CTCAE) grading system revealed a 9.9% reaction rate for titrated doses. There were zero Grade 1 reactions, seventeen Grade 2 reactions, one Grade 3 reaction, and two Grade 4 reactions. Post data after rolling out flat dose administration across all infusion centers revealed a 10.5% reaction rate for the same patient population. There were zero Grade 1 reactions, fifteen Grade 2 reactions, one Grade 3, and zero Grade 4 reactions. In the pre-intervention group, five patients were unable to complete their prescribed dose, while in the post-intervention group, only one patient was unable to complete their prescribed dose. While there was a 0.6% increase in infusion reaction rate, there was a decrease in severity of reaction. Post intervention demonstrated zero Grade 4 reactions and only one patient required a change in therapy. This intervention allows more patients to complete their prescribed doses and decreases delay in patient care with more patients receiving preferred therapy. This practice also allows infusion centers to decrease infusion time and nursing time spent titrating.

P89
PAVING THE WAY WITH PALLIATIVE CARE
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Symptom Management and Palliative Care
Discussions about life limiting illnesses and end of life care are difficult. These necessary conversations are especially challenging in the hospital where relationships with patients are often not well established. Inexperience can often lead care team members to avoid them. End of life planning is an integral part of life planning, especially for patients facing a terminal condition. One team of dedicated professionals with the support of their administration has found a way to make these conversations meaningful. The palliative care team assists physicians and the multidisciplinary team in providing holistic care to patients. The palliative nurses are specially trained, many holding palliative and hospice certifications. Their role includes assisting patients and families with establishing goals of care, educating about disease processes, managing symptoms of chronic illness, completing advanced directives, and providing resources and guidance for optimal discharge scenarios. The palliative team consists of a medical director and registered nurses who come from a variety of backgrounds and years of nursing experience. A policy exists that highlights the process and reasons to consult the palliative team. They work Monday through Saturday and strive to see consults within 24 hours, prioritizing by urgency. Measures to ensure continuity of care include a daily list in the EMR of admitted patients followed on prior admissions by the palliative care team and indication of the primary palliative nurse. It is difficult to directly measure the impact palliative services provide for patients and the hospital. While the administration of this hospital recognizes this, they believe by providing the resources for this program, they improve patient and staff satisfaction. Further evidence of the program’s success is demonstrated by fewer readmissions, decreased days spent, and resources utilized in the ICU, and shortened hospital stays. For staff, there is reduction in moral distress, a promotion of teamwork, and a sense of belonging which aids in retention and longevity. On a national level, Palliative Care is a consult service that...
P90
OPERATIONALIZING BISPECIFIC T-CELL ENGAGER (BITE) THERAPY ADMINISTRATION IN THE AMBULATORY ONCOLOGY SETTING
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Oncology Nursing Practice
The landscape of treatment options for patients with relapsed or refractory multiple myeloma has increased with the recent approval of bispecific t-cell engagers (BITEs). While the benefits of these drugs are life-altering, providing care for these patients can be challenging due to adverse events, risk of cytokine release syndrome (CRS) and the need for continuity of care in both inpatient and ambulatory settings. Due to the unique challenges associated with these drugs, a need for standardizing practice was identified. An interdisciplinary approach was used to establish a standardized workflow and education process to ensure safe and effective care. A team of physicians, advanced practice providers (APPs), nurses, educators, pharmacists, finance, admission coordinators, and schedulers was formed. This group developed a workflow to transition patients between inpatient and outpatient settings, a method to track active patients, and a workflow for clinical recommendations for CRS and other adverse event management. Additionally, effective communication practices were implemented to enhance collaboration. The tracking system, workflow and communication plan, and clinical recommendations were disseminated to staff expecting to care for these patients. All providers, nurses, and pharmacists were educated on BITE therapy and CRS/adverse event management using pharmaceutical educators and experienced physician/APP presentations. By implementing these processes in advance, nurses and providers reported increased comfort in caring for patients receiving BITE therapy. Nurse educators and leadership fielded less questions regarding these therapies given clear guidelines were established and accessible. Tracking of patients across disciplines resulted in all party awareness of where patients stood in their therapy. There has been successful, safe treatment of hundreds of patients receiving BITE therapy with no medication errors or detrimental adverse events. Communication and collaboration are essential when administering high-risk drugs in multiple settings. Given that all stakeholders contributed to process implementation, a comprehensive workflow was established in a timely manner before any patients were treated. As more patients receive treatment with BITE therapy, nurses and providers have learned more about the unique aspects of these drugs. The collaborative team continues to use feedback from all stakeholders for continuous quality improvement. However, the system created by the interdisciplinary care team continues to serve as the backbone of BITE therapy for this patient population.

P91
BENEFITS AND FEASIBILITY OF THE IMPLEMENTATION OF A MUCOSITIS SCREENING TOOL AT AN OUTPATIENT INFUSION CENTER
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Oncology Nursing Practice
Oral mucositis is a frequent adverse effect of cancer treatment, especially prevalent in patients receiving cytotoxic drugs and head and neck radiation treatment. These treatments can lead to a complex series of events causing a breakdown of oral mucous membranes, resulting in very painful ulcerations, infections, a decrease or discontinuation of oral intake leading to treatment delay, and is potentially life threatening. Oncology patients receiving cytotoxic drugs and concurrent chemotherapy/radiation are seen often by infusion center nurses. While oral hygiene is part of nurse teaching at this outpatient infusion center, currently there is no formal toxicity screen performed addressing mucositis. The purpose of this project is to increase awareness of the oral status of the infusion center chemotherapy patients and have in place a more accurate assessment and documentation of mucositis. By observing a grading scale each visit and recognizing an increase in a patient’s toxicity number, we can expect to have a more accurate assessment of oral mucositis at the infusion center. The Oral Assessment Guide (OAG) is a validated tool designed by oncology nurses that outlines eight categories of mucositis assessment. The OAG will be integrated into the charting system and nurses will be able to document a score of 1-3 on each 8 categories of the oral assessment. The categories include voice, swallow, lips, tongue, saliva, mucous membranes, gingiva and teeth. An assessment will be done with each treatment until the completion of the regimen. Chart audits will allow for collection of the data.
A STANDARDIZED APPROACH TO SPECIALIZED PATIENT EDUCATION
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Patient Education and Safety

The Pandemic posed staffing challenges in our Hematologic Malignancies and Cellular Therapeutics (HMCT) program and identified gaps in patient care including the ability to provide consistent education to patients to prepare them for transplant. The purpose was to create a nursing role that allows a masters prepared nurse to solely focus on patient education concentrating on allogeneic and autologous transplant, cellular therapies, and acute leukemia patients. A master’s prepared nurse was hired in the Education Specialist (ES) role within the HMCT program. The Implementation plan included spending 40% of their time in the outpatient setting and 60% in the inpatient, providing education specific to the transplant process. A timeline was used to outline education topics needed and when the information should be delivered. The ES was responsible for teaching a 2-hour online class to patients and caregivers prior to starting transplant. This class reviews what to expect during transplant and covers the large volume of information patients receive in a written pre-transplant manual. The ES meets with hospitalized patients during the transplant process to review topics including orientation to the hospital unit, oral care, neutropenic precautions, diet guidelines, central line care, fall risk precautions, the importance of daily hygiene, exercise, and what to expect once discharged. In addition, the ES is responsible to chair and lead the interprofessional Patient Education Committee charged to review and create patient education materials. One year after implementing the ES role, over three hundred hospitalized patients have received individual patient education and attended the online class. Patient evaluations indicate the approach to education is beneficial and have had few suggestions for changes or improvements. Frontline nursing staff provide positive feedback regarding the ES role and their accessibility in the practice setting. The role allows the bedside nurse to prioritize day-to-day care while ensuring the ES supports this specialized education. In a complex patient treatment program with specific guidelines which impact patient outcomes, having standardized education delivery meets adult learning principles and ensures opportunity for understanding. This ES role is beneficial to the program success. Future work includes integrating newly diagnosed leukemia patients into this workflow.

MAKING BREATHING A LITTLE EASIER:
ESTABLISHING A STANDARD OF CARE FOR SUPPLEMENTAL OXYGEN NEEDS
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Coordination of Care

Hypoxia, defined as an oxygen saturation of less than 88% on room air, is a common occurrence among pa- tients with a variety of respiratory illnesses, including advanced cancer. The process of procuring supplemental oxygen for home can be time consuming for the registered nurse (RN), impact patient safety and result in discharge delays from both the inpatient and outpatient setting. At one National Cancer Institute (NCI) designated cancer center, a multidisciplinary task force was convened to standardize this process. The purpose of the task force included streamlining the coordination of care for obtaining home oxygen for patients, standardizing the test for assessing oxygenation, and the creation of resources to support the delivery of high-quality care. A multidisciplinary team of nurses, respiratory therapists, case managers, nurse practitioner, clinical nurse specialists, nurse leaders and quality improvement nurses came together to look at the current workflow for patients that require home oxygen. A comprehensive literature review was completed to evaluate the evidence on the walking oxygen
A saturation test. A nursing role was innovated to assist patients arriving to the ambulatory setting with supplemental oxygen. Resources were developed for nursing staff in both the inpatient and outpatient settings which included a standard of care, nursing guidelines and care coordination algorithms. This institution wide initiative was approved through the nursing shared governance. Incident reporting system events were reviewed to help inform the trajectory of this project. The above-mentioned resources were developed to standardize care across the institution. The presentation will include data review such as statistical analysis, nursing education curriculum, and a knowledge assessment of the nurses. The program achieved the goal of developing a standardized approach to optimize coordination of care. In the future, this program or similar approaches could be used at other institutions to establish a standard of care for the management of supplemental oxygen.

**P94**

**FACING A POSITIVE RESULT OF THE GENETIC TEST FOR HEREDITARY COLORECTAL CANCER SYNDROMES: PATIENT EXPERIENCES**

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Screening, Early Detection, and Genetic Risk

Colorectal cancer (CRC) diagnosis uncertainty can lead to significant psychosocial strain on patients and their families. Addressing these concerns and understanding coping strategies is pivotal. We aimed to explore the lived experiences of Hispanic individuals following a positive genetic test result for hereditary CRC syndromes. The study sought to understand and interpret the impact of these positive results on their lifestyles and overall quality of life and how these experiences influence their adherence to CRC prevention guidelines. An interpretative phenomenological qualitative approach was adopted. Semi-structured interviews were conducted in nine persons with positive genetic tests for hereditary CRC syndromes who receive services in the Metropolitan area. The findings suggest that participants in the study exhibit a range of emotional responses, including worry, fear, and anguish. Interestingly, some individuals adopt a positive attitude, viewing the result as an opportunity for self-care and cancer prevention. The influence of the family was also evident, both in the attitude upon receiving the diagnosis and in the motivating factors for their healthcare decisions. Similarly, family history of cancer and the incidence of cancer-related deaths affected their perceptions when facing the diagnosis. The most reported lifestyle changes were related to dietary habits and exercise. Additionally, spirituality represented a significant coping mechanism when managing a positive test result. Moreover, participants highlighted that family and friend support, psychological help, reading and writing, relaxation exercises, music, work, and staying busy were effective strategies to cope with the diagnosis. Finally, most participants show they are committed to complying with the treatment guidelines, thus recognizing the importance of empowering themselves with self-care. Confronting a positive genetic test for CRC risk brings worry, fear, and uncertainty, influencing individual healthcare choices. Personal and family experiences, perceived benefits and barriers, and support from healthcare professionals and spirituality drive preventive actions. This knowledge can guide support, information sharing, and specialized referrals. Genetic counseling should integrate interventions that include fears of cancer-related death, emotional aspects, and family support. Healthcare professionals must plan empathetic, unique, flexible, and sensitive interventions that integrate patients' feelings and concerns to help patients and families navigate this challenging diagnosis.

**P95**

**NO PHARMACY, NO LAB, NO PROBLEM: NCI DESIGNATED COMPREHENSIVE CANCER CENTER’S SATELLITE CAMPUS USES INNOVATIVE PATIENT EDUCATION TO ENSURE PATIENT’S READINESS FOR TREATMENT**

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Preparation of patients for oncology infusions at an NCI Designated Comprehensive Cancer Center satellite campus, with no lab or pharmacy onsite, presents unique challenges when ensuring patients are ready for treatment. Medications are prepared and transferred via courier to the remote location daily. A pretreatment checklist, completed by the infusion nurses, must be sent to pharmacy the day before scheduled treatments to afford adequate time for medication preparation. Patients must go to external labs for bloodwork prior to their treatment day and lab results must be resulted no later than the day prior to treatment to allow for decision making about care plans. Delays in obtaining results can cause increased workload for pharmacy, the need for a second courier delivery and delays in treatment. When looking at initial data, pretreatment lab issues were noted on 54% of days examined. Further drill down identified that patient noncompliance accounted for 66% of these impedances and lab error, 34%. A nurse-driven performance improvement project set out to create a reliable process that would lead to a decrease in the number of lab deviations through patient accountability and improved education and follow-up. An innovative way to capture patient engagement and accountability in their care was developed through designing patient education handouts showing typical labs and lab tube colors at time of collection. Additionally, business cards with lab tube information, specific to their infusion regimen was also created that patients can keep in their wallet as a reminder to refer to at time of lab draw. These are given to all new infusion patients along with personalized treatment education by the medical oncology nurse. Infusion nurses also supported by providing follow-up calls to patients 2 days prior to their infusion. After initiation of the new process, there has been a continued downward trend in the number of days with lab delays from 54% to 21%. Lab draw errors, which accounted for 34% of these issues, dropped to a notable 0%. Patients showed more awareness and engagement in their preparation for treatment. This project has led to a decrease in the number of days where lab issues were noted, has improved the bottom line related to drug waste and courier costs, and has improved pretreatment checklist completion time, and overall staff satisfaction.

THE PURPLE LUMEN PROJECT: DOES COLOR MATTER?
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Treatment Modalities
Total parental nutrition (TPN) and lipid infusions pose a higher risk of infection via peripherally-inserted central catheter (PICC) or central venous catheter (CVC) due to being an excellent source for bacterial growth. Despite this, policies and procedures frequently don’t specify actions for preventing central line-associated bacterial infections (CLABSI) from TPN and lipid infusions. Overwhelming evidence indicates that TPN should infuse via one designated lumen in a central line, yet designating the lumen by its color for additional safeguarding has not been well researched. The purpose was to reduce CLABSI by improving staff compliance of TPN administration via one designated PICC lumen through color coding. Staff were educated to infuse TPN through the PICC purple lumen. Education sessions were performed during staff meeting and daily change-of-shift safety huddles for 2 weeks. A flyer was created and placed in multiple locations around the unit. An audit tool was created for charge nurse data collection during every shift: type of central line, dressing change date, needless connector change, and whether TPN was infusing in the designated purple lumen. Data was collected over 6 months, October 2022 to April 2023, for a total of 182 audited days. 122 audits were completed, resulting in 67% completion rate. 183 of 190 TPN infusions were administered through the purple lumen, showing an overall 94.5% compliance over the 6 months. The project showed an overall improvement in compliance from 85% at baseline to 97.9% with one month achieving 100%. While one CLABSI was reported, it was attributed to factors not related to the lumen designation. Based on our results, specific lumen designation for TPN compliance can be obtained by adopting a policy to have TPN infusing through a designated color lumen of PICC lines. While these results are inconclusive for reducing/preventing CLABSI, this strategy can be easily replicated in any setting where TPN is administered to potentially reduce CLABSI. Next steps include further evaluation whether designating a color lumen reduces CLABSI.
During the months of March-July 2023, the medical oncology and hematology units experienced an increased number of patients transferring to the ICU due to sepsis. Sepsis also led to increased mortality in the population. Approximately 80% of bedside leaders caring for the oncology population have less than five years of experience and have not developed the knowledge in recognizing initial signs and symptoms of sepsis. In order to prevent patient deterioration, early recognition is imperative. The project goal was to educate staff on sepsis and sepsis-specific interventions. Additionally, the correlation between neutropenic fever and sepsis was explored. Clinical improvement opportunities for septic patients experiencing care delays were identified by the leadership team. Based on the identified gaps, an action plan was developed. Through a survey, staff were able to provide feedback on their knowledge level and identify further gaps. The results were then used to develop an educational plan. Multiple classes were held. Topics addressed in the educational sessions included sepsis criteria, Epic tools, and sepsis SBAR communication. A case study with questions related to identification of sepsis was incorporated into the content. Badge-buddies were provided listing sepsis criteria and providing SBAR communication to assist with provider discussions. Improvement was observed in all survey questions and positive staff comments were given regarding the educational offerings. The number of RRT's post-education increased indicating early identification and intervention. Future plans include an educational offering for patient care technicians. Content has been incorporated into the oncology orientation process for RN employees. Bedside nurses are utilizing EPIC tools often, including consistent documentation of MAP, and consistently utilizing the sepsis SBAR for communication with providers.

P98
CHEMOTHERAPY EDUCATION FOR NON-ONCOLOGY UNITS
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Patient Education and Safety
With the expansion of oncology treatment options, the frequency of chemotherapy being administered to hospitalized patients on non-oncology units has been steadily increasing. This means that patients are being monitored by staff who are unfamiliar with the treatments they are giving and their required monitoring. As two chemotherapy-competent nurses are required for all chemotherapy initiation, administering off-unit chemotherapy impacts the oncology nurse workflow as they are away from their own patient assignments. Additionally, the oncology nurses provide non-oncology staff guidance in chemotherapy monitoring and symptom management. The purpose was to describe implementation of an Oncology Reference Notebook (OncRefBook) for non-oncology nurses as a means to increase patient and staff safety related to chemotherapy administration, as well as decrease the strain on chemotherapy certified nurses. As this gap in practice was identified for a nurse residency evidence-based project, an OncRefBook designed for non-oncology nurses was developed. This contained information on specific drugs, precautions, chemotherapy policies, and additional educational references. Three non-oncology units were selected for pilot implementation. Staff were offered educational sessions to discuss chemotherapy administration and introduce them to the notebook and resources. Pre-post chemotherapy knowledge and comfort related to caring for oncology patients were assessed. Oncology nursing workflow impact was measured by time off-unit for chemotherapy administration for all non-oncology units. Regarding comfort and safety, 50% of non-oncology nurses reported feeling comfortable caring for oncology patient’s pre-implementation, improving to 59.3% post-implementation. 47.3% of non-oncology nurses reported that they feel chemotherapy is given safely on their unit pre-implementation, improving to 65.3% post-implementation. Regarding workflow impact for chemotherapy certified nurses, chemotherapy administration averaged 17 minutes (40 drug administrations, range 10-45 minutes) for the pilot units as compared to 19.5 minutes (44 drug administrations, range 10-50 minutes) for all other units. Chemotherapy administration of greater than 20 minutes was more frequent on non-pilot units, n=8, as compared to pilot units, n=3. As working with any unfamiliar patient population can be uncomfortable, the pilot program with the OncRefBook has been well received by non-oncology staff. This program can be easily replicated and focused on specific agents or populations as providing nurses with user-friendly educational resources and support is the key for safe and successful patient care.
NURSE DRIVEN PILOT TO IMPROVE GUIDELINES FOR PATIENTS WITH PERIPHERAL ACCESS RECEIVING CHEMOTHERAPY IRRITANTS
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Oncology Nursing Practice
Chemotherapy irritant agents can cause burning and pain for patients when administered peripherally. At an NCI-designated cancer center, current institutional chemotherapy guidelines were lacking clear direction for nurses on timing and rate of administering compatible fluid and/or decreasing rate of chemotherapy infusion. This lack of specific guidance led to inconsistent nursing practice and documentation. Prophylactic hydration could potentially reduce pain for patients receiving these irritants and lead to better vein health.

This project was implemented to create new guidelines for administering chemotherapy irritants via peripheral IV access and standardize workflows for nursing practice. A multidisciplinary team of nurses, pharmacists, and physicians were brought together to revise and update the guidelines for chemotherapy irritant agents administered via peripheral IV access. This committee looked at national guidelines, articles and drug package inserts to gave direction for guidelines created. The proposed guideline included specific guidance for prophylactic hydration and rate changes of chemotherapy irritant agents when pain at IV site occurred. The new proposed guideline was reviewed by a nursing practice committee with representation of all chemotherapy units. A pilot was then implemented in one chemotherapy unit to track data of interventions. After pilot was completed and proved successful, education slides were presented at various multidisciplinary committees. Representatives of these committees brought education slides to their specific chemotherapy units. Using the proposed guideline change and new documentation workflow, a pilot occurred in one 27 chair chemotherapy unit over 6 weeks. Data tracked 52 visits for patients receiving gemcitabine via peripheral IV access. With prophylactic hydration given per new guideline, 78% of patients tolerated with no reduction in infusion rate needed. 22% needed the rate of infusion decreased either 25% or 50%. All infusions were completed within 1 hour. It is important for nurses to have clear guidelines to guide nursing practice. Using a multidisciplinary approach, guidelines were created to improve administration of chemotherapy irritant agents leading to consistent nursing practice and improved patient satisfaction.

THE EVOLUTION OF THE NEUTROPENIC DIET
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Oncology Nursing Practice
Neutropenia, a condition identified by a reduced absolute neutrophil count (ANC), is a common and life-threatening complication in oncology patients as they are a particularly susceptible population in the healthcare setting. This can be disruptive to their treatment and subsequently, is critical to monitor neutropenia in oncology patients due to treatments including chemotherapy which suppresses the hematopoietic system. Historically, neutropenic precautions have included strict dietary restrictions that were once implemented to reduce the risk of infection. However, recent advancements in understanding neutropenia through evidence-based research and gathered data have led to a paradigm shift in clinical practice, advocating for the elimination of the neutropenic diet in the typical neutropenic precautions practiced in the clinical healthcare setting. The purpose of this evidence-based research project was to determine if there is significant data to support the restriction that lies within the traditional neutropenic diet for oncology patients. This project also aims to understand the opinions and knowledge of nurses who have experience working with neutropenic oncology patients. A systematic literature review including multivariable models, randomized control trials, and multiple meta-analyses coupled with thorough professional research into the topic all were used to determine the effect of the neutropenic diet. Informal interviews with nursing staff were also conducted to gain insight into their perception of this impactful restriction. The interventions resulted in the agreement that the neutropenic diet is not significant in reducing infection, nor does it have a beneficial impact on the holistic care of patients. The limitation of fresh fruits and vegetables has been the traditional cornerstone of safety relating to the neutropenic diet, but ultimately this diet should be eliminated as it is not...
supported by current research. The elimination of the neutropenic diet represents a progressive shift in the care of oncology patients diagnosed with neutropenia. The adequate understanding and opinions of nursing staff coupled with evidence-based research resulted in plentiful data and results that dismiss the diet. This project lays the foundation for improving patient satisfaction, comfort, and holistic care by allowing patients increased autonomy to make healthy dietary decisions, while prioritizing their safety. "This work was conducted by a student in the Flynn Fellowship program.

P101
BEDSIDE HANDOFF AND PATIENT’S PERCEPTION OF THE QUALITY OF THEIR CARE
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 patient Education and Safety
Nurses often give report to each other in hallways, and then walk into patients rooms to introduce the oncoming nurse. This takes away the patient’s opportunity to be a part of discussions surrounding their care, limiting their understanding of their schedule for the day and their overall health status. This also hinders the patient’s development of a trusting and collaborative bond with their healthcare team. Conducting a bedside report has been linked to higher patient satisfaction, therapeutic communication established between nurses and patients, smoother communication between healthcare staff and less patient confusion and frustration. The purpose of this project was to determine if implementing a bedside handoff helps to build trust, rapport, and communication between nurses, patients, and patient care assistants (PCAs)? This project implemented a patient centered bedside handoff, which included nurses and PCAs performing a change of shift report at the bedside that focused on a summary of the day and what should be expected for the next shift. Nurses also updated the whiteboard in each patient’s room during this time to act as another form of communication. A survey was also sent to the nurses on the unit that assessed staff attitude and capabilities towards the bedside handoff. Patients were asked to provide feedback about their stay and what they felt was lacking. The results of the survey showed that the majority of staff felt that they didn’t have time to check-in with patients outside of med passes. They also felt that the plan of care was only communicated to patients “some of the time” due to staffing issues and communication break-down. 70% of patients felt that their emotional needs aren’t being met and they wanted more communication with their caretakers. They stated “I want more emotional support through diagnosis and readmit” and “I’m not getting out of bed as much as [the patient] would like to”. The results from the surveys revealed a need for increased communication between healthcare staff and patients. A handoff done at the bedside allows for communication between staff and the patient without distractions while alleviating any miscommunications. Promoting the use of a more consistent bedside handoff allows nurses and PCAs to have better communication and increase patient satisfaction. "This work was conducted by a student in the Flynn Fellowship program.

P102
FERTILITY PRESERVATION IN FEMALE PEDIATRIC ONCOLOGY PATIENTS: A SYSTEMATIC REVIEW OF LITERATURE
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Survivorship
Given the advancements in oncologic prognoses, it is crucial to shift the focus of care towards post-treatment quality of life for female pediatric oncology patients. Five year survival rates in pediatric oncology patients have increased from 58% in the mid-1970s to 85% currently. Consequently, the topic of childbearing and fertility has gained increased significance for both female pediatric cancer survivors and their parents, making it essential to prioritize research addressing future fertility in this population. The research and data regarding fertility preservation suggests the majority of fertility research is being completed for male pediatric patients, while advancements in female fertility services are lacking. The purpose of this study is to address and better understand the emerging issue of female pediatric fertility preservation barriers through a systematic review of the literature. This investigation was conducted through a systematic literature review of peer-reviewed journal articles published from 2008 through 2020 regarding the state of fertility preservation in female pediatric oncology patients. Findings suggest the main barriers were provider referral rates, availability of clinical educational resources and the prevalence of research focused on female pediatric oncology patients. The future of these services relies on the combination of additional research into female fertility, availability of educational resources and increased provider referrals. When these factors work
together, patient quality of life in survivorship improves and excellence in nursing care can be reached. Given the continued improvement of prognoses for female pediatric oncology patients and the disparity in available research compared with male pediatric oncology patients, it is more critical than ever to investigate existing female fertility research to identify barriers and improve survivorship. This work was conducted by a student in the Flynn Fellowship program.

P103 HELPING MEDICAL ONCOLOGY PATIENTS MAINTAIN OR INCREASE THEIR MOBILITY USING AM-PAC SCORE TO DRIVE MOBILITY GOALS

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Patient Education and Safety

The Activity Measure for Post-Acute Care (AM-PAC) is a standardized assessment tool to measure six aspects of patient mobility and physical activity completed by nursing and physical therapy in our EMR. The tool was implemented at our cancer center in 2021 as required documentation to assist nurses in developing mobility plans to prevent deconditioning during hospitalization. The AM-PAC score is then converted to the patients target highest level of mobility (HLM) score, which has an associated mobility action. Nursing leadership on our inpatient medical oncology unit identified significant gaps in practice, including consistency/knowledge of AM-PAC scoring and implementation of HLM interventions. The purpose of the project is to improve utilization of the AM-PAC tool to help patients admitted on the Medical Oncology unit maintain or improve their strength and mobility. Staffing challenges, increased patient acuity, and patient volume contribute to decreased ability of staff to mobilize patients. Significant education on utilization and importance of the AM-PAC score and the importance of daily mobilization was provided. To target this, current Patient Care Associate (PCA) resources were reimagined so that one PCA from 11am to 3pm was removed from the assignment to mobilize patients. An interactive adaptation of the Johns Hopkins HLM chart found in EPIC was created that included spaces where nursing could fill out the patient’s AM-PAC score and easily show the patient their target mobility goal for the day. Education for RNs, PCAs and providers was initiated in October 2022 and the PCA mobilizer role was implemented in May 2023. Data was calculated using the Helix dashboard to identify the percent of patients that were mobilized at or above their target HLM and through audits of the visual tool use. This rate increased from November 2022 to April 2023 to 52.5% after providing education and displaying the visual tool. The rate remained above the benchmark after the PCA mobilizer was implemented in May-August 2023 at 47.75%. The visual tool was rarely used, with an average of 4/28 tools filled out per day in the first month, and less in the months following. Ongoing education was the most effective in increasing the rate of patients mobilized at or above their target HLM when compared to the PCA mobilizer alone. After implementing the PCA mobilizer, leadership significantly decreased active education to staff.

P104 AN EVIDENCE-BASED REVIEW OF REMOTE CHEMOTHERAPY VERIFICATION

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Oncology Nursing Practice

The independent double check of chemotherapy or high-risk medications by two nurses has long been a standard of administration. Due to nursing shortages and the lack of specialty trained nurses, innovative and safe solutions are necessary across the cancer care continuum. The emergence of telehealth opportunities accelerated by the COVID-19 pandemic has supplied the ability to be in one location and remotely assist others from miles away. This project’s purpose was to determine what literature exists for remote chemotherapy verification. The following PICO question guided the literature search: “In patients requiring chemotherapy or high-risk medications, how does an in-person independent double check compare to a virtual second observer double check effect errors?” A detailed search strategy was developed and translated into CINAHL, PubMed, and Scopus databases yielding 444 results. After removing duplicates and exclusions, 19 studies were assessed for eligibility. Of these 19 studies, 9 were excluded due to wrong intervention, study design, or patient population. 10 articles were kept for final appraisal. Of the 10 keeper articles, 60% were focused on pharmacy services and practices and were not relevant to this search topic. The remaining four articles had substantial heterogeneity in the outcome measures and intervention procedures. Three articles used video virtual technology and one utilized technology-assisted...
workflow systems using barcodes and digital photography. Early evidence suggests virtual technology for two-person independent checks may be equal to live two-person checks; however, lack of consistency and rigor in the interventions makes a determination on safety or efficacy challenging without conducting more research. Final presentation will discuss the search process, synthesis of evidence, and recommendations for application of evidence-based findings into practice. Standards of chemotherapy and high-risk medication administration supply direction for nursing practice. These findings can guide future standards of administration, ensure safe high-risk medication verification by trained nurses, increase access to care, and maximize use of telehealth interventions but will require well-designed nursing research to validate this innovation as effective and safe. Organizations exploring this innovation should be sure to publish their work to continue to build the body of evidence around this area of practice.

P105
VEIN ASSESSMENT ALGORITHM
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Oncology Nursing Practice
PIV insertion success is dependent on patient, clinical, and product factors. The patient population at an NCI-designated Comprehensive Cancer Center experiences multiple peripheral intravenous (PIV) stick attempts in about 15-20% of patients across outpatient sites. According to INS (2021), multiple unsuccessful PIV insertion attempts cause patient pain, delay in treatment, limit vascular access, increase cost, and increase risk for complications. The Standards for Infusion Therapy (2021) recommend protocols for vascular access device placement are embedded in organizational policies and procedures. This assessment is currently performed without a standardized assessment. The purpose of this clinical inquiry is to review and discuss relevant literature, establish a standardized vein assessment protocol, and implement an evidenced-based algorithm for conducting vein assessments in adult oncology patients. The PICO(T) question, “In patients requiring vascular access, how does a standardized vein assessment compared to no standardized vein assessment affect patient outcomes?” guided an extensive literature search. 23 articles resulted; 9 articles were critically appraised; 2 were considered high quality and relevant to the clinical inquiry. Based on literature, internal policies and consideration of vein assessment tools used by external Comprehensive Cancer Centers, an algorithm was developed. Of the 2 keeper articles, performing a vein assessment had a positive decrease in infiltration rates and a positive increase in identifying difficult intravenous access (DIVA) patients. No standardized, validated tool currently exists for the oncology population. Several questions were developed for a vein assessment algorithm, including: the A-DIVA scale, patient’s past medical history such as receiving a vesicant, irritant with vesicant potential or irritant, arm precautions/restictions, palpable or visible veins, fragility and/or tissue malnutrition. Outcome measures include extravasation rates, chair time, number of PIV attempts, supply cost, and use of ultrasound guided PIV. Vein assessment algorithm is still a pilot instrument that needs to be assessed for validity. This algorithm could play an important role in oncology settings, simplifying the evaluation of venous conditions in patients undergoing peripheral chemotherapy, especially those at risk of difficult intravenous access. It can enable the implementation of strategies to enhance the chances of successful catheter placement and the thoughtful assessment of alternative routes or venous devices.

P106
INPATIENT APPOINTMENT
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Coordination of Care
Cancer is one of the leading causes of death worldwide, and the number of people who have had cancer in the last four decades has increased tremendously. Care coordination is essential for ensuring cancer patients receive the timely and comprehensive care they need. To improve the quality of care and patient experience for inpatient oncology patients, an extensive healthcare system in Texas implemented a care coordination process to ensure that all patients have a scheduled follow-up appointment with their oncologist upon discharge. The purpose was to measure the improvement in scheduling the follow-up appointment with an oncologist upon discharge by reducing the number of oncology patients discharged without a follow-up appointment. The project team developed a process flow document that outlined the steps involved in care coordination for inpatient oncology patients. The team also implemented a number of interventions, including:
ONNs attend daily inpatient huddles to collaborate with the IP Cancer Care Team.

ONNs provide patients with resources, education, and contact information.

ONNs collaborate with the new patient coordinator in the Cancer Center and the financial counselor to schedule Clinic appointments.

ONNs follow up with patients within 72 hours of discharge.

The project team found that the new care coordination process was effective in increasing the percentage of inpatient oncology patients with a scheduled follow-up appointment within seven days of discharge (from 75% to 90%) and decreasing the amount of time it took for patients to receive a call from an ONN (from 48 hours to 24 hours). Patient satisfaction with the care coordination process also increased significantly. The project evaluation indicates an improvement in the process for cancer patients to have a scheduled appointment with an oncologist upon discharge. This process was easy to follow and well-received by all stakeholders, including physicians, nurses, and the scheduling department.

**P107 IMPLEMENTATION OF AN ELECTRONIC HANDBOFF TOOL FOR IMMUNE EFFECTOR CELL PATIENTS RETURNING TO PRIMARY CARE LOCATION AFTER TREATMENT**

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**Coordination of Care**

Immune effector cell (IEC) therapy is a rapidly expanding program in which there are frequently new clinical trials as well as FDA approved products. Currently, IEC therapy is administered centrally at our main academic hospital location for 8 weeks before returning to one of the organization’s 13 care center locations across the state or to their community physician. There was not a formalized handoff process between sites. Our purpose was to develop an electronic handoff tool for nursing in order to streamline and improve nursing communication regarding ongoing care needs and responsibilities. A pre-implementation survey was disseminated to staff at one care center location which asked about the current state of handoff of IEC patients from the main campus location to the care centers. Initial responses included 60% of staff stating they had concerns about the IEC handoff for Chimeric Antigen Receptor T-Cell (CAR-T cell) products with the remaining 40% stating they felt neutral about the process. There were no reported positive results. Comments included that nurses wanted to better understand where their patients were in the follow up process and the plan of care. An electronic handoff tool was created in the electronic medical record (EMR), including information about the CAR-T infusion, toxicities experienced, medication changes, ongoing plan of care, and follow up appointments. This allowed for clear, concise communication to be readily available to nursing staff. A smartphrase template was also created which will pull information from the handoff tool into a note in the medical record for community physicians using an alternate EMR platform. A post-implementation survey will be conducted after three months of implementation to assess the impact of the handoff tool on care center staff perception of communication and if other critical information that can be added to improve communication. Nursing knowledge and confidence will be measured by qualitative questions using a Likert scale in the post survey.

The electronic handoff tool directly impacts patient care and safety by improving communication between care sites and ensures continuity of care. It allows for a clear summary of the patients’ plan of care and follow up needs. The expected outcomes are that nurses will self-report increased satisfaction with patient handoff, an increase in knowledge of IEC therapy, and confidence in patient care.

**P108 ORAL ANTICANCER MEDICATIONS: IMPROVING CONSENT AND ADHERENCE ASSESSMENT PROCESSES**

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Oncology Nursing Practice

Oral anti-cancer medications (OAMs) are increasingly being used to treat cancer. While this offers patients convenience, it also places responsibility on them to take their medications accurately and consistently. The literature shows adherence rates can run as low as 46%, leading to negative outcomes including drug resistance, altered treatment response, disease progression, higher mortality rates, and increasing toxicities and healthcare costs. This highlights the need for increased attention to ensure adherence. The aim of this project was to improve patient and staff compliance with accurate adherence assessments, and to improve compliance with consent completion in an outpatient blood disorders center at a large academic medical center. After reviewing current literature and processes, staff were surveyed to identify barriers to consistently...
completing ongoing OAM adherence assessments. Audits of the electronic health record (EHR) revealed informed consent documentation was present for only 47% of patients prescribed an OAM. In addition to making consents more accessible to providers, a row was added in the EHR to trigger consent completion. A shared Pharmacist education and Provider consent visit was implemented as well. A system-wide OAM “champions” group was created to foster collaboration and standardization across the oncology service line. The group consisted of front-line nurses, nurse leaders, and medical assistants who created an operational workflow outlining OAM management best practices. In the outpatient blood disorders center, staff from the lab, clinic, and infusion areas increased collaboration to ensure timely adherence assessment completion. Information on optimized workflows and expectations was disseminated to staff. Compliance with obtaining informed consent for OAMs increased to 69% (a 47% increase). Documentation of OAM adherence assessment increased by 42% following the interventions. Collaboration among team members, combined with standardization of a process, resulted in improved OAM consent completion and adherence assessments. Increased attention to support patients on OAMs is vital to ensuring treatment compliance for optimal outcomes. Continued focus will be placed on incorporating best practices into the unique workflows of individual practice settings across the health system.

P109
PREVENTING IMPLANTED PORT NEEDLE DISLODGE MENT IN PATIENTS DISCHARGED WITH AMBULATORY CHEMOTHERAPY PUMPS
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Oncology Nursing Practice
There are many chemotherapy regimens that require an ambulatory infusion pump for home administration. Many of these regimens are administered via an implanted port with the risk of needle dislodgement without proper monitoring and securing. There is cause for concern if a needle dislodges including vesicant extravasation, central line infections, hazardous drug spills and exposure, missed chemotherapy doses, and additional patient appointments. Despite patient education on tubing securement and home monitoring of the ambulatory infusion, there were twenty-six accidental needle dislodgements from February 2021 to May 2023 in a large academic Midwest outpatient cancer center. The purpose of this project was to decrease the incidence of accidental needle dislodgement of implanted port needles for patients receiving vesicant chemotherapy via a home ambulatory infusion pump. A nursing team was formed to develop interventions based off of evidence to secure port needles. The interventions chosen focused on identifying patients at risk for needle dislodgement and implementing additional securement. For patients receiving home-infused vesicants, nurses were required to add additional securement on the port needle along with the standard practice of securing the tubing. In addition, all vesicant treatment plan orders were updated to include a nursing order to add securement to the port needle. Educational resources, such as tips sheets on when and how to add additional securement, and where to document this intervention were developed to support the interventions. As of September 7, 2023, no further needle dislodgments have occurred in any patient discharged with chemotherapy via a home ambulatory pump. The compliance rate of nursing documentation for the required additional securement for vesicant patients increased from 6% after the first month of implementation to 60% the second month and continues to improve with ongoing education and feedback. Implementing interventions to prevent needle dislodgements leads to a decreased risk for vesicant extravasation, missed chemotherapy doses, hazardous drug spills and exposure, central line infections, and additional patient appointments. Other organizations may wish to develop interventions such as securement of port needles to prevent a high-risk treatment population from needle dislodgements.

P110
GETTING ON THE SAME PAGE DURING PROLONGED HOSPITALIZATIONS: REWRITING THE PROCESS FOR PATIENT CENTERED CARE FOLLOWING A BMT
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Coordination of Care
Bone Marrow Transplant (BMT) patients often...
have complex medical needs secondary to acute and chronic health conditions that lead to prolonged hospitalization lasting several weeks to months. Lack of patient centered care and communication of goals during prolonged hospital stays can lead to decreased patient, caregiver, and health care provider satisfaction. The purpose of this project was to increase collaboration amongst the inpatient multidisciplinary care team for BMT patients with prolonged hospitalizations lasting greater than fourteen days. This collaboration aimed to facilitate enhanced communication and documentation of the plan of care. This documentation included the multidisciplinary care team’s plan for addressing the patient’s acute medical needs, as well as patient centered short-term and long-term goals. The primary intervention included implementation of a bimonthly meeting with the entire multidisciplinary care team during an already established standing meeting. A secondary intervention was a standardized note template for the documentation of the discussion during the meeting. This multidisciplinary team included physicians, nurse practitioners, nurses, dieticians, social workers, and case managers. Every two weeks, the inpatient BMT nursing leadership team identified both autologous and allogeneic BMT inpatients meeting criteria for a prolonged hospital stay to discuss during the standing meeting. The patient and caregivers were engaged in conversation by the care team prior to the standing meeting to identify patient centered short-term and long-term goals for their care. A note template was utilized to capture standardized elements of the discussion to communicate within the electronic health record. Over a one-year period, twenty-one multidisciplinary care team meetings occurred. During these meetings thirty-one unique BMT patients’ goals were discussed, established, and communicated. During the 21 care team meetings, the standardized note template was utilized 100% of the time. Over the one-year timeframe, 70% of the patient and/or care team goals were successfully achieved. Utilization of an already standing multidisciplinary care team meeting to facilitate the patient care goal conversation was key to greater engagement and collaboration amongst the care team. During implementation, the team realized patient goals were often different than the care teams goals. Patients, caregivers, and the health care team expressed appreciation of the collaboration and plans to address goals of care during the prolonged hospital stay. When everyone is on the same page, trust develops, and teams can grow and succeed together.

P111

UTILIZING A DIGITAL PATIENT EDUCATION PLATFORM IN THE ONCOLOGY SETTING

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Patient Education and Safety

Access to patient education can have a direct impact on overall patient outcomes. Staffing ratios and complexity of patient acuity can impede the nurse’s ability to provide comprehensive patient education. Furthermore, verbal education is often forgotten, and printed education is often misplaced (Turkdogan et al., 2021). The purpose of this project was to determine if a digital education platform would be useful resource for patients and their caregivers. Also, if nurses and patients on an acute oncology unit liked the proposed digital education tool and would recommend continued use. Oncology patients require extensive education on treatment and maintenance to promote optimal outcomes. A digital platform was presented on an acute care oncology unit utilizing a QR code posted in patient’s room. When scanned, it directed patients to an online platform that housed system approved education on oncology specific topics, patient safety strategies, and links to additional online oncology resources. Twenty patients were surveyed on the use of the QR code and 100% of them recommended continued use and stated the digital information would be useful after discharge. Twenty nurses were also surveyed and 100% recommended continued use. Digital tools are becoming more useful in healthcare as technology evolves. Providing a digital patient education platform allows patients to receive specialized education for their diagnosis, admission, and treatment to improve outcomes. Compared to the past standard of printed and verbal education, a digital tool allows patients continuous and convenient access to oncology education. Future implications include using digital education to provide educational videos for patients to review while they are home.

P112

HELPING NOVICE ONCOLOGY RNS ADMINISTER CHEMOTHERAPY- IMMUNOTHERAPY IN AN ACUTE CARE SETTING

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Oncology Nursing Practice

Learning to administer in-patient chemotherapy and immunotherapy for the novice Oncology RN is fraught
with challenges. In this 350 bed community hospital, chemotherapy and immunotherapy are not administered very frequently due to the fact that most chemotherapy and immunotherapy is administered in the outpatient setting. This can make it quite difficult for the novice oncology RN to develop and maintain competency in the administration of chemotherapy and immunotherapy in this setting. The purpose was to provide a tool to increase the confidence and competency of novice Oncology RN who is newly certified to administer Chemotherapy and immunotherapy in the inpatient setting. A checklist tool was developed to help guide the Novice RN with the steps necessary to confidently and safely administer chemotherapy and immunotherapy in the inpatient setting. Since the tool was implemented approximately 6 months ago, the novice Oncology RN’s have expressed much less anxiety and uncertainty when they have to administer Chemotherapy and Immunotherapy in the inpatient setting. The detailed instructions provide the novice RN with the step-by-step plan for the entire Chemotherapy and Immunotherapy process. This helps to demystify a process which they have had little experience with. It also is a refresher for the more experienced staff when they have not had to administer chemotherapy or immunotherapy that recently.

P113
REDUCING CENTRAL LINE ASSOCIATED BLOOD STREAM INFECTIONS BY IMPLEMENTING A COLLABORATIVE TEAM OF EXPERT NURSES AND AN EVIDENCED BASED BLOOD CULTURE KIT
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Oncology Nursing Practice
The blood culture is the gold-standard test used to identify blood stream and central line infections. Accurate results are critical for identifying infecting organisms to guide treatments and procedures for optimal healthcare outcomes. False positive rates typically range between 20%-50% of all positive cultures, which may lead to inappropriate care, expense, more extended hospital stays, and elevated reportable infection rates (Snyder et al., 2012). The purpose was to ask the following question: Will adhering to an EBP blood culture drawing practice using a kit and expert nursing personnel reduce blood culture contamination and CLABSI reduction? A standard blood culture kit was created and implemented in the summer of 2021. Staff education was completed by October of 2021, with re-education to the oncology group completed in June of 2023. An expert group of oncology and IV team nurses exclusively started blood culture collection in late April 2023. Kit revisions with instructions reached the units in July of 2023. Our oncology departments found a significant reduction in blood culture contamination and reportable CLABSI after the standard kit was used by nurses who are experts in oncology or IV insertion practices. The Oncology department was responsible for 55% of all positive blood cultures in 2022. All oncology nurses received education on blood culture best practices during oncology education days in the spring of 2023. A blood culture packaged kit has the latest adjustments from the original implementation of summer 2021, including site labels, the reintroduction of chlorohexidine, and step-by-step instructions. In April of 2023, drawing blood cultures was limited to a designated expert team of oncology and IV team nurses. The oncology department’s contamination rate has plummeted to below 1% since this change in practice and all four oncology units went 100 days without a CLABSI.
implementing the NN, there was no systematic triage process for lymphedema patients. Appointments were based on referrals, leading to improper scheduling and numerous cancellations due to extended wait times. At SCCC, the purpose of utilizing the NN in this setting was to enhance the precise scheduling of lymphedema patients in this context. Before the initial appointment, the NN reaches out to all new patients. In this intake, the NN reviews the patient’s information and criteria for either a surgical or a PMR provider and based on that criteria ensures they are scheduled with the appropriate provider. Additionally, they gather medical records to assure a comprehensive plan of care and visit. Within the first three months of implementation of the NN (May to August 2023), all new patients have been contacted and intake completed within one business day, with receipt of medical information to the provider within 10 days prior to the scheduled appointment. Cancellations also decreased from 31% in May to 16% in August 2023; while the number of appointments for intake has increased 256%. The findings indicate that NN has positively influenced resource utilization and care coordination for the lymphedema program. Also, the providers can efficiently see patients and provide a comprehensive visit due to the support of the NN. Moreover, the NN enhanced scheduling efficiency, reducing inappropriate appointments, and minimizing the need for extra visits and cancellations. Future directions will involve assessing intervention types and metrics for this non-cancer specific navigation program.

P115
SUPPORTING YOUNG BREAST CANCER PATIENTS TO NAVIGATE MANAGING POST TREATMENT SIDE EFFECTS
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Patient Education and Safety
About 9% of all new cases of breast cancer in the US are found in women younger than 45 years of age. Being diagnosed at a younger age brings a host of issues to an already complicated diagnosis. At this younger age, the patient has much higher levels of circulating hormones than if they were going through or had gone through menopause already. Treatment often thrusts these patients into early menopause and the long-term effects of that combined with treatment can be devastating physically and emotionally. Addressing the potential later-term effects and ways to manage them has been a significant topic overlooked in early survivorship for these patients. The patient often goes back to their life after treatment unprepared to handle the various concerns and unsure who can best help them as they now meet with their oncologist every few months. We partnered with Living Beyond Breast Cancer’s Young Breast Cancer Survivorship Program, a training for managing late term effects from breast cancer treatment. We were trained as leaders to share the material with our patients to help support their post-treatment recovery, provide a place to learn, be empowered and connect with other patients their age. Using the material from Living Beyond Breast Cancer- Young Breast Cancer Survivorship Series- we have offered the four classes on four consecutive weeks in the evening. The topics included: self-care, body image, fertility, intimacy and managing menopausal symptoms. The sessions were formatted with lecture and a discussion after. This series will be given quarterly to allow patients to attend whenever it supports them. Participants completed a pre and post evaluation of each session and many shared their appreciation for these important needs being addressed. They took away a lot of valuable information and were comforted by the shared experiences from other patients- allowing them to feel like they were not alone on this journey. Meeting the educational needs of this unique population on the current and late-term effects of breast cancer treatment is very important. We are hoping that this kind of support can help to improve quality of life, overall health and well-being and compliance with any adjuvant anti-estrogen therapy. We hope to better prepare our younger breast cancer patients for the journey ahead as a breast cancer survivor.

P116
NEXT GENERATION: AN OVERVIEW OF GENOMIC TESTING TECHNOLOGIES FOR PRECISION CANCER CARE
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Psychosocial Dimensions of Care
Genomic testing is an integral part of oncology care across the cancer care continuum. Genomic results inform risk identification, diagnosis, prognosis, and treatment selection. The testing methodologies as well as interpretation of test results is quite complex as there are multiple genomic testing methodologies offered by many different laboratories with diverse indications. Most oncology nurses receive little if any
information on laboratory science and genomic testing technologies during formal education, yet are expected to educate patients and families on testing indications and how results inform care for the patient and sometimes the family. Oncology nurses have mastered calculating absolute neutrophil counts, mastery of the vast array of genomic technologies is the next frontier of knowledge and competence. The purpose was to provide an overview of the methodology and indications of various genomic testing technologies in precision oncology, as well as the application and interpretation of genomic testing across the cancer care continuum.

A review of the literature was conducted using the following key words: genetics/genomics and testing methodology. Common themes were identified, including test types, regulatory standards, marketing practices, indications, clinical utility, and nursing implications. Genomic testing can include germline and somatic testing on the tumor. Oncology nurses encounter multiple types of genomic testing including molecular tests which include single nucleotide variant, single gene, sanger sequencing, next generation sequencing, exome, and whole genome testing. Chromosomal tests might include karyotyping and large rearrangement testing. Other techniques include RNA analysis, multiplex ligation-dependent probe amplification (MLPA), polymerase chain reaction (PCR), and fluorescence in situ hybridization (FISH). Liquid biopsy is an emerging type of test with different analytes tested (circulating DNA, free cell DNA, etc.). Understanding the basic testing techniques, applications, as well as limitations is important knowledge for oncology nurses to master and apply to clinical care. The type of genomic test and the clinical indications and implications of each test guide treatment decisions and in the case of germline testing opportunities for prevention and early detection for the patient and family members. Oncology nurses can assist patients and families to understand the implications of a specific type of genomic testing. Additionally, oncology nurses must understand clinical utility of the different genomic testing technologies in order to assess the value of genomic testing in cancer care.

P117
THE ROLE OF COORDINATORS AND ITS IMPACT IN ONCOLOGY CARE
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Coordination of Care
Oncology care is a complex and multidisciplinary field that requires effective coordination to ensure optimal patient outcomes. Coordinators play a pivotal role in managing the various aspects of oncology care, including treatment scheduling, communication, and patient support. This systematic review highlights the positive association between care coordination and improved outcomes in cancer patients. The findings emphasize the need for skilled coordinators to facilitate seamless care transitions, enhance communication between healthcare providers, and ensure timely access to treatment. This scoping review explores the multifaceted role of oncology care coordinators in providing patient-centered care. The study identifies key responsibilities, such as treatment coordination, symptom management, emotional support, and education, that contribute to improved patient satisfaction and overall quality of care. As one of the leading healthcare services in the world and at the Gulf region, we aim to deliver the best of the best of patient care, that includes guiding patients with cancer and helping them with their journey. The objective is to highlight the role of the coordinator in easing the patient access into CCAD (get the proper treatment for cancer or at least, attend the initial consultation) and its impact on oncology patients’ experience. The data collection was mainly time to treat as one aspect and when patients are being contacted for the first time, after reaching out to the oncology team. We created metrics to capture those numbers and total volumes coming into the cancer centre at CCAD. It is revealed that coordinators play a vital role in managing treatment scheduling, facilitating communication between caregivers, coordinating multidisciplinary care teams, providing patient education as much as possible including guidance on the next steps and support, and ensuring seamless care transitions. Just like any project that is created, we are faced with various challenges, such as heavy workload, time constraints, complexity of cases, and finding slots for those patients in a timely manner with the larger MDT. But we have had a good outcome from this, impacting a huge effect on patient experience, as effective coordination positively impacts the patient satisfaction scores. Since patients are receiving coordinated care, the reported scores revealed higher satisfaction levels, better understanding of their treatment plans, and increased emotional support throughout their oncology journey. This was shown in our monthly patient experience scores - likelihood to recommend.

P118
CANCER SCREENING PRIOR TO DEFINITIVE RADIOTHERAPY FOR PROSTATE CANCER
Kathleen Maloney-Lutz, MSN, RN, OCN®, CNRN, NYU
**P119**

**STANDARDIZATION OF CHEMOTHERAPY/IMMUNOTHERAPY COMPETENCIES, POLICIES, AND PROCEDURES ACROSS A REGIONAL HEALTHCARE SYSTEM**

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**Oncology Nursing Practice**

Our regional healthcare system is comprised of various facilities, including twenty-one hospitals, clinics, home care, and hospice care, serving both adult and pediatric patients. These facilities exhibit variations in the volume of oncology patients, chemotherapy and immunotherapy administration, and the availability of oncology expertise, including clinical nurse specialists and educators. The significance of the project lies in addressing the critical need for standardization within this diverse healthcare ecosystem. This presentation aims to share the outcomes of the collaborative efforts involving three larger-volume sites to standardize competencies, policies, and procedures. The objective is to support smaller-volume sites by establishing a framework that ensures the safe and effective administration of chemotherapy and immunotherapy. Feedback was sought from stakeholders across the region, including inpatient, outpatient, and homecare settings, to ensure comprehensive coverage. Building upon a thorough review of existing literature and Oncology Nursing Society guidelines, a dedicated team worked diligently to enact vital interventions. These interventions include the development of electronic competencies for chemotherapy administration and comprehensive care of oncology patients. Importantly, these competencies are designed to benefit both oncology and non-oncology nursing staff, acknowledging the mobility of oncology patients throughout the healthcare system. Additionally, online modules were created to educate all nurses on oral chemotherapy administration, and the care of oncology/immunosuppressed patients. Standardization was further enhanced by developing separate policies and procedures for chemotherapy and immunotherapy administration. The chemotherapy administration policy is under review, while the immunotherapy administration policy is currently in development. Both policies are anticipated to be approved across regional centers by the end of 2023. Furthermore, the competencies, initially documented on paper at the three institutions, are slated to transition
to electronic formats for seamless regional adoption by the same deadline. The online modules are assigned to every inpatient nurse across the region. Standardization offers the promise of reducing variance and enhancing quality and safety in patient care. The initiative addresses two pivotal issues: the movement of oncology patients across diverse care settings and the need for robust support in smaller-volume sites without dedicated oncology resources. While this endeavor has faced challenges, such as staff and leadership turnover since 2020, it underscores the importance of not only standardization but also the adoption of best practices within a collaborative regional healthcare system.

**P120 MALNUTRITION SCREENING IN AMBULATORY GASTROINTESTINAL CANCER PATIENTS**

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**Symptom Management and Palliative Care**

Patients with gastrointestinal (GI) cancer often suffer from malnutrition, which can have an impact on quality of life, increase the toxicity of chemotherapy and reduce overall survival. GI cancer patients were identified as “high risk” for unplanned admission within 30 days of chemotherapy administration by Anthem Oncology Medical Home™ proprietary analysis. The ambulatory clinical nurse specialist (CNS) partnered with registered dietitian (RD) team to identify ambulatory patients that would benefit from nutritional support during treatment. The purpose was to identify the need and volume of ambulatory gastrointestinal oncology patients at risk for malnutrition that would benefit from nutritional support during cancer treatment using a malnutrition screening tool. Developed to determine need and volume. Literature review of malnutrition risk and gastrointestinal cancer patients completed. Education on malnutrition risk in oncology gastrointestinal patients given to ambulatory nurses by CNS. Education on use of a validated ambulatory oncology malnutrition screening tool (MST) was provided by RD. MST was administered by nursing (taking about 1-2 minutes) during GI oncology clinic visits within a two-week pilot. Total patients screened (n=226) with patients eligible for pilot (n=190). Total surveys completed (n=150) was 79%. Patients were seen by an RD via telemedicine if MST scored greater than 2. Patients with low-risk MST with patient request for nutrition support was also offered. Current state revealed that 20% of patients with GI primary diagnosis discharged from hospital were readmitted within 30 days. Historically, a reactive approach for RD referral was initiated after patient was experiencing nutritional decline. As 37% (n=64) of patients recommended RD referral based on MST and/or patient request, scheduled appointments were available within six weeks. This delay was a result of ambulatory RD availability (1 RD) to provide usual medical nutritional therapy comprised of initial consultation and follow-up visit. Pilot revealed need for additional personnel to intervene early, enabling a proactive and preventive approach. Including malnutrition screening did not disrupt usual nursing assessment workflow. Over one third of outpatient GI cancer patients were at risk for malnutrition at screening. Pilot revealed volume and need for concurrent RD consultation, yet scheduling was delayed due to RD availability. Other cancer diagnosis may have similar malnutrition risk. Nursing staff reported the MST was an easy and efficient screening tool. Interprofessional collaboration can enhance patient outcomes in the ambulatory setting.

**P121 STAFF EDUCATION FOR ENHANCING RADIATION ONCOLOGY NURSE COMPETENCY**

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**Patient Education and Safety**

Treatments for cancer patients have changed over the years. Oncology nurses in areas of medical oncology and radiation oncology need to have appropriate knowledge and competence in the area in which they practice, allowing for the best outcomes. The aim of this project was to develop staff education to aid in the assurance of a newly established competency guideline designed for the radiation oncology nurse. The clinical practice question for this project explored whether education on a guideline for competency for radiation oncology nurses would enhance the knowledge and skills of these nurses within on department among a large network of cancer care sites. As recommended by the Teaching Excellence in Adult Literacy (TEAL) Center funded by agencies of the Office of Vocational and Adult Education, a learning tool for the guideline project addresses areas of self-directed learning including encouraging the willingness to learn and apply this information. An education tool was approved by an expert panel of five control team managers and three
nurses from the education and radiation oncology departments. The education tool was administered to 13 radiation oncology staff (3 radiation oncology nurse managers and 10 radiation oncology nurses). The mean pretest score was 80%, and the mean posttest score was 100%. There was a 20% increase in knowledge that supported that knowledge was gained. The potential for a positive social change is anticipated through yearly competency education and evaluation. Increased competence of nurses allows for best practices for the radiation oncology nurse to foster improvements in care of the cancer patient, who can have improved quality of life.

P122
IMPROVING INTAKE & OUTPUT DOCUMENTATION COMPLIANCE UTILIZING EPIC BRAIN REMINDERS ON A HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT) UNIT
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Oncology Nursing Practice

Hematopoietic stem cell transplant (HSCT) involves the administration of high-dose chemotherapy and subsequent cellular therapy infusion. Following a transplant, patients experience poor appetite, mucositis, and poor oral intake (Murray, S. & Pindoria, S., 2017). Patients’ inability to take oral medications necessitates the need for medications to be administered intravenously (Farhadfar et al., 2020). All patients are ordered for strict intake and output for weight-based medications and supplemental care (Hingorani, 2017). Noting a practice opportunity, HSCT nurses looked to leverage EPIC technology to improve documentation compliance. The EPIC Brain prompts nurses to complete tasks throughout the shift, but I&O documentation does not appear on the EPIC Brain. The purpose was to improve compliance with documentation of intake and output by 20% within 3 months of implementing an EPIC Brain task reminder every 4 hours. A gap analysis was conducted regarding the HSCT unit’s I&O documentation. Pre-intervention documentation compliance was: PO intake 0%, intravenous medications 56%, and output 50%. Education was provided to nurses and nursing support staff through huddles on the correct way to document I&O and complete infusions. A chart of the most commonly used PO fluids was developed and posted on the unit. EPIC Brain task reminders were created for all patients and on admission based on the ordered frequency of I&O measurement. Once entered under one user, they remained for the duration of the admission and subsequent admissions. EPIC Brain reminders for I&O documentation improved unit compliance. Compliance was monitored weekly. Overall, average I&O documentation compliance increased by 56%. PO intake compliance increased by 56%, from 0% to 56%. Intravenous medication documentation compliance documentation improved by 20%, from 56% to 86%. Output documentation improved by 50%, from 50% to 100%. Compliance improved each week throughout the measurement period. This initiative has been integrated into the unit workflow. With competing priorities of high-acuity patients on the HSCT unit, nurses employed EPIC technology to send reminders for required shift documentation. The use of reminders to document I&O demonstrated improvement in documentation. The success of this initiative has been escalated to the enterprise-wide informatics workgroup for optimization. This project can easily be replicated in other areas that use EPIC and has been implemented across the oncology service line and is ongoing on the HSCT unit.

P123
THE ESSENTIAL NURSING SKILL SET: RESILIENCE
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Professional Development

Given the challenges and complexity of patient care, it is understandable that oncology nurses are experiencing high-stress levels and burnout. The literature documents that resilient nurses are essential to providing quality patient care. Decreased job satisfaction is linked to increased nurse turnover that can have an undesirable impact on patient safety and outcomes. While nursing recruitment and retention have become organizational priorities, the key is creating the tools and environment to develop and support a resiliency skill set for our nurses. This presentation will share and allow participants to experience an evidence-based resiliency program that promotes micro-shifts to support the development of a resiliency skill set for oncology nurses. While the literature provides consistent evidence that resiliency mediates burnout, it is essential to acknowledge that there is no one-size-fits-all approach. Much like a patient’s care plan being individualized to their unique needs, resilience requires a multifaceted, individualized approach to meet the dynamic needs of each nurse. A resiliency skill set will support nurses as they face adversity in the complex clinical setting. Since resiliency is a unique experience, the literature strongly supports a mixed-methods resiliency program.
to individualize the experience. Five micro-shifts will be discussed and practiced during the session. This series of interventions is repeatable and can be done in-person or virtually. The themes for the micro-shifts include defining burnout, mindfulness-based interventions, stress reduction strategies, self-care training, and peer support. Validated measurement tools were administered prior to the experience and at one and three months. t-tests were performed for each outcome using a confidence interval of 95%. Statistically significant changes will be shared in resilience and burnout and were observed at all measurement intervals. Program evaluations were extremely positive. The program trended self-care activities over the 3-month data collection period to measure engagement. Nursing resilience is a practice issue affecting the nurse, the organization, and the patients we are entrusted to provide care. Developing and sustaining resiliency is a skill set that nurses and organizations view as critical to individual and organizational well-being. Tailoring evidence-based resiliency practices to your staff requires a thoughtful commitment to sustaining a healthy nursing workforce.

P124
YOU ARE NOT ALONE: FROM AN INDIVIDUAL TO A COLLABORATIVE MODEL OF ONCOLOGY AMBULATORY NURSING CARE
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Oncology Nursing Practice
In an ambulatory cancer clinic, a breast oncology team seeing 10,000 appointments annually. Analysis was completed on the single provider/nurse care model & opportunities were identified for improvement in continuity, consistency, & responsiveness to patients’ needs. The nurse practice model placed an expectation of sole accountability for a provider’s panel, which was unreasonable given the volume & complexity of patient needs. New EMR-messaging together with the clinic education & assessments, phone calls, & secure chats with interdisciplinary team complicated how best to sustain patient engagement & respect the work life balance of nurses. The purpose was to explain the process and outcomes of redesigning oncology ambulatory nursing care delivery from a single individual supporting a provider’s panel to a collaborative team (“pod”) that provides comprehensive management of daily care demands to multiple providers’ panels. RNs on the existing team were assigned into “pods” that began to collaboratively manage the in-person RN visits, phone calls, inbasket messages, team secure chats, & shared email inboxes for two oncologists. For effective change management, the team had to address the necessity to relinquish total individual accountability for a provider’s patient panel’s needs. This took time & facilitation for the nurses and providers involved. New roles were established to delineate accountability across the daily needs of the team. Each nursing “pod” was given shared phone extensions, in basket pools, & clearly defined roles within the pod. The newly redesigned care model created a constructive collaboration between the clinical team, improving efficiency & communication. There was a shared rather than singular accountability. Nurses felt like they could take a vacation without being a single point of failure or success. In the previous model, no other RNs knew the provider’s patients, which decreased the continuity of care when the RN was out. Often, the tasks would pile up until the nurse returned. This often resulted in frustrated providers, nurses, & patients. With the new collaborative model, multiple RNs were familiar with the patients’ care & team processes, allowing the care and tasks to move forward smoothly despite a nurse’s days off. We saw an increased live call answer rate, which is a priority for our team so that we can resolve patient’s concerns more quickly & efficiently & be responsive to patient’s needs.

P125
OUTPATIENT CHEMOTHERAPY INFUSION CENTER BED UTILIZATION: A REVIEW OF MULTIFACTORIAL DELAYS INHIBITING EFFICIENCY - TERTIARY CARE CENTER – SAUDI ARABIA
Angelique Mendoza, RN, King Faisal Specialist Hospital & Research Centre, Riyadh, Riyadh; Tena Brown, RN, King Faisal Specialist Hospital & Research Centre, Riyadh, Riyadh
Oncology Nursing Practice
With increasing rates of cancer diagnoses globally, outpatient chemotherapy infusion centers around the world have seen an increase in demand to accommodate this rapidly growing population. When it comes to bed utilization, the infusion center in Saudi Arabia is no different as it struggles to maintain manageable bed utilization with growing number of oncology patients, creating delays/waiting list for patient to receive chemotherapy. The aim of this project is to explore the root causes that are creating inefficient bed utilization in infusion center. Exploratory research design used to better understand the current bed utilization process.
and where the most treatment delays occur. A data collection sheet was developed by senior oncology nurses who work in the infusion center. Validation of the final collection form was reached after multiple discussions. Data was collected over a month. Using over 40 nursing auditors and 3 data analysts. Over a month, a total of 2,231 patients visited the infusion center (average 112 patients/day). On an average day we found over 100 hours of cumulative delays stemming from 5 main categories: patient related 30.5%, clinical presentation 10.5%, clinic issues 24.5%, infusion center issues 18.5% and pharmacy delays 16%. On a daily basis, infusion center nurses are addressing a large number of issues due to inefficiencies. This leads us to believe there is potential for significant improvements that will benefit bed utilization, along with workflow, patient/staff satisfaction, and hospital resources. We recommend a multifaceted approach to address each category. This may include a “Treatment Ready Campaign” for patient adherence, standardized workflow, increased technology equipment and others. In the future, to improve efficiency, the data findings (multifactorial delays) highlight where focus is needed. With a multi-disciplinary approach, the finding will guide infusion centers on where to start implementing change.

P126
IMPROVING REFERRAL RATES TO A RURAL HOSPITAL-AT-HOME PROGRAM FOR ONCOLOGY PATIENTS
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Coordination of Care
This year, approximately 52,000 individuals are expected to receive a cancer diagnosis in the Mountain West region, with nearly 14,000 cases in Utah alone. Social Determinants of Health exert a profound influence on the quality of life and health outcomes among oncology patients, a reality amplified for those in rural and frontier regions. An urban hospital-at-home program specifically adapted for rural and frontier patients holds the potential to significantly reduce hospitalizations and improve care outcomes for rural patients and families yet, enrollment of rural patients in this hospital-at-home program remains low. This project aims to evaluate the program and increase enrollment by assessing program effectiveness, identifying barriers and facilitators, and gauging stakeholder satisfaction to bridge the gap between rural patients and equitable cancer care. A comprehensive review of program policies and procedures, in collaboration with key stakeholders, will provide insights into the current inpatient referral processes. Stakeholder feedback collected through short answer surveys and structured small groups discussions about health disparities, patient centered care, and resource allocation will be incorporated into recommendations to hospital staff to increase enrollment. Additionally, recommendations and details related to the referral process, eligibility criteria, and the services offered from the hospital-at-home program will be accessible via QR codes posted in high visibility areas. Referral rates will be assessed before and after project implementation. Data collection for this project is pending as this project implementation phase is scheduled to commence on October 5. This project aims to evaluate facilitators and barriers to enrollment in a hospital at home program for rural oncology patients to address healthcare disparities, foster patient-centered care, and optimize resource allocation. The final outcomes and conclusions will be discussed in the final poster presentation April 2024.

P127
NURSING PERSPECTIVE: HOW DOES THE ONCOLOGY NURSE NAVIGATE THROUGH THE CONUNDRUM OF AUTOIMMUNE DISEASES AND CANCER DIAGNOSES?
Catherine Messere, BSN, BS, RN, OCN, Eviti Nanthealth, Macungie, PA; Susan Gorman, MSN, RN, CRNP, NP-C, AOCNP, Eviti NantHealth, Horsham, PA
Oncology Nursing Practice
Inflammation affects cells differently. Chronic inflammation can change the genetic makeup of a cell which allows the cell to mutate into a cancer cell. Where there is inflammation, there is an increased blood supply which is necessary for cancer cell growth. According to the Arthritis foundation having rheumatoid arthritis and being a smoker increased the risk of developing lung cancer by 40 percent (Rheumatoid Arthritis and Cancer Risk, 9/11/23). Certain cancer treatments suppress or stimulate the immune system which can cause a disturbance and increase the risk of developing an autoimmune disease. The risks and benefits of each treatment must be evaluated prior to initiating therapy to determine potential long term consequences. Although there are clinical trials for cancer and autoimmune diagnoses, there are few trials for dual diagnoses. The purpose of this project is to increase awareness in how autoimmune diseases and cancer are related, review common medications, discuss contraindications of using immune checkpoint inhibitors with a dual diagnosis and review education necessary to improve patient care. Finally, common themes around diversity, inequities and disparities across oncology and autoimmune
diseases will be investigated. A team consisting of a senior oncology case review nurse and an oncology nurse practitioner will be established to identify the significance, background, and purpose for the project. Educational content will be developed based on the expected outcomes. The most common autoimmune diseases will be identified along with the associated cancers that can develop. Information on disease processes, treatment, potential complications, and nursing management of cancer and autoimmune diseases will be beneficial to healthcare professionals regardless of specialty. Upon completion of the program, a questionnaire will be emailed to the participants asking the following questions: Was this information helpful? How will your practice change? What content was most helpful? What content was least helpful? The completion date for the initial phase of this project is March 31, 2023. After completing the information sessions and reviewing returned questionnaires, the team will create a blog on the company website. The blog will include the initial presentations and additional content which will be available for clinical staff and consumers to review.

**P128**

**FACTORS PRESENT IN LATE-STAGE PRESENTATION OF PATIENTS WITH CANCER OF CERVIX AT OCEAN ROAD CANCER INSTITUTE, DAR ES SALAAM, TANZANIA.**

Mwanga Mhoka, Mwanga, ocean road cancer institute, Dar es salaam, ILALA

Oncology Nursing Practice

Cervical cancer is the 4th most frequently diagnosed cancer and 4th leading course of death all cancer with an estimate of 570,000 cases and 311,000 deaths worldwide. Approximately 90% of cervical cancer related deaths happen in low/middle income countries (LMIC). It is estimated that by 2030 cancer of cervix will kill more than 443,000 women yearly worldwide and most of them will come from LMIC. The purpose of this study was to report the factors that are present with the late-stage presentation of cervical cancer among women in Tanzania. The study identified individual, community, institutional, and public policy factors present with the late-stage presentation of cervical cancer among women in Tanzania. The study was conducted at the Ocean Road Cancer Institute in Dar es Salaam and utilized a descriptive cross sectional research design. Structured questionnaires were used to collect quantitative data from women with cervical cancer stage IIB-IV (n=310) and health care professionals (N=80) working for ORCI. Data were analyzed descriptively. Age, marital status, education status, occupation, lack of health insurance, and poverty were identified as socioeconomic, demographic and clinical characteristics of patients present with late-stage presentation of cervical cancer among women in Tanzania; limited knowledge of cervical cancer symptoms, ignorance of causes of cervical cancer, lack of practicing gynecological examination were identified as individual level factors; inability of women to make own decision on issues related to their health, and religion discouraging women from being diagnosed by male physicians were identified as community level factors; limited screening and diagnosis services, insufficient health care providers, insufficient screening and diagnosis equipment, insufficient funding, and inadequate knowledge of cervical cancer among HCPs were identified as institutional level factors; and insufficient fund for cervical cancer screening and diagnosis services and poor communication of policy and regulations governing screening services to stakeholders at all levels were identified as policy level factors. The study highly recommends integrating methods of sensitization and screening campaigns across the country as well as intensive study of the quality of cervical cancer screening according to WHO guideline to assess the gap on health care providers.

**P129**

**OUTREACH EDUCATION FOR STAFF CARING FOR THE HEMATOLOGY ONCOLOGY PATIENTS: TUMOR LYSIS SYNDROME, INFUSION REACTIONS, AND TROUBLESHOOTING CENTRAL LINE COMPLICATIONS**

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Oncology Nursing Practice

Knowledge of current clinical practice is imperative when caring for the Oncology Hematology Patient Population. Lack of up-to-date knowledge can impact on care resulting in poor patient outcomes. Knowledge is power when providing care to a specialized and diverse patient population. Studies show that staff who have been oriented and participate in ongoing education are more comfortable treating complex patient situations. Gaps in knowledge can impact healthcare. Ongoing education builds the diverse team population
clinical confidence. A quality project was implemented that included quarterly Lunch & Learn sessions provided by the Outpatient Hematology Oncology Infusion Staff. Multidisciplinary meetings were held. Nursing staff, the education department, and physicians identified key education topics for lunch and learn sessions. Clinical scenarios requiring complex interventions that were high risk and low incidence were identified and presented. Topic’s included management of patients at high risk for tumor lysis, management of central line complications, and management of a patient experiencing an infusion reaction. Session included content on both medical and nursing management. All sessions were recorded so staff could access the content on demand. Evaluation of the education included posttest questionnaire and subjective feedback from participants. All responses were positive. Since the onset of COVID in person education ceased. During this time education focused primarily on COVID management and prevention strategies. Limited lunch and learn sessions were available on oncology topics. Staff in the infusion unit met in an effort to strategize options. Feedback on the sessions was positive and attendees successfully completed the posttest questionnaire. In an effort to impact patient outcomes, the planning team implemented quarterly staff education. An education needs assessment will be developed in collaboration with the education department to determine future quarterly offerings.

P130
AN ANALYSIS AND EVALUATION OF THE NEED FOR DISEASE-SPECIFIC NURSING UNITS IN HEMATOLOGY ONCOLOGY
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Oncology Nursing Practice
According to the article “Competencies Create Expert, Accountable Nurses Delivering Quality Care” by Chris Pirschel, “oncology care is a highly specialized subset of nursing.” Oncology nurses ensure safe delivery of cancer treatments, manage symptoms, and optimize quality of life. In a large academic medical center, the lymphoma and multiple myeloma departments have grown 7% and 48% respectively, since 2021 with patients dispersed throughout medical-surgical units. With the growing departments, new treatments, and complex disease management, our team recognized the need for a lymphoma, multiple myeloma unit with oncology-trained nurses. The purpose of this study is to open a lymphoma, multiple myeloma unit with oncology-trained nurses to provide quality care as evidenced by hospital consumer assessment of hospital providers and services (HCAHPS) scores. On January 26, 2023 the fifteen- private bed lymphoma and multiple myeloma unit opened. In preparation for the opening, seventeen chemotherapy-trained nurses transferred from two oncology medical-surgical units. An additional seven new graduate and experienced nurses were hired. The staffing ratio for the unit was set at four patients to each nurse. These nurses were expected to treat oncology patients admitted for treatment and oncologic complications. In order to provide support, a clinical nurse specialist was hired for clinical support and education needs. Oncology-specific annual competencies were also made mandatory to validate skills. In addition, daily interdisciplinary rounds, monthly staff meetings, disease-specific meetings, and a unit-based council were established to help support and develop the new unit. As of September, the unit has had 374 lymphoma and 80 multiple myeloma admissions since opening. The unit received 33 HCAHPS responses with a score of 87.9% compared to the overall hospital at 74.7%. In addition, newer treatments, such as bispecific antibodies, have been initiated on the unit given the specialty care. Limitations to this study include the short duration the unit has been opened. Opening the combined unit with oncology-trained nurses has provided quality care to patients while maintaining HCAHPS score of 87.9%. To effectively care for oncology patients, all nurses and members of the interdisciplinary team should be supportive and work together. In the future, we plan to continue the education and growth of these oncology nurses by offering additional education, support and encouragement of certification, and advancement on the clinical ladder.

P131
“WHAT ABOUT MY KIDS?”: HELP FOR THOSE CARING FOR ADULT ONCOLOGY PATIENTS PARENTING YOUNG CHILDREN
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Psychosocial Dimensions of Care
About one-third of cancer patients are diagnosed at an age when they may be caring for children under the age of 18, and the rate of cancer diagnoses for this population has increased almost 30% since the 1970s. Based on these rates, in 2020, it was estimated that between 2.85-3.5 million American parents had cancer. Having a
parent who has cancer creates adverse childhood experiences (ACEs). According to the Center for Disease Control (CDC), ACEs can have lasting, negative effects on health, psychological and emotional well-being, and life opportunities like education attainment and job potential. 95% of children whose parents have a cancer diagnosis have increased school absenteeism, and nearly all parents (96%) observe behavioral changes in their children ranging from anxiety and depression. Pickles Group’s program design and survey tools are based on research that is summarized in an article from the journal of Anticancer Research published in 2017 entitled “Impact of Parental Cancer on Children” by Binay K. Shah, Jeffery Armaly, and Erin Kwiatek. The research summary shows that parental cancer impacts children in ways including: changes to routine, role changes, and psychological and behavioral changes. The summary recommends the following interventions: 1) open communication and honest, accurate, and complete information about the disease; 2) coping strategies; and 3) peer support are cited as evidence-based ways to support kids through this lived experience. Dual Certified Child Life Specialist, Licensed Clinical Professional Counselor, and Chief Clinical Officer of Pickles Group non-profit will help oncology care providers: 1) Understand developmental responses by age and corresponding interventions. 2) Master tips to guide patients talking with their kids about cancer. 3) Get ready for the “What about my kids?” question. 4) Identify how and when to use external resources.

THROMBOCYTOPENIA AND CVC INSERTION: WHAT DOES THE EVIDENCE SAY?
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Oncology Nursing Practice

Patients with cancer require central venous catheters (CVC), and the demand for intravenous access devices for the delivery of cancer therapy has grown proportionally with the rise in cancer diagnoses. Considering that the majority of the patients with hematological disorders will have severe thrombocytopenia, inserting a CVC is a very challenging decision to be taken by hematologists, nurses and intervention radiologist team. In fact, waiting for the platelet count recovery to insert CVC will affect patients’ overall health, delay treatment delivery and disrupt the treatment plan. As per the internal policy and current guidelines, inserting a CVC for thrombocytopenic patients should happen only under two conditions. First, platelet count is ≥ 20,000/µL, and second, a pre-procedure platelet transfusion. A situation that may put patients at risk of transfusion-related reaction. The above situation allowed us to challenge the internal policy and seek the best practice for our everyday dilemma. The purpose is to locate and implement the best practice of central catheter insertion for leukemia patients with thrombocytopenia, taking into consideration the risk of bleeding. Thus, we ask the following question to guide our search. What are the best practices of central venous catheter insertion for a patient with thrombocytopenia? Follow ing the John Hopkin’s Evidence-Based Practice Model (PET Process) the team formulated the question and extracted the relevant keywords then searched the available databases. We started with Cochrane Library, PubMed, and CINAHL databases. We used the following keywords, “CVC” and “thrombocytopenia” and “ultrasound” and “platelet” in different structures. Seven relevant articles were retrieved. One systematic review of an RCT from Cochrane library (level I), two quasi experimental studies (level II), and four retrospective studies (level III). Evidence synthesis revealed that ultrasound guided CVC insertion possess no risk of significant bleeding for acute thrombocytopenia. In addition, there is no significant benefit of prophylactic platelet. Healthcare providers can safely insert central venous catheters for thrombocytopenic patients with platelet count of ≤ 20,000/µL under ultrasound guide. In addition, pre procedure or prophylactic platelets transfusion is not necessary, as the risk of bleeding is low and most of the cases were not more than hematoma. Furthermore, platelet transfusion is associated with transfusion-related adverse events, financial cost and delay in care.

MULTIDIMENSIONAL ONCOLOGY NURSING CARE AND CONSIDERATIONS OF MULTICENTRIC CASTLEMAN DISEASE: A PATIENT CASE STUDY
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Oncology Nursing Practice

Multicentric Castleman Disease (mCD) is a rare lymphoproliferative B-cell disease associated with human herpesvirus-8 or Kaposi sarcoma herpesvirus. It is systemic and frequently observed in the HIV/AIDS population. mCD often includes complications such as anemia, thrombocytopenia, uncontrolled fever, night sweats, and neuropathy. The nursing care for individuals with mCD requires a holistic approach including...
psychosocial dimensions of care. With a complex disease process, addressing the multidimensional aspects of care prioritizes patient milestones on admission. Priorities start with life-threatening physical manifestations to a focus on psychosocial complications with the goal of active participation in self-care on discharge. Each dimension of care requires observation by the Clinical Research Nurse (CRN) to understand patient capabilities for success in all aspects of care. This case study will illustrate the patient-centric nursing care required; a 25-year-old lymphoma patient with mCD was admitted to this 200-bed research hospital and enrolled on a phase 2 chemotherapy protocol. This patient presents with high-grade fever, tachycardia, thrombocytopenia, distress, and overall failure to thrive. Complications included infections, mucositis, diarrhea, skin breakdown, and neutropenic fever. Like others with this diagnosis, this patient demonstrated minimal capability to participate in self-care and exhibited anxiety related to communication with unfamiliar healthcare professionals. Nursing care of critical physical needs during this period was essential and a priority. Due to the increased observation of psychosocial complications within this population and this patient, it is the CRN role to advocate for and address unmet needs. The CRN evaluated existing social support systems and coping mechanisms with consideration to this patient’s age, unemployment status, and limited visitation from family. Patient autonomy was supported by working with nutrition to obtain this patient’s favorite foods, using guided imagery, and participating in mobility exercises leading to independent self-care. Upon discharge this patient became employed, lives independently, and continues adherence to communication tools in the electronic medical record (EMR). The TACO rate on blood products in a busy outpatient clinic, has experienced. Having more flexibility of using a standard rate based on RN’s assessment for patients over 60 years old when medically stable. Staff use communication tools in the electronic medical record (EMR) to communicate the chosen rate. Patient and caregiver education is provided regarding signs and symptoms of TACO and recommended actions if experienced. Having more flexibility of using a standard rate on blood products in a busy outpatient clinic, has allowed for improved patient satisfaction. Patients can be scheduled later in the day and spend shorter time in the infusion clinic. We have also been able to decrease same-day hospital admissions for transfusions as now there is more availability to transfuse in the outpatient setting. Furthermore, with regular audits performed we can confirm that we have had not an increase of TACO incidence since the implementation of this project. Although age can be contributing risk factor for TACO, we have successfully demonstrated with a thoughtful approach that blood products can be administered at a standard rate for the aging cancer patient population. We did not have any increase with TACO incidences since starting this project. The benefits of decreasing chair time and allowing for more scheduling flexibility have been profound.

P134
USING NURSING ASSESSMENT SKILLS TO DETERMINE SAFE BLOOD ADMINISTRATION RATES IN THE AGING ONCOLOGY PATIENT.
Stephanie Nigro, MSN, RN, OCN, BMTCN, CHPN,
CPHQ, University Of Kansas Cancer Center, Westwood, KS; Chelsea Caldwell, BSN, RN, BMTCN, University of Kansas Cancer Center, Shawnee, KS; Ronnie Hollins, BSN, RN, BMTCN, The University of Kansas Health System, Kansas City, KS
Patient Education and Safety
At our Health Institution, Transfusion Associated Circulatory Overload (TACO) rates are set for any patient over the age of 60 years. This is regardless of past medical history and current health. The TACO rate of 85 ml is used for both platelets and packed red blood cells (PRBC). About two years ago we began a Quality Improvement project to override these rates when appropriate in our busy Outpatient Blood and Marrow Transplant and Cellular Therapeutic department. Administering blood products at a standard rate based on medical history and current health and not solely based on age, allows for more flexibility in scheduling these patients in our busy Infusion Center. Safety is our number one goal, and this trial has allowed nursing and medical staff to use critical thinking and assessment skills to determine if a standard rate could be initiated on a patient over the age of sixty. The nurses and medical staff use an assessment tool to determine if the standard blood transfusion rate of 150ml can be implemented per protocol based on RN’s assessment for patients over 60 years old when medically stable. Staff use communication tools in the electronic medical record (EMR) to communicate the chosen rate. Patient and caregiver education is provided regarding signs and symptoms of TACO and recommended actions if experienced. Having more flexibility of using a standard rate on blood products in a busy outpatient clinic, has allowed for improved patient satisfaction. Patients can be scheduled later in the day and spend shorter time in the infusion clinic. We have also been able to decrease same-day hospital admissions for transfusions as now there is more availability to transfuse in the outpatient setting. Furthermore, with regular audits performed we can confirm that we have had not an increase of TACO incidence since the implementation of this project. Although age can be contributing risk factor for TACO, we have successfully demonstrated with a thoughtful approach that blood products can be administered at a standard rate for the aging cancer patient population. We did not have any increase with TACO incidences since starting this project. The benefits of decreasing chair time and allowing for more scheduling flexibility have been profound.

P135
THE EXPEDITION OF ONCOLOGY NURSES
WELL-BEING: CHALLENGES, AND FUTURE DIRECTIONS
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Oncology Nursing Practice

Oncology nurses play a crucial role in the healthcare system, providing specialized care to cancer patients throughout their cancer journey. The nature of their work is emotionally and physically demanding, and it often involves witnessing patients’ suffering, pain, and sometimes even death. As a result, oncology nurses’ well-being, compassion fatigue, and compassion satisfaction are significant aspects of their professional and personal lives. Significance: Identification of trends and patterns that can inform targeted interventions to enhance nurse well-being and mitigate compassion fatigue. Develop evidence-based strategies to promote resilience and job satisfaction. Strategies to enhance the quality of patient care by ensuring that nurses are emotionally and physically equipped to optimize well-being. The purpose of this retrospective review is to identify the prevalence and severity of these problems among oncology nurses, to identify factors that contribute to or protect against these problems, to track changes in nurse well-being, burnout, and compassion fatigue over time, and to make a comparison before during and after COVID-19; and to identify current evidence-based interventions. A comprehensive review was conducted by accessing Sage Journals Online, EBSCO Host, Wiley Online Library, PsycINFO, Science Direct, and InfoTrac Psychology eCollection. Besides, a web search was performed to search for peer-reviewed articles, academic journals, Google Scholar, manuscripts, books, professional and national reports, and peer-reviewed blogs. The search was narrowed to the last 10 years using the words Oncology Nurses’ Well-being, Burnout, Compassion Fatigue, and Compassion Satisfaction. 461 articles contained oncology, nurse well-being, burnout, compassion fatigue, and compassion satisfaction. Workplace factors such as high workload, long hours, and lack of support from colleagues and supervisors were associated with an increased risk of compassion fatigue and decreased levels of compassion satisfaction.

- High prevalence of compassion fatigue and burnout 50-80%
- Low levels of compassion satisfaction 30-50%
- Workplace factors 60-80%
- Personal factors 40-60%
- Need for support 100%

While compassion satisfaction remains a source of resilience, it is imperative to address the growing challenges to nurses’ emotional and physical well-being to sustain high-quality patient care and ensure the long-term sustainability of the oncology nursing workforce. Most of the articles identified the growing problem, but less than 10 articles discussed interventions or offered an action plan tailored toward reducing oncology nurses’ burnout. This retrospective review indicates a need for further action research addressing oncology nurses’ well-being.

P136 IMPLEMENTATION OF A CHECKLIST FOR ONCOLOGY NURSE NAVIGATION
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Coordination of Care

The development and use of checklists for high-stress and high-fatigue situations is attributed to the airline industry. Checklists were adopted by the medical field; “...including the ICU, operating room, and emergency department, with outcomes ranging from improved adherence to evidence-based best practices during critical events to a reduction in morbidity and mortality across a global population” (Arriaga, 2021). Introduction of the World Health Organization Surgical Safety Checklist reduced complications from 11.0 to 7.0% (Haugen, 2019). The care continuum of a cancer patient is complex and requires great attention to detail and collaboration across multiple specialties. Incorporating a checklist into oncology nurse navigation has the potential to provide the same safety and efficiency seen in other specialty areas and industries. It ensures that key aspects of care are completed and that the patient’s needs are met with a proactive approach. The purpose was to improve the quality and efficiency of patient care for oncology patients. Intervention: Implement the use of a checklist for oncology nurse navigators to use in guiding a patient through the cancer care continuum. Evaluation was as follows:

- Nurse navigators report feeling more focused and “knowing what to do next.”
- Nurse Navigators are confident they do not miss anything.
- Anecdotal recognition of reduced errors.
- Perceived fewer patients with missing orders or documentation.
- Perceived fewer phone calls about logistical needs.
- Patients expressed an understanding of their disease and treatment.

Stress and fatigue are known to affect a person’s cognitive acuity. When managing numerous tasks at once work can become chaotic and disorganized. Key
components of a cancer patient’s care may be missed when providers, nurses, and staff are busy and overwhelmed. This may include consents, lab orders, teaching sessions, supportive medications, specialty referrals, port placement, and other critical tasks. A checklist can be a tool to consistently verify the timely completion of these elements for a more proactive approach to patient care. Further research is needed to explore the greater potential of checklist integration into oncology nurse navigation.

**P137 PREMEDICATION PROMPTING FOR TRANSFUSION OF BLOOD PRODUCTS**

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There was identification of near-miss sentinel events relating to premedication of patients receiving blood products. In the Electronic Health Record (EHR), pre-medications for blood products are listed with other PRN medications near the bottom of the medication administration record, thus making the orders difficult to view. The current process heavily relies on the verbal transfer of care between nurses to relay the need for premedication. Nurses identified that premedication is sometimes forgotten. The nurses created the PICOT question, “would an electronic checklist/prompt that populates in the medication administration record for blood transfusions have an effect on pre-medication adherence and the prevention of transfusion reactions?” A literature review was conducted to review evidence based best practices. The use of electronic checklists aids in standardization and can help improve patient safety. A survey was then conducted to evaluate nurses’ perception regarding the root causes of missed premedication. The survey identified that 84% of respondents received incorrect information regarding premedication during verbal report. With 97% of respondents agreeing that an electronic notification prompt for premedication would be beneficial to their practice, a shared governance process was utilized to introduce the hypothesis to nursing leadership and the Inpatient EHR Committee for project approval and collaboration. The nurse residents worked with the Inpatient EHR committee to create a notification linked to the “Blood Product Pick Up” order, and the Clinical Application Development Team created a required question within the blood product order set that must be addressed prior to requesting delivery of the blood product. As patient safety is a priority, this process is intended to protect patients from potential human error. Ultimately, this brings awareness to the nurse and creates a hard stop for nurses if they do not administer ordered premedication. The process change took place in September 2023 and with continued tracking of future sentinel events, the goal is to continue to discover ways to promote patient safety.

**P138 TELEPHONE NURSING ADVICE RELATED TO ORAL ANTINEOPLASTIC CHEMOTHERAPY DURING COVID-19 PANDEMIC: A RETROSPECTIVE STUDY**

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Oral antineoplastic chemotherapy (OAT) has great potential for patient’s convenience and has been widely recommended during the COVID-19 pandemic. However, OAT requires nurses to undertake health education for patients and their families and treatment monitoring to favor quality and safe treatment. During the pandemic, patients treated at a university hospital and who underwent OAT for the first time were monitored by telephone counseling through a university extension project called ATEnf Acolhe-Onco. The purpose was to identify and classify patient care demands reported via telephone counseling during the COVID-19. This is a descriptive and retrospective study. Participants: cancer patients, over 18 years old, treated at a general university hospital in the city of São Paulo, São Paulo, Brazil. Telephone counseling records were stored in the educational institution’s RedCap repository and data from April 2020 to September 2021 were analyzed in the present study using descriptive statistics. The study received approval from the research ethics committee. The total number of consultations was 3,329 in the 18-month period, of which 724 (21.7%) consultations were related to OAT. Most patients were male (53.2%), aged between 18 and 90 years with a mean age of 56.5 years (SD: 15.84). The most reasons for advice were generated by the following medications: Capecitabine (21.2%), Sunitinib (15.7%) and Sorafenib (10.4%) for patients diagnosed with solid tumors and Thalidomide (32.6%) and Cyclophosphamide (20.1%) for...
those with hematological cancers. Side effects, medication dosage and availability for pick up at the hospital pharmacy were the main questions related to OAT. Clinical requests such as management of side effects, scheduling of the therapeutic regimen and worsening of the patient’s performance represented 63.5% of the advice. The total number of administrative demands related to OAT was 36.5%, such as: notification of lack of medication at the hospital, denied authorization of the medication request, expired medical prescription, and need to reschedule a medical appointment due patient no-show to the last one. It was found that the doubts and problems reported by patients could have compromised the therapeutic plan effectiveness and/or patient safety, characterizing the importance of this care resource. This nursing activity contributed to patient-centered care and offered an excellent opportunity to develop clinical reasoning for nursing residents in the oncology residency program.

P139
COMPREHENSIVE GERIATRIC ASSESSMENT TO ASSESS FOR MENTAL AND PHYSICAL RESILIENCE IN OLDER PEOPLE WHO ARE DIAGNOSED WITH CANCER
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Oncology Nursing Practice
Resilience is the capacity of mental and physical recovery from a major insult such as cancer diagnosis and treatment. Resilience places emphasis on ability versus disability that may arise as a result of aging, cancer or cancer treatment. Comprehensive Geriatric Assessment (CGA) is a battery of screening instruments that evaluate functional, emotional, cognitive, and physical factors which are included in the notion of resilience. CGA is often conducted in outpatient oncology settings and provides an illustration of baseline health when beginning and throughout cancer treatment. The purpose was to illustrate the assessment of resilience in older people with cancer. To provide examples of instruments that can help determine resilience and predict risks associated with chemotherapy. Pharmacological options to protect resilience will be offered. Review of literature was conducted focused on assessment, management, and preservation of resilience. The concepts of functional reserve, intrinsic capacity and the relationship to resilience were explored. Common toxicities associated with chemotherapy that can impact resilience were explored. Resilience considers functional reserve and intrinsic capacity in older people diagnosed with cancer. Resilience allows for the estimation of risk of complications associated with treatment and the ability to recover. Resilience may be assessed using CGA which directs clinical management to address the detected limitations. Nurses can use CGA to screen for actual and potential insults to resilience. Based on the findings of the CGA, strategies can be developed to maintain or enhance resilience such as exercise, nutrition, and social engagement. Management of mental resilience can include mindfulness exercise, self-compassion, and stress management. Interventions to maintain or enhance physical resilience can be physical activity, and exercise. Nurses play a sentinel role in motivating older people to exercise and be physically active. Assessment and management of resilience must be individually tailored to meet the needs of the older person who is diagnosed with cancer.

P140
PROCESS IMPROVEMENT TO RELEASE REVLMID AND POMALYST FROM THE TREATMENT PLAN
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Oncology Nursing Practice
When Myeloma patients begin their treatment on Revlimid or Pomalyst, providers add treatment plan in Epic. The prescriptions are already signed in the plan. The clinic nurse has to obtain authorization number from the Bristol Myers Squibb REMS and then release the prescription to the patient’s specialty pharmacy. In the process of adding the authorization number to the prescription, it would get unsigned and had to be routed to the provider to sign again. This was causing delay in patient care and was causing double work for the provider. The provider and the nurses informed the IT team of this issue. IT team worked with the clinical team and was able to figure out a process to add the authorization number to the prescription without unsigned the prescription. The IT team had to meet with the Myeloma clinic nurses and understand the process of prescription release and obtaining authorization number. There were meetings held in person. Communication was in person and also via email to the team. Also, Myeloma clinic nurses did in-service during team meeting/huddle to ensure rest of the clinic nurses are also aware of this process. The IT team and the clinical team were able to figure out a process in which once the prescription is released from the plan, it stays in “task completion” pool in the in basket within epic. The clinic nurse is then able to add the authorization number.
to the prescription and then release it to the specialty pharmacy. This process applies to prescription that are already signed only. This process improvement has been very helpful and efficient. It prevents delay in patient care and also prevents providers from having to do the same thing over and over again.

**P141**

**THE BENEFITS OF HAVING A SERVICE ACCESS NURSE**

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Cooration of Care

While the benefits of nurse navigation is well documented, responsibilities usually start after the patient has established care. However, for a patient newly diagnosed with cancer, the time between the initial diagnosis and arriving to clinic can be scary and challenging for the newly diagnosed patient through the referral and scheduling processes. The purpose was to describe the development and implementation of an oncology SAN program. Most new patient coordinators (NPC) are skilled at scheduling, yet not clinically-trained and lack expertise to determine patient coordination needs that expedite interdisciplinary team collaborations, diagnostic procedures, and clinical trial accessibility. The SAN role is the liaison to collaborative, multidisciplinary programs involving medical, surgical and radiation oncology by partnering with the scheduling team to ensure that the first visit with the care team is beneficial for all parties involved. The SAN can also identify who might be eligible for onco-fertility preservation, genetic testing and clinical trials. The first SANs were hired in 2016. Due to inconsistencies in role actualization the SAN role was redesigned in 2021. In September 2012 the first nurse was hired and onboarded under the new design supporting the breast oncology program. Subsequently, there has been substantial improvements in patient scheduling, appointment turnaround time and medical record availability. Referral lead time (time from referral to appointment scheduled) has decreased by 45% and cancelled appointments have decreased by 52%. Initially, 45 genetic POCT were performed in 2022, increased by 68 by June 2023. Over nine months, the clinical trials team identified 37 potential participants and enrolled 8. The greatest benefit has been the development of trusted connections between patients and SAN that occur prior to their first clinic encounter; the SAN answers general questions about their new diagnosis, introduces the care team, and eases patient-family anxiety. As the SAN is not the point of contact for the NPCs, provider satisfaction has improved as the SAN has reduced new patient interruptions from their busy clinical duties. Discussion: The SAN role has been a highly successful role and can be easily implemented in other settings and populations. In 2022 service access nurses were hired to support urology oncology, the Blood Cancer Center and our Cancer Diagnostic Clinic.

**P142**

**LAUNCH OF A NEW MULTIDISCIPLINARY GENETIC CANCER PREVENTION CLINIC (GCPC): INITIAL SIX MONTH EXPERIENCE**

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Screening, Early Detection, and Genetic Risk

In January 2023, our National Cancer Institute-designated comprehensive cancer center launched a weekly multidisciplinary clinic for individuals at an increased risk for hereditary cancer due to a known pathogenic variant (PV). As part of the multidisciplinary team, the genetic nurse navigator (GNN) provides education about hereditary cancers and assists with coordination of high-risk surveillance and/or prophylactic procedures, as well as support for cascade testing of family members. The GCPC mission is to prevent and reduce cancer incidence through coordination and implementation of longitudinal cancer risk reduction efforts, promotion of cascade testing, and research. Data collection was gathered through retrospective chart review and determined to be non-regulated research through our Institutional Review Board. Patients are seen annually by a genetic counselor, advanced practice provider or physician, and GNN. Before the appointment, the GNN reviews the chart and calls the patient to confirm genetic test results, updates personal and family history, and status of recommended screenings. Each case, along with pertinent updates and plans, is discussed in a multidisciplinary conference prior to clinic. National Comprehensive Cancer Network guidelines and recommended screenings are shared with the patient and each of the patient’s relevant providers. The GNN follows up with patients after
clinic to answer any questions and facilitate referral scheduling or cascade testing. From January through June 2023, 58 patients attended GCPC. PVs in 16 different genes were seen; 78% of patients had PVs in the following genes—BRCA1, BRCA2, CHEK2, PALB2, and PTEN. Five percent of patients had two PVs. Eighty-five percent were previvors. All reported family history of cancer. Eighty percent were female; 65% were under age 50; 98% English-speaking. Patients residing in 14 Texas counties were served. Twenty-one percent of patients underwent updated genetic testing because of their GCPC visit; of these, 1.7% had a newly identified PV. There were 61 referrals placed, and 366 pieces of educational/reference materials provided. Patient Satisfaction Survey feedback has been very positive. Patient volumes have continued to grow in recent months; most current data will be included if invited to share in a poster. A second clinic type has since been added to include a GI physician specializing in Lynch syndrome. The GNN has played an integral role within the multidisciplinary team in the development and ongoing adjustments to GCPC.

P143
CORRELATION BETWEEN COMPASSION FATIGUE LEVELS AND GENERAL HEALTH COMPLAINTS IN ONCOLOGY NURSES
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Oncology Nursing Practice

Oncology nurses are an essential component of the cancer care team, caring for cancer patients along their treatment trajectory. As such, they are exposed to the prolonged suffering of the patient and family. This repeated exposure can lead to compassion fatigue and increased general health complaints. Current literature on compassion fatigue is expansive, but there is a lack on the relationship between compassion fatigue and general health complaints in oncology nurses; how they perceive compassion fatigue and its relation to their general health. The purpose of this mixed-method study was twofold. The quantitative purpose was to examine the relationship between compassion fatigue and health complaints. The qualitative purpose was to explore nurses’ perceptions of compassion fatigue. Data were collected from a sample of 55 oncology nurses through two separate Survey Monkey links. All 55 participants completed quantitative data points including a demographic questionnaire, the Professional Quality of Life 5 tool, and the Giessen Subjective Complaints brief form. Participants selecting the second link also completed qualitative questionnaires (n = 15). Pearson’s correlation test revealed statistically significant positive correlations: burnout with exhaustion and musculoskeletal complaints (p = .000 and .036, respectively) and secondary traumatic stress with exhaustion, gastrointestinal complaints, and cardiovascular complaints (p = .000, .022, and .007, respectively). Qualitative data revealed nine themes including fatigue and being overwhelming. Combining quantitative and qualitative data showed the strength of the relationship between compassion fatigue and general health complaints. Key findings from this study include that oncology nurses do believe compassion fatigue is a very real phenomenon characterized by feelings of mental and physical exhaustion, anxiety, depression, and irritability. The qualitative responses from oncology nurses revealed they felt this way because they have “cried,” “stayed in bed,” and “felt it was a chore to interact with people.” Quantitative data revealed a statistically significant positive correlation with burnout and secondary traumatic stress and exhaustion (r = .613, p = .000, and r = .521, p = .000, respectively). There was also a positive statistically significant correlation between burnout and musculoskeletal complaints (r = .294, p = .036). Other positive statistically significant correlations were seen in secondary traumatic stress scores with regards to gastrointestinal complaints and cardiovascular complaints (r = .321, p = .022, and r = .370, p = .007, respectively).

P144
IMPROVING NURSING CLINICAL PRACTICE IN THE MANAGEMENT OF REFRACTORINESS TO PLATELET TRANSFUSION AMONG ONCOLOGIC/HEMATOLOGIC PATIENTS
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Platelet refractoriness is a clinical problem for patients with oncologic and hematologic disorders. It is the repeated suboptimal response to platelet transfusions after two sequential post-platelet increments of less than 10 x 109/L. Front-line nurses should be familiar with the causes of platelet transfusion refractoriness, its assessment, and management to improve patient’s clinical outcomes. The goal is to improve clinical nursing practice in managing platelet refractoriness by...
Educating nurses on the non-immune-mediated and immune-mediated factors and discussing the steps of interventions. An algorithm of strategies and counter-measures recommended by evidence-based research articles on identifying the causes of platelet refractoriness will be shown and discussed with staff nurses, and the type of platelet unit to be given—platelet crossmatching or HLA matching for immune-mediated causes. A literature review was conducted through the ONS and Medscape databases. The words: “cancer,” “patient,” “platelet transfusion,” “post-platelet count,” and “refractoriness” were used to generate articles. The articles were analyzed for variables causing platelet refractoriness and recommended care plans. Retrospective data collection from 15 thrombocytopenic patients with 100+ transfusion platelet events (post-chemo treatment, post-autologous stem cell transplant, post-allogeneic stem cell transplant, and chronic thrombocytopenia related to aplastic anemia) were used to identify the rates of the variables that might influence platelet refractoriness. An in-service was presented to the nursing staff with an evaluation algorithm and interventions during suspected refractoriness. A survey was captured to grade improvements in the nurses’ understanding of platelet refractoriness. The retrospective study showed the highest non-immune related variables were sepsis/infection, current medication, and active bleeding. A case study of a sample patient showed once their non-immune clinical condition is resolved, their platelet refractoriness resolves. Nurses given education on platelet refractoriness offered positive feedback on the surveys. Nurses feel more empowered by the knowledge. Nurses feel confident in asking for platelet antibody tests for suspected immune-mediated factors. This project aims to improve front-line nurses’ clinical practice through effective collaboration with physicians and transfusion services. The intention is to empower front-line infusion nurses with knowledge to promote a standard guide of practice that helps nurses to effectively respond when post-platelet increments are suboptimal so they can properly advocate for their patients if further interventions are appropriate.

**P145**

**DEVELOPING A CERTIFIED NURSING ASSISTANT ORIENTATION WITHIN THE ONCOLOGY SERVICE LINE TO EDUCATE NURSING ASSISTANTS ON SKILLS, TREATMENT MODALITIES AND COMPLEXITIES WITHIN THE ONCOLOGY POPULATION.**

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Oncology Nursing Practice

Oncology nursing education is an essential part of orientation for new nurses entering inpatient oncology. Nursing assistants reported areas for enhancement of the education they received regarding oncology specific needs, as they felt education was marginal in their hospital orientation. An Oncology CNA Orientation was developed to address these gaps in knowledge and worked to expand on the care continuum for oncology patients. The orientation was created to meet the needs of Nursing Assistants, all while continuing to expand their clinical practice and education. The Oncology CNA Orientation was developed to address the lack of oncology specific training received during onboarding. In doing so, the program also focused on specific skills or individualized areas of opportunity to the CNAs in attendance. Each Oncology unit identified engaged and experienced nursing assistants that were interested in leading orientation. After creating the course, the Clinical Practice Leaders worked with these CNAs to review course content and identify additional topics. CNAs held orientation sessions once a month for nursing assistants onboarded within the last two years. These sessions are now held quarterly, rotating between conference rooms on each unit. 23 nursing assistants have completed the program since inception, with two sessions pending targeting an additional 19 nursing assistants. The post-course evaluation included 5 questions ranging from 1 (poor) to 5 (excellent), with the average overall evaluation being a 5 out of 5. Feedback and suggestions for future topics supported the lapse in education for nursing assistants and how this program worked to address this. Additionally, CNAs shared they felt more confident in their skills, documentation and maintaining a better foundation of understanding of the patient population. It was evident that our nursing assistants were unable to build upon a foundation of oncology specific knowledge that would allow them to better care for our patients. This course opened dialogue surrounding opportunities for growth in CNA education and it is evident that it will remain a staple in how inpatient oncology units onboard their nursing assistants. This program successfully offers a safe outlet for discussion, how to standardize best
practice, and how to build upon the understanding of why we elect to provide care in the way that we do in oncology – not just how we provide care.

**P146**
PROTECTING OUR PATIENTS’ LIFELINES: A STANDARDIZED APPROACH TO PERIPHERALLY INSERTED CENTRAL CATHETER MANAGEMENT
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Oncology Nursing Practice

Peripherally Inserted Central Catheters (PICC) require meticulous care to prevent line complications, including occlusions, phlebitis, thrombosis, hemorrhage, and infections. Consistent documentation is also imperative to keep the patient safe. There was a marked increase in reported PICC dressing change errors when patients arrived for treatment at an outpatient infusion center. Some examples of errors include lines without clamps attached, gauze left underneath the dressing for more than forty-eight hours, and certain components of the PICC were not covered appropriately by the transparent dressing. There were also inconsistencies in the documentation of dressing changes, such as varied measurements. There have been recent changes to the securing devices utilized with PICC lines, which have changed the dressing process. Anytime a process is changed, there is a potential for error. Dressing changes can be completed within the hospital but also by homecare nurses. Close collaboration in developing educational materials with the PICC team was imperative to their successful use. Two educational pamphlets were created to help ensure that homecare nursing staff, patients, and caregivers have a clear understanding of PICC dressing changes and flushing instructions. The pamphlets include step-by-step instructions on dressing changes and PICC line flushing for the patient and family. Pictures and access to how-to videos using a QR code will be included. These educational pamphlets will give patients and their caregivers a way to advocate for themselves and have a specific document to refer to if they feel their dressing change is being done incorrectly. Championing a culture of safety and quality in patient care and education surrounding PICC lines is necessary for good patient outcomes. Implementing a standardized approach and providing educational tools to staff, patients, and their caregivers minimizes the risk of errors. Working together to educate multiple parties, the PICC pamphlets and videos will help create a safer, more reliable approach to caring for patients with PICC lines. The trial educational rollout to nurses in infusion was successful. After a dressing change demonstration, there were discussions about measuring correctly and clarifying many points in the process. Further investigation is needed into whether these interventions will improve patient outcomes and patient/caregiver satisfaction.

**P147**
EXPERIENTIAL COMMUNITY LEARNING EXPERIENCE FOR INCREASING STUDENT INTEREST IN ONCOLOGY NURSING AND DECREASING CANCER DISPARITIES
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Screening, Early Detection, and Genetic Risk

Despite the nursing shortage, recruitment of preservice nursing students into the oncology practice setting after graduation continues to be challenging as graduates are opting for environments, they consider to be high-tech, intriguing, or exciting. Increased disease prevalence and developments in treatment have made the need for oncology nurses more severe. Results from a recent large nationwide study demonstrated that students desire oncology education commensurate with clinical experiences to be adequately prepared to care for patients with cancer; however, prescriptive nursing education programs require educators to consider alternative learning approaches for specialty nursing content. In addition, nursing education credentialing bodies require students to learn about social determinants of health to mitigate healthcare disparities. Since cancer health disparities occur most often in medically underserved areas, there is a significant need to expose nursing students to the oncology environment with the objective of encouraging them to enter this understaffed subspecialty. The purpose of this pilot study is to offer volunteer experiential oncology nursing experiences to preservice baccalaureate nursing students to stimulate interest in the oncology nursing specialty while attempting to positively influence cancer disparities within the medically underserved community. This is a descriptive design pilot study. Students will be educated and trained in cancer education and social determinants of health (SDOH) prior to conducting cancer awareness and screening at community events for the medically underserved. Quantitative data will be collected through an original questionnaire.
delivered pre and post cancer education/training and event. Descriptive statistics and paired t-tests will be used to analyze student data and effectiveness of the intervention relevant to the study purpose. Findings from this study will broaden our understanding of student interest in the oncology nursing specialty through volunteer community partnerships. The insight obtained will be valuable for program improvement and expansion; vital for student education about SDOH and attempts to mitigate cancer disparities in the medically underserved community.

P148
NURSING PRACTICE IN THE DIGITAL AGE. TRANSFORMING PATIENT CARE THROUGH ARTIFICIAL INTELLIGENCE
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Professional Development
Artificial Intelligence (AI) has transformed the healthcare field at a fast pace. As healthcare providers strive for clinical excellence, it is essential to explore and embrace innovative technologies (Soriano et al., 2022). The presenter will discuss the integration of AI in nursing practice and its implications for nurses, patients, and healthcare systems. This review will provide an overview of AI applications in nursing practice. Starting with an AI related poll, the session will discuss various AI applications. Participants will gain general understanding of how AI enabled devices are currently being utilized in nursing, and their impact on patient care. The presenter will explore the challenges and potential risks associated with AI adoption (Pepito et al., 2020). The trend of AI-enabled technologies to assist and augment nursing care is rapidly growing, and the AI utilization is expected to further increase in the near future. Caring and technology has become inseparable, hence keeping abreast of the AI applications is imperative to nursing practice (Morrow et al., 2023). The AI applications in nursing practice include vital sign monitoring, data analysis, automated medication management systems, virtual health assistants, AI-powered chatbots, predictive analytics, AI-based image analysis, robots that assist in lifting and transferring patients, natural language processing, machine learning, and AI-driven research and evidence-based practice (Soriano et al., 2022). Potential challenges to AI include breach in data privacy, errors or biases in algorithms, and the lack of human touch and emotions in patient care (Morrow et al., 2023). Overall, AI empowers nurses to deliver more efficient care in a rapidly advancing healthcare landscape. The critical role of AI in transforming nursing practice underlines the need for nursing community to harness AI’s potential to revolutionize patient care delivery.

P149
CLABSI REDUCTION EFFORTS FOR AN INPATIENT ONCOLOGY UNIT
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Oncology Nursing Practice
Central line associated bloodstream infections (CLABSI) pose a major threat to hospital inpatients. They add to length of stay, contribute to hospital costs, and can even lead to death. In an effort to reduce the rate of CLABSIs at Abington Hospital, the medical oncology unit set a focus on central line education and implementation of standardized precautions. Central line-associated bloodstream infections are among the deadliest of healthcare-associated infections. 2WW is the oncology inpatient floor and has the highest rates of central lines at Abington Hospital. Simple interventions have been proven successful in reducing the rates of CLABSIs, and we have sought out to implement them across our unit. We began with increased utilization of CLABSI champions on the unit. We created central line precautions signs which are posted outside patient rooms. A CLABSI board was posted at the front of the unit and updated weekly with unit specific and hospital wide stats. We created a central line dressing change education, which is now shown in the residency program for all new nurses. Additionally, we involved the patient and provided increased education on importance of sterility and cleanliness with their central lines upon insertion, throughout their stay, and on discharge. In December 2021, there were 3 CLABSIs on 2WW. Line necessity compliance was 77.2%, CHG compliance 707.7%, dressing change compliances 73.0%. In Sept 2022, halfway through the project, line necessity compliance 95.745, CHG compliance 88.63%, dressing change compliance 94.44%. There have been 0 CLABSI on 2WW for 26 months, ever since June 2021. These are never before seen numbers on our unit. This project taught us that one of the most effective ways of preventing CLABSI is simply raising awareness and emphasizing sterility when dealing with central lines. On 2WW, CLABSI education has become a mission for all staff. Our efforts have been reflected in zero CLABSIs on 2WW for the 26 months, which coincides with
incorporation of CLABSI education into our residency project. We will continue to educate and advocate for patients and staff members, not only for the reputation of Abington Hospital, but for the health and safety of our patients.

P150
IMPLEMENTATION OF NURSING DEVELOPMENT SUPPORT STRATEGY: HUDDLE CARD EXPERIENCE
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Professional Development

Specialized oncology care requires specific knowledge and skills. The educational and development process of expert teams is a challenge, particularly in low- and middle-income countries. Educational actions enable the implementation of evidence-based learning tools, enhance team competencies, and improve patient care. Pocket Cards are among the quick learning instruments that can be explored in nursing practice. The purpose was to report the nursing team’s experience in conducting an EBP (Evidence-Based Practice) project stemming from a practice problem involving the ongoing education of the nursing staff. The Johns Hopkins model was used to conduct the EBP project. A literature search was conducted based on the following question: “For the education of nurses in oncology units, is the use of Pocket Cards compared to other teaching-learning strategies effective in team knowledge acquisition?” The review results were evaluated, and recommendations were made. A total of 50 studies on Pocket Cards were evaluated, and a total of 10 studies formed the basis for the recommendation. Through literature analysis, the team gained access to the Oncology Nursing Society’s (ONS) Huddle Card Library, which met the specific content needs of a Pocket Card in the specialty. The final recommendation included the implementation of Pocket Cards in inpatient and outpatient patient care points. To define the topics, a prioritization survey was conducted with nursing leadership. All topics from the ONS library were made available for review, and the most voted ones were: chemotherapy, fertility preservation, immunotherapy, radiation, sepsis, sexuality, and late effects of oncological treatment. A free translation of the text from English to Portuguese (Brazil) was made for the Cards provided by the ONS. After translation, they were organized into a specific template, ensuring compliance with ONS’s copyright terms. Huddle Card is an option for obtaining quick and practical knowledge in nursing routine. ONS’s knowledge sharing through the publication of Cards is relevant to global nursing, especially in countries with scientific development challenges. Conducting EBP projects encourages nurses to seek and incorporate the best available scientific evidence into bedside practice.

P151
NURSING LED INTERVENTIONS IN CLABSI REDUCTIONS
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Oncology Nursing Practice

Healthcare-associated infections (HAIs) cost the US healthcare system billions of dollars annually (CDC, 2023). Central line associated blood stream infections (CLABSI) are a preventable HAI that create a significant physical and financial burden for patients and healthcare providers. CLABSI not only increase average length of stay and 30-day readmission rates, but patients who develop a CLABSI are faced with increased mortality rates (Chovanec et al., 2021). Our goal is to enhance nurses’ knowledge of current strategies associated with reducing central line associated blood stream infections. A selection of evidence-based interventions were implemented by nursing staff in a Midwest comprehensive cancer center. Interventions included a peer-to-peer skills check off process, a universal protocol for CHG bathing/treatment, and incorporation of bedside nursing representation at CLABSI focused quality improvement workgroups. Ninety percent of a staff nurse-led shared governance council were checked off on CLABSI prevention skills.
prior to implementation of peer-to-peer review. All patient education documents were reviewed and updated with new language for daily CHG treatment. Bedside nurses became members of CLABSII focused quality improvement groups. Nurse Council members returned to their own units to check off their peers using the reviewed checklists. Checkoff included: central line dressing changes; the sequential line access process; scenarios to identify the correct central line dressings and correct infusion cap and tubing change practices. The council successfully changed the paradigm from thinking of bathing as optional to considering a CHG bath a medical treatment. Nurses were empowered to educate patients to adhere to this treatment. Historically there have been multiple workgroups across the enterprise that have a CLABSII reduction component. A recent culture shift was made to ensure staff nurses were included in quality improvement workgroups. Listening to the staff nurse has led to the success of this multifaceted project.

**P152**

**ONCOLOGY NURSES MASTER PROCEDURAL SEDATION SUPPORT FOR PATIENTS RECEIVING BONE MARROW BIOPSY AND ASPIRATE TO IMPROVE OUTCOMES & EFFICIENCY**

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**Coordination of Care**

At a large academic medical center, four inpatient hematologic malignancy unit’s staff care for patients who require bone marrow biopsy and aspirate for diagnostic evaluation. A subset of patients requires or request sedation to tolerate the procedure. This high-risk procedure occurs infrequently in the inpatient setting at this center. Data collected in 2022 showed 39 inpatients required sedation. Post pandemic changes including nursing staffing shortages and wide variations in nursing skill level have made it difficult to maintain competency. Recent restructuring of patient care levels restricted the practice of administering sedation. Nurses who support moderate sedation procedures are required to demonstrate competency and receive training. These changes demanded a different approach. This project’s purpose was to transition inpatients needing sedation for bone marrow biopsy and aspirate to an established oncology procedural area. The oncology procedural area allows for a safe space with trained and dedicated staff who administer sedation for patients. The nurses in the procedural area are oncology nurses trained to support and perform various procedures, including about 750 moderate sedation procedures annually. Nurses in this area are trained using an initial and annual competency for medication administration, monitoring, recovering, and the use of reversal agents for procedural sedation. The inpatient oncology nurse champions partnered with their unit educator, advanced practice providers, the nurse lead for the oncology procedural area, and nursing leadership to transition inpatients requiring sedation to the oncology procedure area. A comprehensive workflow for the safe transition of inpatients requiring sedation to the procedure area was developed. With the transition of these patients to a dedicated procedure area, trained staff can provide a safe and controlled environment to promote the best patient outcomes. The patient’s full recovery occurs in the procedure room, taking the burden off the inpatient staff. Inpatient staff members have expressed relief in having a dedicated team performing unit procedures. Due to collaborative efforts, the transition from patient sedation to the procedure area has been successful, and compliance with proper documentation and protocol adherence has increased. By performing all sedations in the oncology procedural area, the oncology inpatient can remain in the department with oncology staff for most of their care and ensure safety and quality are met by appropriately trained dedicated staff.

**P153**

**STANDARDIZED PROCESS FOR OUTPATIENT CVL MAINTENANCE**

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**Patient Education and Safety**

ONS publications and 2022 Congress presentations advocated for change in the standard of practice for the care of the central venous line (CVL) from the long-held method of a heparin lock to the use of normal saline. Inpatient professional governance adopted this change, but the process lacked a long-term maintenance plan and education to system providers and patients who like nurses were accustomed to a heparin lock. Heparin increases the risk of harm to patients including heparin induced thrombocytopenia, bleeding, anaphylaxis, biofilm formation that can lead to central line infections and interference with anticoagulation lab results. ONS publications indicated normal saline using a push-pause technique (PPT) increased turbulence...
which allows for more effective catheter clearance of residual blood. The outpatient infusion clinic (OIC) goal was to adopt this recommendation and a consistent process that would apply to all CVLs. In addition, there was a need identified to engage the patient in the long-term maintenance and care of their CVL. The two most common CVLs in the OIC are the PICC line and Port. The goal for the OIC was to develop one maintenance plan for all CVLs. The decision was made to adopt a 20cc PPT normal saline flush every 12 weeks. As a multidisciplinary project, the OIC clinical specialist (OIC-CS) presented the recommendations for change to the cancer providers, unit and system professional governance and pharmacy. During the inpatient implementation it was noted that patients and providers were unaware of the flush change and questioned rationale. Patient education documents were created using health literacy concepts. Professional education included the change in practice and patient education workflow expectations. Pharmacy removed the heparin flushes from the med dispense system. The use of a heparin lock is an established practice for both providers and nurses, as such implementation requires cultural persuasion with a variety of communication methods. The OIC-CS consolidated multiple CVL policies into one. Communication was shared throughout the system using intranet, learning modules, newsletters, and flyers. This allowed for application across the system as a unified process for both inpatient and outpatient areas. Six months after the inpatient implementation and during the OIC process review with providers there were gaps in communication noted with non-admitting community providers, home health, and interventional radiology. These disparities were addressed, and CVL care standardized.

P154 USING PREDICTIVE AND PRESCRIPTIVE ANALYTICS IN IMPROVING THROUGHPUT AND CAPACITY AT THE INFUSION CENTER
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Using health literacy concepts, professional education included the change in practice and patient education workflow expectations. Pharmacy removed the heparin flushes from the med dispense system. The use of a heparin lock is an established practice for both providers and nurses, as such implementation requires cultural persuasion with a variety of communication methods. The OIC-CS consolidated multiple CVL policies into one. Communication was shared throughout the system using intranet, learning modules, newsletters, and flyers. This allowed for application across the system as a unified process for both inpatient and outpatient areas. Six months after the inpatient implementation and during the OIC process review with providers there were gaps in communication noted with non-admitting community providers, home health, and interventional radiology. These disparities were addressed, and CVL care standardized.

P155 HOME IS BEST: DECREASING INPATIENT LENGTH OF STAY FOR ACUTE HEMATOLOGIC MALIGNANCIES
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Traditionally, patients are assigned into specific chairs within the infusion center in advance of their appointment. At times, the patients arrive early for their appointments and at times they arrive late for a variety of reasons. In 2021, the Infusion center had a 89.7% utilization of templated hours resulting in gridlock at times of the day, while in 2022 the infusion center had a 83.5% utilization rate of templated hours. The utilization of the templated chair hours was not fully being maximized due to the frequency of patients having delays, secondary, to office practice appointments, transportation delays, lab results delays etc. These patient delays resulted in empty chairs not being utilized to their maximum capacity. A decision was made that we needed to optimize the availability of chairs within the current space that was had rather quickly. The decision was made to pull the patients into chairs as they arrived to the center rather than assign them to specific chairs in advance. The patients now wait in the waiting room until their labs are resulted and an RN clears them for treatment based on the parameters. Once cleared they are brought to the first available chair. This has helped to improve the utilization of templated hours to 71.5% while maintaining the wait times for the patients. Through improving the utilization they were able to accommodate an additional 10 patients per day on average.
patients length of stay, improving their quality of life, and facilitating the transition of care to the outpatient setting. The outpatient care team consisting of Physicians, ACPS, Nursing, Laboratory, Pharmacy and Operations collaborated to facilitate appointment availability, a dedicated exam/treatment space, as well as protocolized workflow to ensure the safe and effective care of this vulnerable patient population. Patients awaiting biopsy results were discharged with frequent follow ups in place of an extended hospitalization. These patients were scheduled three times weekly for a medical visit with the Dedicated ACP and subsequent same day treatment and interventions as required. Patients undergoing inpatient chemotherapy were identified as early discharge candidates meeting certain criteria to await count recovery in the comfort of their home. These patients were also scheduled for frequent follow ups in place of an extended hospitalization and received their treatments and interventions in the ambulatory setting. This program while still novel has resulted in a decrease in hospital length of stay, increase in patient satisfaction, and the improved continuum of care between the inpatient and outpatient setting. This program has identified the need for increased exam room space, infusion chair capacity, coordination with the laboratory and blood bank, and continued dedication to the enhancement of collaboration within the multidisciplinary team. As a result of the lessons learned during the inception of the Early Discharge Program expanded patient populations and diagnoses are being considered for inclusion within this care model.

**P156 NORTHWESTERN HEALTH CANCER CARE DIRECT: COMPREHENSIVE NURSE NAVIGATION PROGRAM**

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**Coordination of Care**

After a successful rollout of our Breast Navigation Program in 2021, the Northwell Health Cancer Institute focused its effort to expand nurse navigation to all oncology specialties. In 2022, our navigated patients saw a significant decrease from diagnosis to surgical consult comparative to our system average time to appointment. Our navigated patients were getting a consult on average of 6.6 days from their biopsy comparative to 22.8 days pre navigation. This further proved the value a nurse navigator can have on efficiency and access to care. Our system goal was to guarantee that all our patients have access to a nurse navigator should they want one. In doing so, we needed to develop a concierge program that delivers personalized care upon a cancer diagnosis, through survivorship. Disease specific pathways were created with our oncology leadership to help guide our navigators on how to manage the patients needs from one specialty to the next. On January 9, 2023, Northwell rolled out a system wide navigation program called Cancer Care Direct. The program utilizes one phone number and one email address that allows a patient to be directly connected with a nurse navigator who is knowledgeable on the cancer that they are facing. Our team is made up of 11 navigators and 8 administrative coordinators who have oncology backgrounds. The coordinators are in place to aid the navigator in scheduling appointments and obtaining imaging records so that the navigator could function at the top of their clinical license guiding patients through their journey. One challenge was ensuring that as we expanded this program, our navigation team was set up for success to effectively navigate all patients. Navigation literature suggests that one oncology navigator can effectively navigate up to 230 active oncology patients.

*Our team built daily caseload reports to monitor the volume of disease specific patients coming through. In 10 months, we had over 400 referrals to Cancer Care Direct and our navigators have navigated over 3,200 patients. In addition to creating tools to measure time to appointment throughout disease specific cancer journeys, our team measured patient experience feedback on how useful Cancer Care Direct was as a program for both providers and patients. The results were positive across the board.

**P157 BLINATUMOMAB DECISION MAKING TOOL**

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**Oncology Nursing Practice**

Blinatumomab is indicated for CD 19+ Acute Lymphoblastic Leukemia (ALL). Patients in a large New York City cancer center begin their infusion as an inpatient and then transition to the outpatient setting. The outpatient infusion nurses verbalized confusion surrounding Blinatumomab bag changes and central line management. Blinatumomab has been associated with both Cytokine Release Syndrome (CRS) and neurotoxicity with the risk increasing if medication is flushed
through the central line. Due to the significant risks associated with this medication, the outpatient oncology educators sought to design a decision-making tool, to ensure safe and standardized care. Oncology educators collaborated with nurses, advanced practice providers, and physicians to develop a Blinatumomab decision tree. The decision tree includes pathways for managing and infusions via Hickman catheters, Peripherally Inserted Central Catheters (PICC), and implanted single and double-lumen port-a-catheters. The decision tree also includes pathways for troubleshooting line occlusions, loss of blood return, and processes required for bag changes and infusion completion. The Blinatumomab decision tree was presented to infusion center nurses at annual competency sessions, included in a resource binder in the nursing stations, and on the ambulatory oncology resource webpage. Nurses reported enhanced knowledge and increased confidence in caring for patients on Blinatumomab after utilizing the decision tree. Feedback on the Blinatumomab decision tree has been overwhelmingly positive. Nurses report that having an easily accessible, clear reference aids them in providing safe and efficient care. Additionally, they report that they are better equipped to escalate concerns to advanced practice providers and physicians based on guidance from the decision tree. As a result of this feedback, the oncology nurse educators are implementing a decision tree for management pathways for hepatic arterial infusion pumps.

**P158 GOING HOME WITH A PERIPHERAL IV**
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**Oncology Nursing Practice**

At the Southern Illinois Healthcare Cancer Institute, oncology and hematology infusion services are provided to patients within the local community. Within the infusion department, oncology and hematology patients utilize various types of intravascular (IV) devices including central and peripheral lines. In 2023, we observed an increase in patient-reported distress due to repeated peripheral IV placements over consecutive treatment days. The institutional policy required that an IV must be removed prior to discharge. To address patient distress, we identified the need to implement an evidence-based practice project to develop and evaluate a protocol for maintaining multi-day, extended use peripheral IV access. The purpose of this evidence-based practice project was to reduce multi-day peripheral IV accesses and patient distress, as well as nursing time and overall cost. An analysis of practice guidelines and national standards was conducted. Based on evidence-based guidelines, a nursing bundle was developed that included peripheral IV insertion care and maintenance standards. Specifically, the bundle includes: information on patient selection, vein selection, vein preparation, dressing, maintenance, and patient education. A patient education sheet with visual aids was created for discharge. Nurses were trained on using the bundle. Following implementation, success rates for patients being discharged with peripheral IVs over consecutive treatment days was evaluated. An estimated cost-savings based on nursing time saved was calculated. The implementation of the bundle was evaluated by assessing the percent of IV lines maintained for multiple days compared to the number of patients eligible to receive an extended use IV line, patient satisfaction, and cost over a 12-week period. Among 11 eligible patients who received anti-cancer therapies and other medications, 10 received an extended use IV line that was maintained for up to 5 days (90.9% success rate). Calculating savings in nursing time for these 10 patients only, the project was estimated to save $1,365 dollars. Patient distress also improved. Select patient comments included: “You guys have no idea how much this means to me!” and “This makes it so much easier, I am a hard stick”. We were able to decrease patient distress by implementing this evidence-based peripheral IV bundle with an additional focus on time and cost-savings. Implications include standardizing this bundle and developing a new practice of care that can be utilized across institutions.

**P159 AN INTEGRATED APPROACH TO STANDARD ONCOLOGY TREATMENT AND PATIENTS UNDERGOING RESEARCH**
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**Oncology Nursing Practice**

Advancements in oncology care rely on clinical research trials for discovery of new regimens and treatment options for patients. Traditional research institutions may segregate patients on clinical trials from patients undergoing standard of care (SOC) treatment, which may limit the ability to accept clinical trials. The opportunity to integrate both populations of patients...
into a singular unit may improve access to care for both populations, while maintaining quality and safety. Oncology nurses assigned to support both populations of patients must be supported in their cross-training to ensure safety, accuracy, and compliance. The goal of this project is to integrate two classically segregated patient populations into one area to improve access to care for potentially lifesaving research, while maintaining quality and safety. The project has been implemented in a large cancer center’s infusion suite where both clinical research patients and SOC patients receive care by oncology infusion nurses. Infusion nurses have been cross trained to provide care for both patient populations, with the addition of a pool of infusion nurses with specific expertise to provide care for the higher acuity research trial patients. The implementation of daily huddles to support this care model include leadership from research, infusion, and pharmacy. Infusion nurses, clinical research nurses, and clinical research coordinators also participate to ensure a collaborative approach. A standardized documentation template was created for use in both patient groups to minimize redundancy in charting. Finally, a Charge Nurse bootcamp was implemented to provide support for the clinical research patient integration within the SOC population. It is anticipated that the current number of clinical trials open in this infusion center will more than double by the end of 2023. Protocol deviations for clinical trials are reported through the iRIS Protocol Violation/Incident Reporting Form. This project’s plan is to show the data of increase in research trials compared to the number of deviations. National benchmarking on protocol deviations is limited, this data will be useful in adding to the current literature base. The integration of clinical research patients into standard oncology infusion centers requires investment in nursing education and infrastructure changes to support the new model of care. Clear communication across all teams is instrumental to a successful workflow and requires flexibility among all participants to provide safe and effective care.

**P160**

**CREATING A NURSE DRIVEN NEW PATIENT CHEMOTHERAPY/IMMUNOTHERAPY EDUCATION COURSE**

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**Patient Education and Safety**

Patients newly diagnosed with cancer require extensive education regarding diagnosis, treatment, side effects, and resources. A gap in patient education was observed in the outpatient infusion setting due to lack of time, resources, and a formally taught course. 70% of surveyed outpatient infusion nurses at a large academic medical center agreed patients would benefit from an educational course prior to starting treatment. Encouraging patient participation in a monthly nurse driven virtual class offered to all patients receiving treatment at a large academic medical center. A course presentation was created for the introduction to chemotherapy/immunotherapy class. The presentation included basics of cancer, types of treatment, safety precautions, side effects, mental and physical self-care during treatment, and available resources including social work, nutrition consultations, financial services, and community resources. The course was then presented to the clinic managers, administrators, directors, and several committees for feedback and approval. A message basket was created for clinic nurses and ancillary staff to refer patients who were good candidates to attend the class, and flyers with a QR code were posted in the main waiting rooms and clinical laboratory allowing patients to directly sign-up for the class. Lastly, a presentation on the course and anticipated participation needed from staff was conducted at staff meetings for stem cell transplant clinic, solid tumor clinic, and patient navigators. After attending class patients are sent a survey to provide feedback and grade their satisfaction with the course based on if expectations were met, the quality of content, pace the class was taught, and if they felt any information was missing. Patients reported both verbally and through survey submissions that the course content was “very beneficial” and were “very satisfied” with the overall learning experience of the course. The outcomes of the class have provided patients and families with a greater understanding of what to expect when beginning treatment. A limitation to the course is only offering it once per month hindering the number of patients able to attend. With the help of the class, the first day of treatment is a less anxiety-inducing experience and patients begin their cancer journey with more knowledge and peace of mind.

**P161**

**AN INTERNATIONAL COLLABORATION: THE DEVELOPMENT OF A FERTILITY PRESERVATION POSITION STATEMENT BETWEEN THE ASSOCIATION OF PEDIATRIC HEMATOLOGY AND ONCOLOGY NURSES, THE CANADIAN ASSOCIATION OF NURSES IN ONCOLOGY AND THE ONCOLOGY NURSING SOCIETY**

Kyle Stimpert, MSN, RN, ACNP, VA Northeast Ohio Healthcare System, Cleveland, OH; Kyle Stimpert,
patients and survivors on fertility preservation practices and policies that advocate for evidenced-informed care. The evidence-informed position statement will be evaluated by the respective associations board of directors for approval and subsequent dissemination. Anticipated outcomes include increased nursing awareness and communication with patients and families.

P162
HAZARDOUS DRUG EXPOSURE IN THE POST-CHEMOTHERAPY PERIOD
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Oncology Nursing Practice
Disposing post-chemotherapy excreta has the potential to expose healthcare workers (HCW) to hazardous drugs. National Institute for Occupational Safety and Health (NIOSH) guidelines recommend HCWs use proper personal protective equipment (PPE) to increase safety. A literature review was conducted to determine best practice to mitigate risk of exposure when disposing of post-chemotherapy excreta. The purpose of this project is to increase awareness of post-chemotherapy drug exposure via excreta and measures to reduce this risk. Registered Nurses (RNs) and Patient Care Technicians (PCTs) were provided education on hazardous drug exposure and interventions to decrease exposure. At an NCI-designated Comprehensive Cancer Center, that does not have a published standard for disposing hazardous excreta, education was provided to RNs and PCTs on the risk of post-chemotherapy excreta exposure. Education was completed to increase knowledge and interventions to mitigate exposure. RNs and PCTs were surveyed pre- and post-education on their knowledge of potential surfaces containing hazardous drug residue, settings where exposure can occur, and level of concern. The same eight-question survey was provided to 16 participants pre- and post-education addressing knowledge and feelings of hazardous drug exposure in post-chemotherapy period. Post-intervention, an increase of 12% recognized that chemotherapy is primarily excreted through urine and unused surfaces may be contaminated. There was a 6% increase in recognizing some chemotherapy agents take longer to metabolize. Post-education, all participants could identify current PPE guidelines during administration. 43% of participants answered that the institution has PPE requirements for the post-chemotherapy period, despite education. The final two...
questions addressed HCW’s feelings on safety in the post-chemotherapy period and knowledge of institution procedures to which 93% stated their concern about exposure in the post-chemotherapy period. An increase of 32% recognized the institution does not have guidelines for disposing of post-chemotherapy excreta. Within the cancer institution, there are no centralized guidelines for HHCs on the disposal of excreta in the post-chemotherapy period. Post-education surveys, when compared with pre-education surveys, showed increased awareness and knowledge about hazardous drug exposure post-chemotherapy. Providing education on the risk of post-chemotherapy excreta exposure empowers healthcare professionals to take best measures to decrease exposure.

**P163**
**ELEVATE INPATIENT ONCOLOGY CARE: AN EARLY MOBILITY PROGRAM TO REDUCE FALLS AND SHORTEN STAYS**

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**Patient Education and Safety**

Hospitalized cancer patients face many unique challenges, including rapid deconditioning, an increased fall risk, and a significantly higher rate of fall-related injuries compared to other patient groups. In this context, nurses play a crucial and distinctive role in fall prevention within healthcare settings. Their specialized skills are essential in driving early mobility programs, which have demonstrated promising results in reducing falls and ultimately improving outcomes for hospitalized oncology patients. Our study aimed to address patient falls and extended hospital stays on a medical oncology unit by introducing the “Rise to Shine” (RTS) early mobility program. This structured program promoted early and frequent mobility by ambulating patients to a chair for every meal. Our objectives were to decrease the unit’s total monthly falls by 20% and reduce the average length of stay by 50%. Before initiating the program, staff members received training on mobility techniques and gait belt usage through videos, bulletin boards, verbal instructions, and hands-on practice. Nurse buy-in and compliance were encouraged with fun activities, weekly gift bag raffles, “RTS” badge reels, and dedicated time for staff feedback. Upon implementation, patients were enrolled in the program by nursing staff based upon the following criteria: orders to ambulate were present, the patient was in a private room, and the patient passed the Dionne-Egress test. Night shift nurses were responsible for ambulating enrolled patients to a chair for breakfast, and day shift nurses were responsible for lunch and dinner. Weekly electronic medical record audits ensured consistent performance. A remarkable 50% fall reduction was achieved, surpassing our first goal. While our second goal regarding length of stay was not met, there was still a commendable 20% decrease. Additionally, we discovered increased staff engagement and enthusiasm toward fall prevention lasting beyond the program’s conclusion. Nursing staff attributed this finding to the high volume of staff engagement activities held on the unit. Our results highlight the importance of maintaining structured early mobility programs on inpatient oncology units. Such programs can substantially reduce falls, shorten stays, and create positive staff engagement, ultimately enhancing oncology patient care. In future projects, prioritizing staff education and engagement while focusing on patient safety and improved outcomes is recommended.

**P164**
**EPISTAXIS PREVENTION AND MANAGEMENT IN A BLOOD AND MARROW TRANSPLANT UNIT**

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**Oncology Nursing Practice**

Patients on the Blood and Marrow Transplant (BMT) Unit at an academic medical center experience new onset epistaxis and recurrent epistaxis due to thrombocytopenia. Epistaxis leads to increased use of blood product transfusions, use of consult teams, medical interventions and nursing time. After a few life-threatening epistaxis events, nurses took action. A 2020 chart review revealed that 40 BMT patients (4%) on the unit had one or more nosebleeds during their hospitalization. The number is likely underestimated due to underreporting by patients and under-documentation by staff. Ninety-eight percent of nurses stated they were not adequately trained in epistaxis prevention and management. The purpose was to implement an evidence-based nursing clinical practice guideline for assessment, prevention and management of epistaxis. Nursing practice change was supported by the...
development of educational material for specific nasopharyngeal assessment, interventions on the prevention and management of epistaxis. Development of a patient handout and specific electronic health record documentation was created to capture epistaxis assessment and management. A risk stratification assessment tool was implemented where high-risk patients receive Nasal Saline Gel prior to sleep. Effective, timely and consistent care was implemented for patients that experience epistaxis including the as needed availability of oxymetazoline (Afrin). Data was collected for 15 months pre-intervention (January 2020 – March 2021) and 15 months post intervention (June 2021- August 2022). Staff survey results increased from 2% to 84% regarding staff feeling adequately trained in managing epistaxis. The majority of BMT patients who experienced epistaxis were identified as 92% high-risk for epistaxis compared to 8% low-risk. Ear Nose and Throat consults decreased from 39% to 27% and oxymetazoline use increased in epistaxis events from 54% to 76%. The average number of platelets used to treat the initial bleed decreased from 1.22 units to 0.82 units. The percentage of epistaxis in the BMT population decreased by 0.5%, with the understanding that pre-data documentation of epistaxis was rare. October 2022 through September 2023 continues to show a sustained decrease in epistaxis episodes. Implementing epistaxis practice guidelines in the BMT population empowers nurses, reduces related healthcare utilization and decreases overall epistaxis events. Oncology nurses are first responders; being able to assess and intervene to prevent epistaxis or promptly treat during an epistaxis event improves outcomes.

P165
IGNITING INNOVATION IN ONCOLOGY CARE THROUGH ONCOCOLING NURSING AND ENGINEERING COLLABORATION
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Oncology Nursing Practice
Collaboration between oncology nurses and engineers facilitates creative solutions to unmet clinical needs. Both professions utilize a problem-solving approach, complimented by specialty knowledge in their areas of expertise, igniting a multidisciplinary team approach to patient care. Two case studies illustrate the result of multidisciplinary collaboration to improve patient care. The first example resulted in the development of a novel medical device to improve clinical practice and safety for the administration of intravesical therapy. The second case study highlights the planning and implementation of a cervical self-sampling device, used in vulnerable populations to improve early detection of cervical cancer. Oncology nursing involvement in both cases provided unique perspectives from idea and design of technology to translation to practice. Case study #1 provides an example of a nurse-driven idea, from concept to technology development, to improve the administration and safety in the administration of intravesical chemotherapy. The collaboration of nursing and engineering led to the development of a stopcock adapter through the use of a 3-D printer. The process of idea inception, device creation, and technology transfer processes will be discussed. Case study #2 provides an example of a patented self-sampling device for cervical cancer screening, including related implementation activities: stakeholder advisory group creation, educational material development, and trauma-informed care applications. Case study #1 evaluation and measure of success involves the use of this new, novel adapter to maintain closed system for safe administration of intravesical chemotherapy, thereby minimizing nurse exposure to antineoplastic agents and promoting patient comfort, privacy, and patient and nurse satisfaction. Case study #2 evaluation and measure of success will be documented through the uptake and use of the cervical self-sampling device in a population that may not otherwise seek gynecologic care. Other measures will include stakeholder satisfaction and care navigation for those who require further follow up. Oncology nursing and engineering collaborations combine diverse skill sets to develop and implement innovative solutions to unmet clinical needs. Creating oncology nursing and engineering partnerships can be successful; however, these opportunities may be uncharted territory. Both oncology nurses and oncology advanced practice registered nurses (APRNs) have the creativity to address patient care needs in concept, leadership, and support.

P166
IT'S POSITIVE! IMPLEMENTATION OF A NURSE-DRIVEN PREGNANCY SCREENING PROTOCOL PRIOR TO TREATMENT AT AN OUTPATIENT INFUSION CENTER
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OUTPATIENT INFUSION CENTER
Many cancer treatments have a high teratogenic potential and are administered to patients of childbearing age. The National Comprehensive Cancer Network guidelines recommend pregnancy testing prior to the initiation of these treatments, but lack guidance for monitoring throughout the duration of therapy. Pregnancy screenings were inconsistent at the Pennsylvania Hospital Infusion Center, as they lacked set guidelines regarding patient testing. Additionally, screenings were not nurse-driven, and providers inconsistently ordered these tests at office visits. Few patients received regular pregnancy tests prior to treatment, leading to the potential for missed positive screenings and administration of harmful medications without counseling. After discussion with the Unit-Based Shared Governance Council, a literature review was conducted to determine qualifications for patient pregnancy testing. Patients of childbearing age were defined as non-menopausal individuals with a uterus under the age of 60 without a history of hysterectomy, tubal ligation, or bilateral oophorectomy. Those on birth control were not excluded from testing. After collaboration with physicians and laboratory staff, a nurse-driven protocol was devised to allow nursing staff to order monthly urine pregnancy screenings. Any patients declining pregnancy testing were referred to their physician for counseling prior to the administration of the medication. A retrospective chart analysis from January to May 2023 showed an average of 47.3 patients per month qualified for pregnancy testing at the infusion center. In that same time period, an average of 3.8 patients per month were screened for pregnancy. On June 1, 2023, the nurse-driven pregnancy screening protocol was implemented. Nursing staff were educated on the protocol, including how tests would be performed and which medications would require testing prior to administration. Post-implementation analysis from June to August 2023 showed an average of 38.6 qualifying patients per month, with an average of 36 patients screened for pregnancy, including one positive screening result. The lack of standardization in pregnancy testing prior to treatment with teratogenic drugs led to the development of a pregnancy screening protocol for individuals of childbearing age at the infusion center. Creating a nurse-driven protocol allowed for frequent and appropriate testing, resulting in potential improved safe patient outcomes. Encouraging nurses to drive a process change that aligns with current practices has assisted with seamless implementation of the protocol, and has empowered nurses to address potential issues for future protocol modifications.
from a cost savings perspective, with the average wage rate for a Registered Nurse being $42.22/hour at UHealth, the implementation of this guideline has resulted in an estimated annual savings of $102,848. These collaborative efforts resulted in safe patient care without negative outcomes while decreasing costs. This guideline has fostered increased collaboration among various departments engaged in the patient’s comprehensive treatment team. With this increase in efficiency, nurses are more available to other patients in the oncology unit and prevent staff shortage. By sharing this nursing guideline already created by the UHealth, health equity can be promoted for other institutions administering newly FDA approved CIBs nationwide. This will result in cost efficiencies for other oncology departments while still prioritizing safety in patient care.

**P168**

**IMPLEMENTATION OF AN USG PERIPHERAL IV PLACEMENT PROGRAM**

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Oncology Nursing Practice

Oncology patients often have difficulty obtaining peripheral IV access due to vein-debilitating conditions and undergoing repeated venipuncture for frequent lab collection and medication administration for treatment management (Stone et al., 2013). The utilization of Ultrasound-guided peripheral IVs (USG PIVs) can lead to a decrease in infection, patient frustration, an increase in patient satisfaction, and improved staff efficiency with placement. USG PIV placement is more cost-effective than central line placement and is a great alternative for oncology patients who no longer require a central line (Stone et al., 2013). Oncology patients often have difficulty obtaining peripheral IV access, which can increase staff frustration and lead to multiple IV insertion attempts for patients or delays in treatment if access in unable to be obtained. The implementation of a dyadic ultrasound guided IV course for nurses in the Oncology service line. The course consisted of a lecture, a review of the ultrasound machine, hands-on practice with a mannequin, followed by completion of a USG PIV competency with individual assistance from a subject matter expert. The USG PIV education course was an eight-hour day and the maximum number of students in a class was five. After 4 months of implementing the USG PIV placement program, 17 nurses were successfully trained to place US-guided peripheral IVs. Additionally, 84.21% of the class attendees rated the program as excellent. Over 94% of nurses that participated in the program felt the USG PIV skill was relevant to their daily practice as an Oncology nurse. When evaluating the course material, 89.47% of nurses rated the material as excellent and 10.53% of nurses rated the material as “good”. Establishing reliable IV access is important in managing the complex care of cancer patients. The USG PIV program provides nurse with an additional skill set and competency which can improve patient satisfaction, nurse confidence, and decrease the need for central venous access.

**P169**

**IMPROVING NURSING RESOURCES AND KNOWLEDGE IN LEVEL 1 IN AN OUTPATIENT ONCOLOGY AMBULATORY TREATMENT CENTER**

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Oncology Nursing Practice

The outpatient oncology ambulatory treatment center services provides various chemo infusions, injections, and central line care for patients. Acuity based scheduling templates schedule patients as Level 1 based on the following needs: non-chemotherapy infusion, dressing changes, routine vascular access maintenance, short treatments, fluid, electrolytes, and antibiotic infusions. Nurses are assigned to Level 1 on a weekly rotation every 2-3 months. Nurses voiced concerns that because of the infrequent time spent in Level 1, a compilation of written resources specific to Level 1 workflow for immediate reference is needed. The objectives of this quality improvement project were to: 1) identify the needs of the nursing staff related to consistency in practice; 2) improve patient throughput in Level 1; 3) improve scheduling of central venous catheters for maintenance and laboratory blood draws; and 4) create a shared resource binder and electronic shared folder for easy access for the nursing staff in Level 1 by March 2023. A needs assessment survey was created to assess the nurses’ knowledge, comfort level, and consistent practices in Level 1. Of 20 nursing staff, 55% felt the resources in Level 1 were readily available, however, 72% of nurses felt the resources in Level 1 were not clear and concise. The team collaborated with nursing staff, business services, and nursing leadership to devise a...
shared resource binder which included charge capture, LDA documentation, information on different injection sites, departmental phone directory and guidelines and procedures for Central Venous Catheters for maintenance/blood draw. Nursing education was provided to nurses one on one, small group huddles, and staff meetings to share the binder and electronic version. Post education intervention survey was conducted to evaluate the project effectiveness. Nursing satisfaction increased from 55% to 100% and 100% of nurses felt the resources available in Level 1 was clear and concise. A 60 day follow up survey to follow up showed that 100% of nurses were still satisfied with the resources and its conciseness. The team will continue to monitor nursing staff satisfaction, updated processes, and potential barriers monthly or more frequently if needed. Relevance in Clinical Practice: A written and electronic resource binder specific readily available and frequently updated with institutional practice and guideline is beneficial to ensure a more efficient workflow in Level 1.

P170
ENHANCING AUTONOMY: NURSE-DRIVEN TOCILIZUMAB ORDER FOR TREATMENT OF CYTOKINE RELEASE SYNDROME WITH BISPECIFIC ANTIBODIES
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Oncology Nursing Practice
Per the Oncology Nursing Society (ONS) Chemotherapy and Immunotherapy Guidelines and Recommendations for Practice, “verbal orders for chemotherapy, targeted therapy, and immunotherapy medications are not permitted, except to hold or stop drugs.” Our large academic medical center’s verbal order policy aligns with this ONS guideline. However, with the growing popularity of chimeric antigen receptor T cell and bispecific antibody therapies, the potential urgent need for tocilizumab to treat cytokine release syndrome (CRS) has also grown. Therefore, our lymphoma-multiple myeloma unit examined the potential for developing a nurse-driven workflow that would facilitate verbal tocilizumab orders and streamline the standard of care. The purpose was to create and implement a verbal tocilizumab order workflow in which the provider verifies the indication and dosage, and the nurse enters the order into the electronic medical record (EMR).

In March 2023, the 15-private bed lymphoma-multiple myeloma unit administered its first commercial bispecific antibody. In preparation, the nurses and providers were educated on the new medications and workflow. A low threshold for administering tocilizumab was set, which allowed for the administration of the drug after a single grade one CRS event. However, it was ultimately the provider’s discretion when to dose. The workflow included the provider obtaining tocilizumab consent on admission, followed by a physician communication order to list the indication and the patient-specific dose of tocilizumab. Upon verbal confirmation from the provider, the nurse places the order in the EMR and administers the medication. Since March 2023, the lymphoma multiple myeloma has administered 56 doses of bispecific antibodies and ten doses of tocilizumab. All tocilizumab orders were placed with the new workflow. There have been zero tocilizumab medication errors with the new workflow. Limitations include the limited number of tocilizumab administrations. Creating a standardized verbal tocilizumab order workflow provided safe delivery of the drug. To effectively care for oncology patients, all nurses and members of the interdisciplinary team should be supportive and work together. In the future, we plan to continue the workflow within the growing bispecific antibody field.

P171
BEHIND THE SCENES: A LOOK AT THE PROCESS AND EVIDENCE BEHIND THE ONS SAFE HANDLING OF HAZARDOUS DRUGS 4TH EDITION
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Oncology Nursing Practice
Over 8 million U.S. healthcare workers come into contact with hazardous drugs each year, and not always in oncology settings. While there is training required for all nurses and pharmacists handling these drugs, less guidance and recommendations are aimed at other healthcare workers (nursing assistants, environmental services workers, those in shipping and receiving). The 4th edition of the ONS Safe Handling of Hazardous Drugs Book was written with all healthcare workers in mind and is intended to be a valuable resource to all who come into contact with these drugs. The co-editors of the 4th Edition engaged in a two-year process that included a rigorous review of the literature from the past five years, careful selection of expert authors, suggestions of latest literature for inclusion, consideration
of changes in the clinical setting and in the position statements of the ONS board, and critical review of language for inclusion of all healthcare workers in clinical settings. The purpose of this presentation is to share with ONS members and attendees how the Safe Handling of Drugs 4th Edition was developed; what literature was reviewed, who our authors were, what the review process was like, and how we came to make the updated recommendations we have- with the best evidence available to us. By the time of ONS Congress 2024, the 4th Edition will be available for purchase and we want to give our members and attendees a chance to come behind the scenes and hear how the book was developed so they understand the science behind safe handling of hazardous drugs which is necessary for ensuring protection from hazardous drug exposure in the workplace. We believe that our members and attendees would take advantage of a chance to engage with the editors in this way and would be more likely to return to their clinical settings confident in their ability to advocate for improvements in clinical practice, undertake quality improvement projects, and improve safety in their workplaces.

P172
BLACK AND LATINA BREAST CANCER PATIENTS’ PERCEPTIONS OF PERSONALIZED MEDICINE AND SHARED DECISION-MAKING
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Patient Education and Safety
Understanding personalized medicine and its impact on treatment options is essential for patients. People of color and those whose primary language is not English may have more limited awareness of personalized medicine than other patients. Nurses play a vital role in educating patients on this topic. A cancer advocacy organization and an academic medical institution launched the Personalized Medicine Initiative to deepen understanding of Black and Latina breast cancer patients’ knowledge of genomic or tumor biomarker testing and genetic testing for an inherited mutation, healthcare providers’ (HCP) roles in decision-making, and patients’ preferred learning methods. Using a qualitative study design, we gathered information from Black and Latina women. Semi-structured group interviews were held through virtual focus groups (5 in English; 1 in Spanish) with 29 patients. Twenty-one identified as Black and 8 as Latina. The majority (n=26) had undergone treatment in the last year for stage I-III breast cancer, and 3 had stage IV cancer. Data collection was designed to address the following topics: (1) level of knowledge about genetic and genomic testing, (2) barriers to accessing care, (3) shared decision-making, and (4) preferred ways to learn about complex health information. Four themes emerged: (1) The term genetic testing elicited the most recognition of the terms tested. Perceptions of the value of genetic testing varied, with an emphasis on benefit to family. Genomic testing was recognized less frequently. (2) Barriers to accessing care included cost of care and limitations in health insurance, pressure to act quickly on treatment decisions, limited HCP-patient communication, and COVID-19 restrictions. (3) Participants placed high levels of trust in HCP judgment and expertise. At different points, patients view their HCPs as director of care, expert advisor, and source of emotional support. (4) Patients’ preferred learning formats for processing complex health information were resources offered at multiple junctures in varied formats (such as video), credible websites, and personalized notebooks. Exploring Black and Latina women’s experiences with understanding genetic and genomic testing and barriers to care is important for nurses and other HCPs to close gaps in healthcare access and outcomes by race, ethnicity, and language. A range of HCP roles and educational approaches were cited as valued by focus group participants. Study results were used to develop educational tools about genetic and genomic testing and shared decision-making for nurses, other HCPs, and patients.

P173
LEUKAPHERESIS: WHY OR WHY NOT?
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Treatment Modalities
Apheresis is a generalized term that denotes separation of whole blood and removal of a blood component. Apheresis is an umbrella term, as there are various apheresis procedures including plasmapheresis, erythrocytapheresis, and leukapheresis. Historically leukapheresis has been performed for acute blast crisis in various leukemias. Blast phase is when a leukemic patient has more than 30% immature blood cells in the bone marrow or blood stream.
Leukapheresis is performed when a patient’s white blood count (WBC) >100,000 in acute myeloid leukemia (AML), WBC >400,000 in acute lymphocytic leukemia (ALL), with leukostasis, or when tumor lysis is present. It is used to remove a portion of these cells so that other treatments such as chemotherapy have less tumor burden. It is also used to decrease the number of cells so that the chemotherapy causes less cell apoptosis which could lead to tumor lysis syndrome. The purpose was to educate Oncology Nurses why they might care for patients receiving leukapheresis. Therapeutic leukapheresis with hyperleukocytosis is performed for rapid cellular reduction prior to initiation of aggressive chemotherapy. Leukapheresis is typically performed for 1 to 2 procedures until the WBC count is <100,000.

Leukapheresis was listed as a Category II in American Society for Apheresis (ASFA) guidelines that indicated it was accepted as a second line therapy either as a single treatment or with other modalities. Currently leukapheresis has been downgraded to a Category III in ASFA guidelines which indicates the benefit of apheresis is not established, and the use of this therapy is determined case by case. ASFA 2023 guidelines reviewed the role of leukapheresis, and determined it did not indicate an advantage of symptom management with tumor lysis syndrome with leukostasis. Children with leukostasis and WBC>400,000 develop central nervous system and pulmonary symptoms in more than 50% of the patient population. Leukapheresis may be more beneficial in this clinical setting, and the decision should be made on a case by case basis. With our Apheresis department, leukapheresis was previously indicated as an emergency procedure and would have been performed 24/7, however, with the new guidelines, it is no longer considered an emergency on call case.

P175
STANDARDIZED VENOUS ACCESS ASSESSMENT IS A TEAM APPROACH: IMPLEMENTING VENOUS ACCESS ASSESSMENT TOOL TO REDUCE ADVERSE VENOUS EVENTS.
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Administration of intravenous chemotherapy and immunotherapy is routine practice for treating patients with oncology diagnoses. These treatments and other supportive care medications have irritant and vesicant properties, which could negatively impact patients physically and emotionally. Ensuring patients have reliable venous access reduces the potential for adverse events, improving patient satisfaction and outcomes. Standardized venous access assessment prioritizes patient safety by implementing established guidelines and best practices to minimize the risk of adverse events to
patients receiving chemotherapy and immunotherapy treatment. Before initiating treatment, a systematic approach to venous access assessment ensures that the healthcare team reviews and discusses best practice recommendations for peripheral IV versus central venous catheter device placement based on the patient’s condition and treatment needs. The intervention of evidence-based standardized venous access assessment involves implementing a systematic and consistent approach to evaluating a patient’s peripheral venous access before treatment to determine the most appropriate method of intravenous administration. The evaluation would involve using the Modified Adult Difficult IV Access Scale, which develops clear and comprehensive guidelines for venous access assessment. These guidelines outline the criteria for selecting appropriate central venous access devices and the documentation process. Training on the assessment tool and how to effectively utilize it will be provided to the nurses and licensed practitioners in person and through an online education module. Knowledge assessment will be conducted through pre- and post-testing as part of the online module learning. Initiating protocol-based care has improved outcomes in healthcare. Periodic review and updates to our standardized assessment protocol based on new evidence, best practices, and feedback from healthcare professionals are paramount to success. By implementing a standardized venous access assessment intervention, we can enhance patient safety, streamline procedures, reduce complications, and improve the overall experience for patients receiving chemotherapy intravenously.

P176
SELF-REPORTING OF MEDICATION CHANGES IN AN ONCOLOGY AMBULATORY CARE CENTER
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Oncology Nursing Practice
Ambulatory Gynecologic (GYN) Oncology patients at a Comprehensive Cancer Center are asked to self-identify medication changes, on an iPad, at the beginning of each clinic visit. The GYN Team hypothesized that patients select “no change (NC)” despite having changes to home medications. An inaccurate record of home medications led to an ER visit with at least one known patient. Outdated or incorrect medication lists have the potential to cause undue harm in additional patients and leave the facility vulnerable to ethical and legal ramifications. The purpose was to identify the number of variances in patients who report “NC” on their home medication list. The team developed a quantifiable baseline to identify whether the hypothesis was correct to prompt a plan for clinical practice change. In this quality improvement project, an RN or PharmD met with each patient who reported no medication changes on their initial intake. The medication list was reviewed line-by-line to identify if the list had incorrect or missing medications. Each of the erroneous or omitted medications were corrected in the electronic medical record to ensure an accurate record of home medications. This was completed on 300 patients throughout the four-week pilot period. Of the first 300 patients who reported “no change” to medication history, 220 (77%) required modifications to their medication list. Types of medication changes included incorrect medication, missing medication, wrong dose/instructions, and/or duplicate medications. On average, 3 discrepancies per patient were noted. Self-reporting of medication changes was found to be inaccurate 77% of the time in patients who reported “NC” to medication history. Based on this data, the GYN nurses have integrated a practice change to include a detailed medication review for each patient. Next steps include implementation in all ambulatory care centers throughout the facility.

P177
IN-DEPTH SAFETY ANALYSIS OF PHALLCON: A PHASE 3 STUDY COMPARING PONATINIB VERSUS IMATINIB IN NEWLY DIAGNOSED PH+ ALL
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Oncology Nursing Practice
The use of BCR-ABL1 tyrosine kinase inhibitors (TKIs) in patients with newly diagnosed Philadelphia chromosome-positive (Ph+) acute lymphoblastic leukemia (ALL) can be associated with adverse events (AEs). Primary results from the only global, randomized controlled trial comparing 2 TKIs demonstrated that ponatinib was superior to imatinib in combination
with reduced-intensity chemotherapy in patients with newly diagnosed Ph+ ALL, demonstrating a significantly higher minimal residual disease–negative complete remission rate at the end of induction (EOI) and exhibiting comparable safety. The purpose was to evaluate safety and characterize rates of AEs in newly diagnosed patients with Ph+ ALL receiving ponatinib or imatinib in combination with reduced-intensity chemotherapy. Interventions: Adult patients with newly diagnosed Ph+ ALL were randomized 2:1 to receive ponatinib (30 mg once daily [QD]) or imatinib (600 mg QD) with reduced-intensity chemotherapy through EOI, consolidation, and post-consolidation. Patients then received single-agent ponatinib or imatinib until disease progression or unacceptable toxicity were demonstrated.

Evaluation: Patients (N=245) were randomized to ponatinib (n=164) or imatinib (n=81); median age was 54 years (37.0% ≥60 years). The rate of hospitalizations per patient-year (95% CI) was 0.8 (0.5, 1.1) in the ponatinib arm and 0.9 (0.4, 1.3) in the imatinib arm. AEs were the most common reason for hospitalization (ponatinib/imatinib, 46/42%). Treatment-related AEs and serious AEs were comparable between arms (Table). Arterial occlusive events (AOEs) were infrequent and comparable between arms (ponatinib/imatinib, 2/5/1.2%). Treatment interruptions were higher with ponatinib (68%) vs imatinib (40%). The most common (≥10% of patients) treatment-emergent AEs (TEAEs) leading to treatment interruption with ponatinib were ALT increase (19.0%), neutropenia (14.1%), lipase increase (11.7%), and thrombocytopenia (11.7%). Hypertension and hepatotoxicity occurred in higher proportions of patients with ponatinib vs imatinib; however, the majority of events were Grade 1 or 2 and manageable (Table). In the ponatinib arm, TEAEs leading to study drug discontinuation in ≥1 patient were septic shock, sepsis, ALT increase, and AST increase; no TEAEs resulted in discontinuation in ≥1 patient in the imatinib group. Overall, treatment discontinuations were comparable between arms (10% vs 9%, respectively). Safety data from this pivotal phase 3 study indicate that ponatinib has a comparable safety profile to imatinib when administered in combination with chemotherapy to patients with newly diagnosed Ph+ ALL. TEAEs were manageable when treated in accordance with recommendations in study protocol and proposed labeling.

**P178 IMPLEMENTING SCHEDULED LABORATORY VISITS IN THE COMMUNITY ONCOLOGY SETTING**

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**Oncology Nursing Practice**

Oncology patients in the community do not have easy access to an onsite laboratory to have their blood drawn compared to ease of access in the hospital setting. Patients may need to drive an extra 10 to 15 minutes to the closest outpatient laboratory and wait for the next available phlebotomist, which may be upwards of an hour. This leads to blood work not being done on time or at all, sometimes delaying treatment. The phlebotomists at general laboratory sites are not trained to obtain blood samples for patients on study protocols or specialty lab work needed for genetic/hereditary patients. An oncology community practice in Upstate NY established scheduling patients in the infusion room was the next step in increasing patient satisfaction and compliance with appropriate lab draws for our specialized oncology patients. For more efficient use of resources and chair space, it was identified that ambulatory care technicians (ACTs), as part of their scope, would draw peripheral blood work instead of registered nurses (RNs). By designating a previously unused injection chair for peripheral blood draws by ACTs, we can now easily schedule patients into a lab-only encounter, providing clear communication to the patient about what they are scheduled for. The staff is trained in obtaining what is needed for oncology treatments, clinical trial samples, ensuring compliance, and genetic lab draw kits. Press Ganey scores for “patients understanding of scheduled appointments” and “expected wait times are appropriate” will be monitored. Surveying RNs and ACTs will evaluate if there is increased job satisfaction. Providers will give feedback on their ability to get patients scheduled for treatment and supportive care as this process increases scheduling capabilities in the infusion room. The lack of an onsite laboratory clinic identified a need for easier access to blood work in the oncology community practice. Steps were taken to offer this service to oncology patients onsite for clinic visits. Utilizing the resources available to meet the needs of patients as well as increases satisfaction for patients, staff, and treatment team providers.

**P179 ENHANCED PATIENT EDUCATION FOR**
COLONOSCOPIES TO PROMOTE ADEQUATE BOWEL PREPARATION THE “WHY” BEHIND A SUCCESSFUL BOWEL PREP FOR COLON CANCER DETECTION
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Patient Education and Safety
Colon cancer screening is a vital tactic to reduce morbidity and mortality from colon cancer. In fact, according to the National Cancer Institute “it is estimated that in 2023 there will be 153,020 new cases diagnosed in the United States and 52,550 deaths due to this disease” (NCI, 2023). Despite the importance of colon cancer screenings and advancements in bowel preparation methods, the quality of bowel preparation in some patients undergoing colonoscopy studies remains unsatisfactory. The purpose of this study is to determine the impact a “why” statement within the patient education for bowel preparation has on the patients’ quality of bowel preparation when compared to patients’ bowel preparation that had the education without the “why” statement. Patient education was enhanced to include a more modified diet and an interventional statement in which the “why” behind the importance of an adequate bowel preparation was explained. The quality of bowel preparation of the patients that received the interventional statement of “why” was documented using the Boston Bowel Preparation Score (BBPS) from January 1, 2023 through June 1, 2023. These scores were retrospectively compared to the BBPS of patients that did not receive the interventional statement from June 1, 2022 through December 31, 2022. The comparison of these scores demonstrated that the patients that had the interventional statement had a 5.45% increase in the quality of their bowel preparation as evident by their BBPS. In conclusion, the patients that received the bowel preparation statement and explanation of the reason behind the preparation had increased the BBPS of their colon preparation. When compared to the patients from the year before, prior to the implementation of these advancements, there was over a 5% improvement in the quality of bowel preparation.

P180
ARTIFICIAL INTELLIGENCE PERFORMANCE IN COLONOSCOPY OUTSIDE CLINICAL TRIALS: INITIAL EXPERIENCE IN “REAL PRACTICE”
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Screening, Early Detection, and Genetic Risk
Colon cancer screening is an important strategy to decrease morbidity and mortality from colon cancer. Screening can be done via noninvasive tests such as stool DNA testing or fecal immunohistochemical testing or via colonoscopy which is more invasive. An abnormal noninvasive should lead to a colonoscopy which is needed to detect cancer or prevent it via removing polyps, the precursors of cancer. One limitation of colonoscopy is missing polyps which is one of the causes of interval colon cancer, cancer diagnosed in short interval before a surveillance colonoscopy. Subtle polyps, especially sessile serrated polyps (SSP) are difficult to detect. In addition, endoscopists variable performance are known to contribute to missed polyps. Recently Artificial intelligence technology was introduced to help decrease polyp missed rate via highlighting to the endoscopist polyps with a visual and auditory signal. The purpose of this study was to improve the adenoma detection rate by the use of AI using the GI genius artificial intelligence technology. It has been shown in a meta-analysis of randomized controlled trial to improve adenoma detection rate by 44%. In this study the ADR rate was 36%. There is currently no data available on AI performance outside of clinical trials. As early adopters of the technology we are presenting our Initial experience with AI in the real world. All AI enhanced colonoscopies done for screening, surveillance or as a follow-up after positive stool testing was analyzed. 110 colonoscopies were identified, (94 screening, 9 surveillance and 7 positive fecal DNA evaluation). The ADR was 52%. For average risk screening colonoscopy from our own data. Using AI, our ADR was 54% and SSP detection was 19% compared to 52% and 8% in the year before without AI enhancement. Withdrawal times and preparation quality were comparable. Our initial “real life” experience from early artificial intelligence adoption for polyp detection enhancement was consistent with the published literature on AI. In addition, we experienced a significant increase in sessile serrated polyp detection rate which needs to be further investigated.

P181
OUTPATIENT CHIMERIC ANTIGEN RECEPTOR T-CELL PROGRAM
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Patient Education and Safety
Performing Chimeric Antigen Receptor T-cell (CAR-T)
as outpatient treatment can be beneficial to patients and hospitals. Allowing the patient to remain in the outpatient setting can decrease the risk of hospital acquired infections while keeping the patient active at home and reduce financial toxicity. The Stem Cell Transplant and Cellular Therapy Nurse Coordinator plays a key role in the safety and success of outpatient CAR-T by ensuring patients and caregivers have the knowledge and support necessary for success. CAR-T carries a risk of serious side effects related to activation of the immune system such as cytokine release syndrome and immune effector cell-associated neurotoxicity syndrome. Clinical assessment along with patient reporting of treatment related toxicities are essential to ensuring patient safety and prompt intervention in the event of toxicities. Nurse coordinators educate patients and caregivers on risks of toxicities and what to do when symptoms develop. The nurse coordinator assists in the development of standard operating procedures (SOPs) that utilize a combination of in-person and telehealth visits allowing for successful implementation of an outpatient CAR-T program.

Nurses also aid in the development of safety protocols and pathways for monitoring post infusion. Consideration must also be given to the need for a higher level of care for patients that experience serious toxicities. The nurse is vital for educating patients and caregivers on identifying and notifying teams of treatment related toxicities, monitoring vital signs, infection prevention, food safety, medication adherence, compliance with appointments and telehealth visits. Patients and caregivers must also be educated on how to respond to non-life threatening and life-threatening situations. The nurse coordinator and team meet regularly to discuss quality improvement initiatives. Processes should be evaluated regularly to ensure current pathways are safe and communication lines are effective to manage immune related toxicities. Education provided to patients and caregivers must also be regular to make sure the patient has the tools necessary to be successful. A multidisciplinary team approach is required for outpatient CAR-T. The nurse coordinator’s role in guiding the patient and caregiver through the process safely is vital. By playing such an integral role in education and process development, the nurse coordinator ensures the education provided to the patient and caregiver is accurate and up to date.

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Treatment Modalities
Originally FDA-approved in 1997, rituximab is one of the most successful anti-cancer therapies that has ever been developed. Although it has completely dominated the anti-CD20 market for over two decades, the advent of the biosimilar pathway along with an expedited FDA-approval process has allowed three unique biosimilars of rituximab to become available. Previously in oncology, biosimilars typically offered an alternative therapy for mostly supportive care such as minimizing the occurrences and consequences of neutropenia and anemia. However, these three rituximab biosimilars (r-abbx, arrx, and pvvr) mark a significant change in that paradigm where instead of supportive care measures, these actually offer alternative cancer treatment options at a significantly lower cost compared to the reference drug. For the most part in the United States (compared to other countries where these are available), patients have been quite accepting of this. The purpose of this presentation is to compare these three rituximab biosimilars to help the nurse better care for their patients when they are administering these medications and offer biosimilar-specific education that helps the nurse better communicate the unique nuances of these three treatment alternatives during patient education. This presentation will highlight the similarities, differences, variances, and other biosimilar-specific information that is pertinent to oncology nurses who care for patients who require anti-CD20 therapy using one of these rituximab biosimilars. It is projected that these three rituximab biosimilars collectively will replace the reference drug’s market share and take over approximately 80% of the anti-CD20 market by 2029. Oncology nurses need to be aware of this evolving science, be able to explain the similarities and differences of these biosimilars to the reference drug to their patients, and purposefully seek out new information on these significant practice changes at nursing conferences, by reading nursing publications, and attending professional nursing organizational meetings.

INDUSTRY-SUPPORTED

P182
NURSING 101: A COMPARISON OF THE THREE BIOISIMILARS FOR RITUXIMAB
Eric Zack, DNP, RN, ACNP-BC, AOCN®, BMTCN®, Rush
POST-HOC ANALYSIS OF THE PHASE 3 PLACEBO-CONTROLLED FRESCO-2 STUDY

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Treatment Modalities

Maintaining quality of life (QoL) is an important treatment goal, as metastatic colorectal cancer (mCRC) and its treatment can adversely impact QoL. In the global, randomized, double-blind, phase 3 FRESCO-2 study (NCT04322539), treatment with fruquintinib (a highly selective oral inhibitor of all 3 VEGF receptors) + best supportive care (BSC) vs placebo+BSC significantly improved overall survival (OS) and progression-free survival (PFS) in patients with refractory mCRC, with a manageable toxicity profile and without deterioration in QoL. The purpose was to investigate the effect of fruquintinib+BSC in delaying worsening of Eastern Cooperative Oncology Group performance status (ECOG PS) ≥2 or death. Patients were randomized 2:1 to receive fruquintinib (5 mg) or matching placebo orally, once daily for every 28 days +BSC. This post-hoc analysis assessed time from randomization to first occurrence of ECOG PS ≥2 or death (overall or within 37 days of last dose), and the stratified log-rank test and stratified Cox model were conducted to evaluate the fruquintinib+BSC treatment effect. Patients were assessed on Day 1 of each Cycle, Day 21 of Cycles 1 to 3, at end of treatment, and at safety follow-up (within 37 days after last dose). From August 14, 2020 to December 2, 2021, 691 patients were randomized (fruquintinib+BSC: 461; placebo+BSC: 230) with baseline ECOG PS of 0 (n=298) or 1 (n=393). Patients who received fruquintinib+BSC versus placebo+BSC had a significantly delayed time to first occurrence of ECOG PS ≥2 or death within 37 days after last dose (median 6.6 vs 2.9 months; hazard ratio [HR]: 0.551; 95% confidence interval [CI], 0.436–0.697; Figure). When deaths within 37 days after last dose were censored, patients who received fruquintinib+BSC demonstrated a significantly delayed time to ECOG PS ≥2 or death compared with placebo+BSC (stratified HR: 0.667; 95% CI, 0.508–0.877; p=0.004). When all deaths observed during the study were included in the analysis and not censored, the fruquintinib+BSC group demonstrated significantly delayed time to ECOG PS ≥2 or death compared with placebo+BSC (median 5.3 vs 2.9 months; HR: 0.637; 95% CI, 0.528–0.767). Treatment with fruquintinib+BSC delayed worsening of ECOG PS compared with placebo+BSC. These results, along with the statistically significant and clinically meaningful improvement in OS and PFS and favorable toxicity profile, further support fruquintinib+BSC as a new treatment option for patients with refractory mCRC.

I2 EVALUATING NURSE PREFERENCES: A NOVEL ON-BODY DELIVERY SYSTEM (OBDS) VS. HIGH-RESISTANCE, MANUAL SYRINGES FOR LARGE VOLUME SUBCUTANEOUS DRUG ADMINISTRATION

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Oncology Nursing Practice

Nurses are the backbone of the healthcare system and even more so in the oncology setting where they frequently administer large volume subcutaneous (SC) biologic drugs to patients. Current large volume SC drug administration, such as with daratumumab/hyalurondase (Darzalex Faspro) and rituximab/hyalurondase (Rituxan Hycela), often involves the use of high-resistance, manually pushed syringes. These require significant force during administration, leading to musculoskeletal strain in nurses, many of whom are of an age where recovery from work-related injuries is prolonged. The introduction of on-body delivery systems (OBDS) for large volume SC drug delivery has potential to overcome these challenges for nurses. This double-blind survey aims to evaluate nurse preferences between the current high-resistance, manual syringes and a novel OBDS called “Product X” in the survey. This novel OBDS is hypothesized to reduce nurse burden, improve clinical throughput, decrease the risk of needlestick injuries, and potentially lessen patient discomfort due to its smaller needle size. The blinded device referred to as Product X in the study is the enFuse with the Vial Transfer System manufactured by Enable Injections as a combination product intended for large volume SC delivery. Nurses were surveyed after viewing a short presentation of Product X in action. The survey incorporated both quantitative and qualitative components, assessing the nurses’ perceived ease of use, preference between syringe types, and the factors influencing their preference, including considerations related to patient care and nursing workload. Responses were quantitatively analyzed to
assess overall preference and factors influencing this preference. Qualitative data was examined to explore nurse perceptions in depth, focusing on the potential benefits of reduced physical strain, improved nurse safety, enhanced clinic efficiency, and patient advantages. Preference for Product X was also measured for SC syringe pumps. Additional questions the ability of Product X to reduce needlestick injuries and to facilitate self-administration of oncology therapeutics. Our findings reveal a strong preference for the enFuse due to its potential to significantly mitigate nurse workload and musculoskeletal strain while maintaining high standards of patient care. enFuse may enable nurses to effectively care for more patients, thereby optimizing clinic throughput. In addition, the smaller, hidden needle could reduce needlestick injuries and improve patient adherence and comfort, offering a substantial advancement in large volume SC biologic drug delivery.

### A MULTICENTER STUDY TO MEASURE TOILET AEROSOLS AND EVALUATE THE EFFECTIVENESS OF USING A COVER

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Oncology Nursing Practice

Unlike toilets found in residences, hospital toilets do not have lids and operate at high pressure using Flushometer valves. Laboratory and small clinical studies have shown that these toilets produce large quantities of particles that can contain viruses, bacteria, and hazardous drugs excreted from patients receiving chemotherapy. Most of these particles are small enough to be inhaled into the respiratory tract. In 2023, a small laboratory-based study showed that both a disposable pad and a reusable engineering barrier control effectively reduced toilet aerosols. However, no studies have looked at the effectiveness of covering hospital toilets in actual clinical settings. The goals of this multicenter study were to measure actual numbers of particles generated by flushing uncovered toilets in a variety of clinical settings, and to determine the effectiveness of the Splashblocker (SB). Fourteen hospitals (including 7 NCI-designated cancer centers) located in the eastern, southern, northern, and western U.S. were enrolled in the study. A total of 123 inpatient toilets on oncology, medical-surgical and other floors were tested. Using a TSI optical particle counter, the isokinetic inlet was placed 22 inches above the floor and counted particles from 0.3 to 5.0 um in diameter for 60 seconds. The testing sequence involved obtaining a baseline ambient measurement followed by flushing the toilet using the SB, followed by an uncovered flush (UC). Net SB particles were calculated by subtracting the ambient results. Since testing showed non-significant differences between ambient and flushing with the SB, the UC net was determined by subtracting the SB from the UC. Flushing uncovered toilets in all study sites produced large quantities of particles. A statistically significant decrease in the total number of particles was measured using the SB (p <0.0001), with a reduction of 105% ± 29%. Median net particles were 8,533 compared to 52. Nurses and other healthcare workers do not normally wear respirators when flushing hospital toilets. This can lead to the potential inhalation of bioaerosols and hazardous drugs. These tiny particles can linger in the air for more than 20 minutes before settling on surfaces creating a vulnerability for staff. This study shows that the Splashblocker resulted in a statistically significant reduction of inhalable particles and that covering the toilet should be considered an integral clinical safety component, particularly in the oncology setting.

### PATIENT REPORTED SATISFACTION WITH AN ONCOLOGY NURSE SUPPORT PROGRAM

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Patient Education and Safety

Carcinoid syndrome diarrhea (CSD) is a paraneoplastic syndrome that occurs in patients with functional neuroendocrine tumors (NETs). Patients with NETs report that CSD is a major contributor to physical, emotional, and social distress. However, in a typical busy oncology clinic, supportive care measures may not get adequate attention. To support patients with CSD, a nurse support program (NSP) was developed. Clinical nurse educators (CNEs) employed by industry with expertise in NETs and CSD provided supplemental education to patients on the following topics: (1) a specialty medication (2) NET disease state (3) CSD-related nutrition and (4) patient support and advocacy groups. The goal of the NSP is to provide timely education and support to patients with CSD. The purpose of this survey was to evaluate patient satisfaction and knowledge across the four educational domains of the NSP. A cross-sectional survey was conducted in all patients enrolled in the NSP with an email address
on file (N=268). Three invitations to a 9-item survey were sent from 07/11/2023 until 08/23/2023. A total of 138 patients (51%) provided results for the survey. Most patients (≥90%) agreed that their knowledge regarding their medication’s mechanism of action, onset of therapeutic effect and potential side effects increased since entering the NSP. The majority (≥88%) of patients also agreed that the NSP increased their knowledge of triggers of CSD and nutritional choices that would better manage their CSD. Over 50% of patients agreed that the NSP helped connect them to the local NET community and patient advocacy groups. Patients were overwhelmingly supportive of the program with ≥97% agreeing that their CNE takes time to listen to their questions, is responsive and would recommend the NSP to other patients. The results of our inaugural patient survey were positive and validate the important role of an industry supported NSP. An area for future improvement includes more emphasis on connecting patients to local advocacy groups. Overall, the results of this survey indicate that the NSP is increasing patient’s knowledge of their medication and disease state by providing additional timely educational support.

I5
BIL S. 4260: THE PALLIATIVE CARE AND HOSPICE EDUCATION AND TRAINING ACT: A POLICY ANALYSIS
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Symptom Management and Palliative Care
Palliative care (PC) and oncology aims to support the patient through diagnosis, treatment of oncology disease, symptom management, and overall quality of life. Studies regarding palliative care use in oncology patients have shown that seriously ill patients, such as oncology patients, have a better quality of life and symptom control throughout all stages of their disease while decreasing additional medical services and visits to the hospital. This policy analysis evaluates Bill S. 4260, the Palliative Care and Hospice Education and Training Act (PCHETA), which is going through congress and awaiting Senate approval to aid in funding training and education throughout the palliative care spectrum. The policy analysis of Bill S. 4260 utilized Bradach’s Eightfold Method, thematic analysis, and SWOT analysis to effectively and thoroughly guide the DNP policy analysis. General knowledge, creative alternatives, evaluation identification criteria, evaluating projected outcomes, discussing trade-offs, and reviewing recommendations were all a part of the analysis process. Results were analyzed utilizing the SWOT methodological framework for policy S. 4260. Results were be disseminated to Jacksonville University and local North Carolina United State Senators through a policy brief. The final project was be submitted to the ProQuest repository. While there was some disagreement on the recommendation of incentivizing healthcare professionals due to fear of further holding the Bill form coming to fruition, most participants felt that although there would be a cost for incentivizing HCP’s, it would also benefit the community with greater resources.

I6
ONCOLOGY NURSE PERSPECTIVES ON CLINICAL MEANINGFULNESS IN PATIENT-CENTERED METASTATIC BREAST CANCER TREATMENT DECISION-MAKING: A QUALITATIVE RESEARCH STUDY
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Oncology Nursing Practice
People with metastatic breast cancer (mBC) face many clinical and individual decisions when considering treatment options. Accordingly, oncology nurses (ONs) provide essential services in mBC care delivery and serve as critical members of the care team. However, an understanding of ONs’ role in patient-centered treatment discussions with mBC patients, including how concepts of clinical meaningfulness and clinically meaningful outcomes are interpreted and shared with patients, remains limited. This study examined ONs’ role in treatment discussions with patients and their perspectives on clinical meaningfulness and clinically meaningful outcomes in the context of mBC care delivery. Focus groups with ONs providing care to people with mBC in community and/or academic care settings in the US. Discussions elicited perspectives on ONs’ role in treatment discussions, their familiarity with and interpretation of clinical meaningfulness, and how ONs incorporated these concepts into treatment discussions with patients. Transcripts were analyzed using thematic analysis. Three focus groups were conducted with 17 ONs in May 2023 (mean age: 51.0 years [SD=10.0]; 100% female, 65% practicing oncology for ≥10 years). Participants shared that guideline recommendations and patient goals for care largely influenced treatment decision-making. Patient...
preferences, extent and location of metastasis, symptoms of pain, and cost and insurance considerations further mediated treatment decisions. ONs play a primary role in educating patients about the disease, treatment, and available resources as well as advocate on behalf of their patients. ONs are responsible for patient education, communication, coaching, addressing barriers or challenges to optimal care, connecting patients to resources, and monitoring for adverse events and needed psychosocial support. During treatment, ONs noted that the magnitude of treatment benefits that patients consider most meaningful is critical in discussions, and it is essential to factor these in. These include attaining personal life goals, limiting side effects, and maintaining a quality of life that supports participation in important activities and milestones. ONs serve as a critical member of the oncology care team, eliciting and ascertaining patient needs and preferences, including outcomes most meaningful to patients, and supporting the patient along the care continuum. While ONs reported familiarity with the terms clinical meaningfulness and clinically meaningful outcome, these terms were not considered to be patient-focused and were not typically employed during mBC treatment decision-making discussions, but were accounted for more holistically in practice.

**I7 PREVENTION AND MANAGEMENT OF SKIN ADVERSE EVENTS IN PATIENTS TREATED WITH TUMOR TREATING FIELDS (TTFIELDS) THERAPY**

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**Patient Education and Safety**

TTFields are electric fields that disrupt cancer cell viability delivered noninvasively to the tumor site via skin-placed arrays. TTFields therapy is currently approved by the FDA for glioblastoma (GBM) and CE-marked for grade 4 glioma; as well as for pleural mesothelioma. Efficacy of TTFields plus standard therapies was recently demonstrated in lung cancer; studies in other tumor types are underway. Most TTFields device-related adverse events (AEs) are dermatological, occurring beneath the arrays. Appropriate skin AE prevention and management are important for optimizing TTFields therapy usage, a factor associated with improved survival outcomes in GBM. Oncology nurses are vital in providing care and education related to TTFields therapy. The purpose was to support oncology nurses with practical guidance on prevention and management of TTFields device-related skin AEs. Guidance is based on published literature for the management of TTFields device-related skin AEs (Lacouture 2020; Anadkat 2023). Risk factors for developing skin AEs are categorized as medical- (eg, prior/concomitant treatments, pre-existing skin conditions), product- (eg, chemical irritants, mechanical pressure), patient- (eg, skin condition, lifestyle), and environment- (eg, climate/humidity) related. Skin characteristics (eg, thickness, follicle/adipocyte density, elasticity) and degree of skin movement, which influence development and healing of skin AEs, vary between body regions (eg, torso vs scalp). To reduce risk of skin AEs, patients should be instructed on optimal skin care: shaving with an electric razor, effectively cleaning the skin, and removing natural oils/moisture prior to array placement (Figure). Patients should be instructed on proper hygienic procedures to carefully replace/reposition (-2 cm) arrays every 3-4 days, and to avoid placement of arrays on scarred/damaged skin. Prophylactic treatment can include low-potency corticosteroids, calcineurin inhibitors (cream), and/or silicone-based barriers. Active monitoring of skin can help identify and prevent exacerbation of manageable skin AEs. Treatment for skin AEs includes intermittent use of mid-/high-potency corticosteroids (contact dermatitis), antihistamines or lidocaine/pramoxine-based anesthetics (pruritus), aluminum zirconium formulations or topical glycopyrrrolate (hyperhidrosis), and prescribed antibiotics (infections due to skin erosions). Different formulations can affect the electrical impedance of TTFields therapy; patients should avoid petroleum-based and alcohol-based products while wearing arrays. Oncology nurses play a pivotal role in educating patients and caregivers on practices to prevent, identify, and manage TTFields device-related skin AEs. Awareness of currently published guidelines and implementation of best practices in the clinic will optimize patient care and experience.

**I8 MANAGEMENT OF SKIN, NAIL, AND ORAL SIDE EFFECTS ACROSS CANCER TYPES**

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PENSION VIA NASOGASTRIC AND GASTROTOMY TUBES

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Treatment Modalities

Background/Significance: Dysphagia affects up to 1 in 6 adults, and older adults and patients with chronic lymphocytic leukemia (CLL) with central nervous system involvement have a higher risk of swallowing difficulties. Dysphagia may negatively impact quality of life, medication adherence, and treatment outcomes. Crushing or chewing capsules can alter drug absorption and cause harm. Ibrutinib, a once-daily Bruton’s tyrosine kinase inhibitor (BTKi) approved for the treatment of CLL/small lymphocytic lymphoma, Waldenström macroglobulinemia, and chronic graft-versus-host disease, is the first and only BTKi with oral capsule and oral suspension formulations. This study evaluated the dosing feasibility of 70 mg/mL ibrutinib oral suspension through nasogastric (NG) and percutaneous endoscopic gastrostomy (PEG) tubes. Ibrutinib oral suspension was measured via oral syringe, administered through syringes and NG/PEG tubes, and followed with two 3 mL water tube rinses. The syringes and tube types tested included polypropylene syringes with silicone (SIL) and high-density polyethylene seals; NG tubes made of polyurethane (PU), SIL, and polyvinylchloride (PVC); and SIL low-profile PEG tubes with balloon. A low dose of 0.4 mL (28 mg) ibrutinib was tested for recovery (90%–110%), impurities, and particle size and compared with a control sample. Syringe hold time (60 minutes) was evaluated using tube-compatible syringes with a high dose of 8 mL (560 mg) ibrutinib. NG SIL, NG PVC, and PEG SIL tubes all achieved 90%–110% recovery with one water rinse while NG PU tubes required a second rinse. After syringe hold, silicone tubes consistently reached 90%–110% recovery with one rinse (Table). No degradation was observed after the 60-minute hold time. Study results indicate that benzyl alcohol, the preservative used in the drug product, may be adsorbed into the tube during hold time study. No significant particle size change was observed after being pushed through any tube tested (Figure). Study results demonstrate that ibrutinib oral suspension is stable when dispensed via standard enteral tube administration methods and is compatible with NG or PEG tubes made with PU, SIL,
or PVC. To avoid the potential impact to the enteral tubes due to benzyl alcohol adsorption, immediate dosing without hold time is recommended. Although most NG/PEG tube types did not require a second rinse to meet dose recovery specifications, two water rinses are recommended to ensure targeted dose administration.

I10
TUMOR TREATING FIELDS (TTFields) THERAPY FOR GLIOBLASTOMA: SELF-REPORTED PATIENT AND HEALTHCARE PROVIDER PERSPECTIVES AND EXPERIENCES IN THE UNITED STATES


Patient Education and Safety
TTFields are electric fields that disrupt critical cancer cell processes via a multi-modal mechanism of action. TTFields therapy generated by a portable medical device (NovoTTF-200A) is delivered noninvasively and locoregationally to tumors using skin-placed arrays (Figure). Based on efficacy/safety/QoL data from global pivotal studies, TTFields therapy was FDA approved for glioblastoma (GBM) and CE marked for grade 4 glioma, with further confirmation by real-world evidence. Since studies show device usage positively correlates with improved survival, it is imperative that healthcare providers (HCPs), including nurses, educate patients on available resources that help ensure optimal device usage. The purpose was to evaluate HCP/patient perceptions and experiences with TTFields therapy and assess the utility of available educational resources. In 2022, two independently administered questionnaires assessed the real-world perceptions and experiences of US HCPs and patients with GBM regarding the use of TTFields therapy. Of patient responses (N=1329), 30% were new users; 42% had 2–6 months use and 28% had ≥6 months use. HCP respondents (N=32) were physicians (66%), nurse practitioners/advanced practice registered nurses (22%), and physician’s assistants (12%). HCPs were generally satisfied with the overall educational materials for patients (90% satisfied/very satisfied) and providers (88% satisfied/very satisfied). The highest proportion of satisfied/very satisfied responses were for material on the device manufacturer’s website (84%), videos for patients (81%), and educational webcasts for providers (79%). 78% of HCPs were satisfied/very satisfied with the 24/7 support provided by the device manufacturer for patients and caregivers. Most patients indicated that they were satisfied/very satisfied with TTFields therapy (new user, 58%; short-term user, 68%; ≥6-month user, 72%). Among short-term users, 74% integrated TTFields therapy into daily life within 4 weeks of treatment initiation. Common reasons for lower patient satisfaction included skin irritation and device handling. The majority (74%) of patients using TTFields therapy for ≥6 months were very likely to recommend it to other patients with GBM. Patients and HCPs reported high satisfaction with TTFields therapy, including satisfaction with available educational material and support services. Nurses have vital roles in patient education and care, and ensure patients and caregivers are aware of the available support resources. Active education by nurses can help patients integrate TTFields therapy into daily life and provides a means to share practical skincare guidance to maximize device usage and potentially enhance patient outcomes.

I11
SYSTEMATIC REVIEW OF ARTIFICIAL INTELLIGENCE USE IN ONCOLOGY

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Oncology Nursing Practice
Artificial Intelligence (AI) allows machines to take in and analyze data in a way that mimics human intelligence. AI is relevant to healthcare; however, the specific processes and tasks it is able to support, especially in oncology, are not yet understood. The purpose was to evaluate the quality of the evidence within current literature as it relates to AI use in Oncology. To identify areas for best practice using AI and to discuss the future opportunities for AI in healthcare. The electronic databases PubMed, CINHAL, and MEDLINE were searched from September 1, 2018, to September 1, 2023, for publications related to the use of AI in oncology. Inclusion criteria consisted of English language, article type “study” and keywords Artificial Intelligence, Healthcare, Predictive/Prediction, Fever, Cytokine Release Syndrome, Nursing, Patient Care, Oncology, and Neutropenic Fever applied in a progressive manner to narrow the search. Artificial Intelligence returned over 124,385 studies. Adding “healthcare, predictive/prediction, and oncology” reduced the number of studies to 466. We added “patient care” which reduced the number of studies available to 102. These articles...
were reviewed and categorized as patient care, pathology, radiology, and others. Seven studies were identified that included the term “nursing”. These studies highlight using AI as a clinical decision-support tool to reduce readmissions, increase adherence to schedules, and identify those patients who would benefit from palliative care. Only one study was identified using the term “cytokine release syndrome”. This study discussed the potential benefits of using AI to predict high-risk patients. No articles were identified that included “neutropenic fever”. An additional six studies were identified in the term “fever”. These studies were focused on AI prediction of neonatal sepsis or the development of an infectious disease. This review shows that AI has had limited use in oncology outside of radiology and pathology. AI used to predict symptoms related to treatment was only identified in one study. Reducing readmissions, increasing adherence to schedules, and identifying patients for services are just the beginning. AI is a promising tool for the future of oncology nursing care. This review expands the conversation regarding AI in nursing. Recommendations for future studies include how AI can aid in reducing clinician burnout, care costs, and identifying symptoms related to oncology treatments.

I12

CARE AND BIOSAFETY CONSIDERATIONS FOR THE NOVEL TUMOR-DIRECTED ONCO-LYTIC IMMUNOTHERAPY RP1: A NOTE FROM A NURSING PERSPECTIVE

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Treatment Modalities

Recent Oncology Nursing Society Chemotherapy and Immunotherapy Guidelines and Recommendations for Practice include only brief mention of talimogene laherparepvec, the only US Food and Drug Administration–approved oncolytic immunotherapy (OI). As this field is rapidly growing, understanding safety and care considerations for this class of agents is essential to patient care. RP1 is a herpes simplex virus type 1-based tumor-directed OI modified to enhance safety and increase oncolytic potential. To date, RP1+nivolumab demonstrates clinical activity with an acceptable safety profile in a variety of cancers. This study examined the communal transmission potential of RP1 through assessment of biodistribution and shedding. Patients with advanced cancers were enrolled into an open-label, multicenter phase 1/2 study. RP1 was injected into superficial and deep lesions, and injection sites were covered with occlusive dressings. Samples from blood, urine, dressing exteriors, injection sites, oral mucosa, and any lesions of suspected herpetic origin were assessed for RP1 DNA by quantitative assay. Positive RP1 DNA samples were further assessed by 50% tissue culture infectious dose (TCID50) assay. This analysis included 87 patients, from whom 791 blood, 894 urine, 525 dressings, and 914 injection-site swab samples were assessed. RP1 DNA was detected in 16.9% of blood, 0.9% of urine, and 28.1% of injection-site swab samples, suggesting local presence of RP1. The incidence of RP1 on injection-site dressings (8.2% of 525 samples) was lower than that from injection-site samples (28.1% of 914 samples), suggesting that dressings act as a barrier. RP1 DNA was present at low levels on oral mucosa (1.9% of 931 samples). At follow-up, RP1 DNA was only found on the injected-lesion surface (5.4% and 2.4% of patients at 30 and 60 days, respectively, after last dose). All but one swab positive for RP1 DNA (indicating the presence of the therapeutic agent at the sample site) tested negative for infectious virus by TCID50; all follow-up samples were negative. No RP1 DNA was found on tested swabs from potentially herpetic lesions, with no reports of herpetic infection in caregivers. RP1 administration showed negligible potential for viral transmission to caregivers, patients, and their families. As patients may be treated with RP1 and other OIs in various settings (eg, academic and community health centers), nurses must understand and communicate safety and care considerations to patients and their families.

I13

WHY IS PROPER HANDLING AND ADMINISTRATION OF BIOLOGICAL INFUSION PRODUCTS SO IMPORTANT?

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Oncology Nursing Practice

Biological drug products form an important group of therapeutic ingredients in the oncology. These group of products that contain, among others, proteins and monoclonal antibodies have significant sensitivity for external factors such as mechanical stress (shaking, dropping), light exposure, unintentional freezing etc. The external factors could cause chemical degradation and/or aggregation of the active pharmaceutical ingredient. Therefore, unlike small molecule drugs,
improper handling and administration of biological drug products could lead to insufficient therapeutic effect and even safety concerns. Aside from the external factors, the ancillaries and devices used to prepare and administer infusion doses may be incompatible with a given biological drug product or cause additional mechanical stress (shear, shaking). In the past few years handling and administration of biological drug products has gained significant attention, in literature, working groups, hospitals, large-scale research initiatives and more. This presentation aims to provide deeper understanding about the sensitivity of this group of medicinal drug products; describe where we currently stand with our knowledge about the diverse utilization by the end-user (in terms of preparation and administration); what this eventually means for the drug product development on industry level but also identify the gaps that we still need to fill by cross-functional initiatives.

I14 CONTAINMENT OF A NEW ADMINISTRATION SYSTEM FOR HAZARDOUS DRUGS
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Oncology Nursing Practice
Clinicians are regularly exposed to hazardous drugs (HDs). Existing protective equipment may be more effective during drug preparation than administration. USP 800 now requires the use of Closed System Transfer Devices (CSTDs) during HD administration. A new closed administration system for minimizing exposure of healthcare professionals to HDs was recently marketed. The objective was to evaluate the efficacy of the ChemfortTM CADM system in preventing HD release during administration. Containment was assessed upon the first and final (10th) connection cycle at both beginning and end of shelf-life (four different test groups). The principles of the NIOSH 2015 containment performance draft protocols were followed: isopropanol (IPA) is the drug surrogate; acceptance criterion is <1.0 ppm IPA vapor concentration inside a closed chamber. Three tasks were developed to mimic administration and subsequent disconnection of three different combinations of CADM components. The Bag Adaptor Chemfort™ Port is the required partner of each of the other three CADM components: Closed Adaptor Spike Port (task 1); Closed Y-inline Set (task 2); and Closed Secondary IV Set (task 3). In each task, a 500 ml IV bag containing 70% IPA was connected in series with the tested components and placed inside a closed chamber, which was sealed and connected to a Fourier-transform infrared spectroscopy gas analyzer in a closed circuit. Inside the chamber, administration was simulated, and IPA levels were monitored during the task and for at least 30 minutes afterwards. Each task was repeated four times per test group. The relevant result for each repetition was the highest increase in IPA vapor concentration reached over the course of the task, relative to the average background levels before commencement of that task. IPA concentrations observed for all components in all test groups were well below the acceptance criterion of 1.0 ppm. CSTDs are well-adopted in pharmacy, but less during administration. USP 800 requires use of CSTDs for administration. A new closed administration system was evaluated according to a NIOSH methodology. Results show that CADM prevents the escape of hazardous aerosols and vapors and that new administration systems could potentially raise the safety standard for clinicians to that already adopted in pharmacies.

I15 IRON DEFICIENCY ANEMIA IN PATIENTS WITH HEAVY MENSTRUAL BLEEDING: PATIENT JOURNEY FROM DIAGNOSIS TO TREATMENT
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Coordination of Care
Iron deficiency anemia (IDA) affects approximately five million people in the USA. Heavy menstrual bleeding (HMB) depletes iron stores, leading to IDA. IDA and HMB can hurt many quality of life (QoL) aspects. Iron stores can be replenished through oral iron or, if ineffective or poorly tolerated, through intravenous iron (IVI); however, there is no guidance on when to transition to IVI. The purpose was to understand the IVI treatment journey for patients with IDA and HMB. In 2023, patients (>18 years) in the USA with a diagnosis of IDA who were currently receiving IVI therapy were asked to complete a survey conducted by The Harris Poll. Questions included IDA symptoms, time to diagnosis and treatment, iron infusion appointment logistics, IVI infusion experience, the impact of infusion on daily activities, and patient treatment preferences. Of the 323 patients who completed the survey, 71 (22.0%) reported treatment for HMB and were prescribed ≥
IVI infusions/month. Patients age averaged 33.5 years, majority identified as female (95.8%) and are Caucasian (54.9%). Patients resided in an urban (38.0%), suburban (42.3%), or a rural (19.7%) area. Patients received an average of 2.44 IVI infusions/month and 9.62 total infusions. Patients experienced IDA symptoms for about 35 months prior to diagnosis. Before the first IVI was infused (average of 18 months after diagnosis), >50% reported symptoms of: fatigue, weakness, headache, dizziness, cold hands and feet, and pale skin, most of which improved following treatment. Average reported time (minutes) spent on IVI appointment logistics included: scheduling the infusions (38), traveling to the infusion center (67), arrival to start time of infusion (47), and infusion chair time (90). Patients agreed that IVI treatment logistics negatively impacted their productivity (33.5%), attendance at important events (50.7%), and they scheduled their life around treatment (67.6%). Additionally, 36.6% of patients missed a dose and 83.0% preferred a single dose IVI option. From this survey, patients with IDA and HMB had symptoms for almost 3 years before diagnosis; thereafter, an average of 1.5 years passed before an IVI treatment was prescribed—demonstrating a potential gap in care. With multiple-dose IVI, appointment logistics negatively impacted patients’ perspective on their treatment and more than one-third reported non-adherence. Patient preferences, like a single-dose infusion, should be considered in IVI treatment to improve adherence and QoL.

I16 SAFETY OF TEPOTINIB + OSIMERTINIB IN EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR)-MUTANT NON-CELL LUNG CANCER (NSCLC) WITH MESENCHYMAL–EPITHELIAL TRANSITION (MET) AMPLIFICATION FOLLOWING FIRST-LINE OSIMERTINIB: INSIGHT 2 PRIMARY ANALYSIS

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Treatment Modalities

Promising clinical activity has been reported in the INSIGHT 2 (NCT03940703) study of tepotinib + osimertinib in patients with epidermal growth factor receptor-mutant (EGFRm) non-small cell lung cancer (NSCLC) with mesenchymal–epithelial transition amplification (METamp) progressing on first-line osimertinib, with an objective response rate of 50.0% (95% confidence interval [CI]: 39.7, 60.3) and median duration of response of 8.5 months (95% CI: 6.1, not estimable). To better support patient care and management, we report comprehensive safety data from the INSIGHT 2 study in patients with 59 months’ follow-up (data-cut: March 28, 2023). Tepotinib 500 mg (450 mg active moiety) was administered in combination with osimertinib 80 mg once daily until disease progression, intolerable toxicity, or withdrawal of consent. To manage adverse events (AEs), each drug could be dose reduced but if discontinuation of one was needed, both drugs were stopped. Overall, 128 patients received tepotinib + osimertinib (median age: 61.5 years; female: 57.8%; Eastern Cooperative Oncology Group Performance Status [ECOG PS] 1: 72.7%). Median duration of treatment was 24 weeks (range: 0–109). Treatment-related AEs (TRAEs), graded by National Cancer Institute Common Terminology Criteria for AEs (NCI-CTCAE) v5.0, occurred in 113 patients (88.3%; Grade ≥3: 34.4%). The most common TRAEs were diarrhea in 63 patients (49.2%; Grade ≥3: 0.8%) and peripheral edema in 52 (40.6%; Grade ≥3: 4.7%) (Table). AEs of clinical interest of any grade were edema (composite term including peripheral edema and other types) in 69 patients (53.9%), rash in 34 (26.6%), QT prolongation in 12 (9.4%), interstitial lung disease in 10 (7.8%), pleural effusion in nine (7.0%), renal failure in seven (5.5%), and severe hepatotoxicity in one (0.8%). For edema, median time to onset was 9.7 weeks (range: 0.3–66.1). To manage edema, eight patients (6.3%) had dose reduction of tepotinib and three (2.3%) discontinued treatment. Tepotinib + osimertinib was generally well tolerated in patients with EGFRm NSCLC with METamp progressing on first-line osimertinib. Most AEs were considered manageable with tepotinib and/ or osimertinib dose reduction.

I17 TREATMENT WITH ENZALUTAMIDE IN PATIENTS WITH HIGH-RISK BIOCHEMICALLY RECURRENT PROSTATE CANCER FROM THE EMBARK TRIAL: NURSING IMPLICATIONS

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Within 10 years of definitive therapy for prostate cancer, ~20–50% of patients experience biochemical recurrence (BCR) associated with increased risk of mortality. Nurses are influential in guiding these patients throughout their treatment and prostate cancer journey. The purpose was to discuss the nursing implications of the previously reported efficacy, safety, and patient-reported outcome (PRO) data for enzalutamide + leuprolide and enzalutamide monotherapy in patients with high-risk BCR from the EMBARK trial (NCT02319837). EMBARK is a randomized, phase 3 study of patients with BCR considered high-risk: PSA doubling time ≤9 months and PSA ≥2 ng/mL above nadir post-radiotherapy or ≥1 ng/mL after radical prostatectomy and postoperative radiotherapy. Patients were randomized (1:1:1) to combination therapy (enzalutamide 160 mg/day + leuprolide 22.5 mg every 12 weeks), leuprolide alone (placebo + leuprolide), or enzalutamide monotherapy. The primary endpoint was metastasis-free survival (MFS) of enzalutamide combination versus leuprolide alone, determined by blinded, independent central review. Secondary endpoints were MFS of enzalutamide monotherapy versus leuprolide alone, safety, and PROs. The study included 1068 patients. MFS for enzalutamide combination (hazard ratio [HR] 0.42; 95% confidence interval [95% CI] 0.30–0.61; P<0.0001) and enzalutamide monotherapy (HR 0.63; 95% CI 0.46–0.87; P=0.0049) were statistically superior to leuprolide alone. No new safety signals were observed. For PROs, there were no significant differences in either treatment group versus leuprolide alone, time to first confirmed clinically meaningful deterioration (TTFCD) in worst pain in the past 24 hours or overall quality of life as measured by multiple validated questionnaires. TTFFCD in sexual activity by validated questionnaire was significantly longer for enzalutamide monotherapy versus leuprolide alone; TTFFCD for hormone treatment-related symptoms was significantly shorter for enzalutamide combination versus leuprolide alone (Table). Enzalutamide combination and monotherapy improved MFS versus leuprolide alone without negatively impacting PROs. Sexual activity may be better preserved with enzalutamide monotherapy versus leuprolide alone. Nurses evaluate symptoms, adverse events, and lab results (including PSA levels) for signs of progressive disease and communicate potential implications for patients with high-risk BCR. Nurses may identify patients who could potentially benefit from treatment with enzalutamide, and are fundamental in educating them throughout their treatment. Overall, nurses should emphasize a holistic care plan that considers psychosocial well-being, exercise, a healthy diet, sleep hygiene, non-pharmaceutical resources for pain and stress, and provide referrals if needed.
drive progress, address real-time issues, and share findings at the Unit Council. Additionally, CLABSI project updates were shared during weekly huddles. The Unit Council established a membership board with consistent attendance and monthly meetings. CLABSI projects were completed. CLABSI rates decreased by 65% during the measurement period, decreasing from 2.6 to 0.9 CLABSI per 1000 CVC days. Patient knowledge regarding CVCs increased by 31%. PICC and lab draw validation revealed opportunities for improved CLABSI prevention practice. Nursing engagement and transformational leadership are strategic components to drive innovations, motivating staff to deliver high-quality care to reach organizational goals. The leadership and project development skills obtained by the nurses empowered them, equipping them with the tools to lead future quality improvement projects and mentor future leaders. Unit Council serves as a forum to discuss and support quality projects. Shared professional governance gives nurses autonomy to make decisions and improve key metrics at the unit level.

P184 DEVELOPING A POINT SYSTEM FOR PRODUCTIVITY AND PATIENT ASSIGNMENTS IN A 12-BAY INFUSION CENTER

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Oncology Nursing Practice

COVID changed all of our nursing lives! As a manager during COVID in an oncology infusion center, we had to learn new strategies to maintain staff and keep everyone’s morale up! This was one of the most difficult times for staff, caregivers and especially patients. Unlike internal medicine and private practices, the oncology infusion center never stopped. Patients that we call snowbirds did not fly home. The infusion center was seeing up to 50 patients a day. In order to keep nurses happy and safe, we had to come up with a plan for assigning patients to nurses. The ratio had to be fair, and we had to utilize our own staff. We only used contract help for 12 weeks during this long period. With the help of an excel spreadsheet we came up with a daily schedule of nurse to patient, chair assignments and triage nurses. Our electronic medical record did not help us at all. At the time of COVID we were in the middle of an integration with EPIC, and were learning about Beacon. These are great for providers and pharmacists, but for scheduling it did not help. Each nurse was assigned a different color on the schedule. We could automatically see what nurse was taking care of the patients. We also made columns for chair time. This showed the productivity in the infusion center as well. We used a point system for the treatments and came up with a score for each nurse to patient. A score of 20 for an 8 hour shift meant that this nurse would not be able to take on any add on’s for the day. Our Press Ganey scores were in the top 10% for infusion. Our nurses during COVID were healthy and most of us did not acquire COVID until after the 2nd round. My poster presentation will show an example of the point system that we use along with a sample of a nursing assignment for the day.

P185 PROMOTING EARLY DETECTION OF BREAST CANCER THROUGH AWARENESS AND INTRODUCTION OF A SCREENING PRACTICE CHANGE IN A HOSPITAL IN GHANA

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Screening, Early Detection, and Genetic Risk

The incidence of breast cancer in Ghana is rising. Breast cancer is currently the most prevalent cancer and the highest cause of mortality in young women. Late presentation and poor health seeking behavior are contributory factors to poor outcomes with a five-year survival of 39% compared to 91% in the US. The purpose of the project was to improve awareness of breast cancer and increase screening practices to facilitate early detection that has proven to improve outcomes. A quantitative methodology was utilized using a quasi experimental pre-test post test method. The tool selected was the Breast Cancer Awareness Measure and a screening tool was used to measure rates of screening pre- and post-intervention. An intervention was designed to instruct on breast cancer, the benefits of early diagnosis and treatment, and included the technique of breast self-examination. 68 healthcare personnel participated in the study, a convenience sample of adults who chose to consent. 89.7% female, 82.4% Black African, 38.2% with a degree or higher and 38.2% with a diploma. Data was statistically analyzed using SPSS statistics version 27 and the Wilcoxon signed rank test was used to analyze the pre-test and post test data, a Binomial Test was utilized to calculate the screening rate. The awareness of warning signs and symptoms of breast cancer showed the awareness improved from 27.9% to 83.3%, in the area of confidence and skills statistically significant difference between pre- and post-intervention data of p-value <0.001, and awareness of risk factors all nine categories showed statistically significant results. The screening rate improved from 1.8% to 53.2% with a p-value of <0.001. The findings were statistically
P186
BUILDING A UNIFIED TEAM
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Oncology Nursing Practice

Our Cancer Center has nine different sites spread throughout the city. Over the last five years, with the help of strong transformational leadership, we have built a strong comradery amongst our nursing leaders which as a result has spilled over to the frontline staff. Interventions were:

- Improved Collaboration: We have bi-monthly leadership meetings which has strengthened the relationships with one another and the communication. We also have a combined Practice Council where our frontline staff leads practice changes.

- Sharing Staff: We have increased our float pool which works at all the different sites. We also have had opened it up to our regular (non-floating) staff to help out at other locations. Nursing staff from sites that are closed on the weekends will pick up shifts on Saturday/Sunday at the infusion sites that are open.

- Sharing Patients: Some of our sites are operating at full capacity. This has caused us to encourage patients to get their treatments/infusions at other sites closer to home. Patient education is provided reassuring them that our high standards are practiced equally at each one of our sites and they will receive great care no matter which site they end up going to.

Our Cancer Center has been able to grow in our patient and staff volumes by our continual commitment to work together to being the safest and best Cancer Center in our community. In addition, our combined Practice Council was able to make a significant practice change with the elimination of heparin for every port de-access. This has saved time, money, chair space, and resources. COVID was really a catalyst that started this process of unifying our sites. It forced us to work together, share staff and resources to maintain our operations. We have worked hard over the last few years to improve our culture amongst the different Cancer Center sites. Our upper leadership have supported and fostered this positive partnership amongst leaders/staff at all the different sites.

P187
LYMPHEDEMA LIFELINE: ADVANCING CANCER-RELATED LYMPHEDEMA EARLY DETECTION AND TREATMENT
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Coordination of Care

Lymphedema is a debilitating, progressive condition that is an unfortunate side effect for many patients that have been diagnosed with cancer. Lymphedema is often overlooked, underdiagnosed and untreated. The purpose of this abstract is to describe the development and implementation of a lymphedema clinic. Patients with lymphedema have very little support for evaluation and treatment. The inception of a dedicated lymphedema program was spurred by analysis of the new NCCN guidelines, literature review, and of lymphedema clinics nationwide. A proficient team was formed, comprising a project manager, surgeon champion, nurse practitioner, nurse manager, administrative director, LVN supervisor, and a certified lymphedema physical therapist. Overcoming the significant challenge of procuring the necessary equipment marked a pivotal milestone. Following this achievement, the referral process and clinic workflows were developed. Subsequently, efforts were concentrated on patient identification and the initiation of new patient appointments. Initially, patient referrals for lymphedema evaluation were directly scheduled on the lymphedema surgeon schedule. To enhance efficiency, it was determined patients would first be seen by a nurse practitioner for intake and initial assessments. In April 2023, two slots on the nurse practitioner’s schedule each week were designated for new lymphedema patients. The slot utilization has consistently maintained 100%. Referrals for lymphedema assessment are included in the breast plastics referral work queue, which poses a challenge to quickly assess the number of patients referred for lymphedema care. On a manual audit 98 patients between March 2022 to September 2023 were identified. Currently, there are 10 patients in the referral work queue awaiting scheduling. Furthermore, there are six month follow up appointments are pending scheduling. The next available nurse practitioner appointment is in 30 days. Having a specific department identification for lymphedema would allow for more effective tracking of patient volumes, reimbursement, and follow up. Increased nurse practitioner support is
Cancer related lymphedema can be due to surgical lymph node dissection. Recent research indicates it can also be influenced by multimodality treatment strategies, patient’s inability to form collateral pathways after surgery, and lifestyle factors. Timely intervention is crucial for minimizing the risk of chronic lymphedema and enhancing overall outcomes.

**P188**

**BEST PRACTICE: VIRTUAL WHITEBOARD FOR REMOTE EMPLOYEE ENGAGEMENT**

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Professional Development

In today’s healthcare environment, remote work has become a normalized practice. A virtual whiteboard was introduced to a remote team at a comprehensive cancer center. The outcome desired is an innovative, efficient, real-time model of communication, progress, and change. The virtual whiteboard is an affinity chart, one of the Six Sigma tools that can help implement projects (Six Sigma, n.d.). The presumed impact is employee satisfaction knowing that their voice is being heard and acted upon. The application to practice is to promote change by engagement. The idea for this project was to find a way for staff to brainstorm their process improvement ideas without being present in the office. Employees could type their thoughts on virtual sticky notes and attach them, anonymously, to the brainstorming section of the whiteboard. The leader was then able to categorize the sticky notes with column headings and arrange them according to common themes. High priority issues were identified, and lower priority issues were set aside or identified as items that could be quickly completed. When an employee had an idea, they were able to freely express that idea with peers and leader acknowledgement of their contribution. Along this pathway, the manager’s responsibility is to frequently update the whiteboard so that the employee can see progress being made in their specific areas of concern. This simple yet effective model aligns with Kotter’s eight step model for change. The eight stages to Kotter’s change model are: increase urgency, build the team, get the vision right, obtain buy-in, empower action, create short wins, don’t let up, make it stick. Not all situations needing change will follow this pattern exactly, however, the virtual whiteboard is a launch pad tool to move the needle (Kotter, 2002). Staff need to experience the change even if it is just one small thing. The visual satisfaction the virtual whiteboard creates helps the employee to see the long-term vision of the manager and how it aligns with the organization. The use of this tool can be used in all clinical and non-clinical settings. It can be shared with other groups within an organization to develop larger models and long-term goals. The practicality and ease that this creates for the team can be universally adopted as a standard way of communication.

**P189**

**PROACTIVE APPROACH TO RETAIN AMBULATORY ONCOLOGY NURSES**

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Professional Development

Adopting a culture of retention is key to organizations maintaining adequate staffing levels to meet the complex care needs of patients. Ensuring nurses are supported, heard, and able to practice at the highest level of their license helps to increase satisfaction and retention. A stay interview is a periodic, scheduled, structured informal discussion between a leader and RN regarding satisfaction with their work experience. Unlike the traditional exit survey, where the focus is on why employees leave and is reactionary in approach, a stay interview is proactively focused on exploring what makes team members want to stay. Leaders act immediately on what can be implemented based on the individual need. The purpose was to focus on retention of ambulatory oncology nurses by conducting stay interviews. Questions were developed and tailored specifically to the ambulatory oncology RNs. Nurse leaders at all of our sites asked the same questions.

- What has influenced you to stay in your job?
- What might tempt you to leave your job?
- What would keep you enthusiastic about your job?
- What are the factors that could contribute to you doing the best work of your life?
- What can I (leadership team) do to best support you?

A total of 283 interviews were conducted and the feedback was entered anonymously into REDCap database. It is critical that our leadership team reflect on
the interviews and the results, focusing on common themes. These themes included: recognition of hard work; teamwork among colleagues; positive work environment; supportive senior leadership; professional growth opportunities; effective communication among staff; improve distribution of patients. Work colleagues and the patients were the top 2 reasons a nurse would stay: followed by positive work culture, leadership support, and flexible scheduling. Next steps will consist of actionable items that both the nurse leader and nurses will work on together to address the factors, concerns and requests mentioned during the stay interviews. Development of action plans addressing areas/opportunities identified for improvement will be shared in unit meetings and safety huddles.

**P190**
MEETING THE NEEDS OF ONCOLOGY CARE COORDINATORS AND CHANGING THE WAY THEY WORK
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Oncology Nursing Practice
Meeting nurses where they are and ensuring that you listen to them as a leader is key. Feedback from our caregiver engagement survey showed that our care coordinators needed work life balance and decrease in job stress. We began to see more and more care coordinators leave the position for remote work jobs. We had to determine a way to help with these concerns. The purpose of the project was to allow care coordinators to work from home 1 day a week. This would help to increase work life balance, decrease job stress, retain and recruit nurses for the care coordinator role, without experiencing a negative impact to patient care. The project began with a multidisciplinary working group that included care coordinators, nursing leadership, continuous improvement specialists, and data analysts. It was a several month process and included a pilot with different disease groups to show that work from home could be successful. The steps included identifying pilot disease groups, developing a communication plan, reviewing a coverage plan for the patients that are on site, developing the work that the care coordinator would do from home, productivity metrics, and develop a process for the care coordinator to begin to work from home. The pilot groups were successful in developing and maintaining the structure to work from home. There was positive feedback from both the physicians and nursing teams. We saw a decrease in response time to our patient messages and an increase in patient satisfaction. The care coordinators voiced an increase in work life balance, job satisfaction, and decrease in job stress from our recent caregiver engagement survey. The work from home pilot was successful and they continue to work from home 1 day a week. There has been an overall increase in job satisfaction, recruitment, and work life balance. It is important as a nursing leader to listen to your team and work towards making their job the best it can be. This was an innovative idea for our nursing teams. We continue to look at the work from home model. We review productivity metrics and look for ways to better show productivity. Moving forward, we will review and hope to increase the option to work remotely.

**P191**
ENGAGE-MAZE: BEYOND THE ILLUSION OF EASY
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Professional Development
Positive staff engagement is linked to increased productivity, wellbeing, and organizational belonging. Engagement drives positive change and when realized, contributes to fewer negative outcomes such as absenteeism, turnover, and safety incidents. Approximately 70% of the variance in team engagement is determined solely by the manager, so leaders bear a significant responsibility to understand what drives staff engagement, coach, and inspire employees to help keep engagement high. From FY21- FY22 there was a drop in the Gallup grand mean for Cancer staff from 4.03 to 3.80 (out of 5). The goal was to increase the Gallup grand mean in FY23 by understanding what actions drove staff engagement and which intervention(s) were most helpful in making a positive impact on scores. Annual Gallup scores were reviewed at the initial meeting to reflect on results and discuss the strengths and opportunities of the practice. Needs and goals were outlined along with proposed recommendations to address identified needs. As a team, project deliverables were established and agreed upon. There was a 1 month follow up to check the status of identified recommendations. Two months later, there was a meeting to ensure alignment with goals and adjust/sustain interventions; staff were asked to consider “have we done what we said we would”? “What should we start, stop, or continue?” At the midpoint, we solicited qualitative feedback from staff about progress. Approximately 1-2 months before the next survey, we celebrated
our “wins” outlining all things that were “asked and answered”. Results from FY23 showed an increase in the Gallup grand mean to 4.09, the highest that it has been. In meeting with the staff, we learned that historically they have scored their engagement survey based on what “used to be.” The Gallup survey data should be used a tool and needs further explorations from the team about their rationale for the scores. There will inevitably be areas of opportunity and individual situations that create dissatisfaction for staff. Staff don’t want to participate in action planning efforts to just “check a box.” Staff want meaningful dialogue. Sometimes, leaders must step aside and let conversations go where they may; things are not always what they seem. Staff should “know” how to score, but sometimes lower results are intended to get the leaders’ attention to ignite a deeper conversation.

**P192**

**VIRTUAL ONCOLOGY NURSE LEADERS MEASURE SUCCESS USING QUALITY METRICS AND CONSISTENT FEEDBACK**

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Oncology Nursing Practice

The role of nurse leaders has evolved significantly, particularly in the context of virtual healthcare. Virtual Oncology Nurse Leaders are responsible for managing and guiding oncology nursing staff in remote settings. Ensuring that virtual nurse leaders are equipped with appropriate quality metric tools and structure to effectively manage staff nurses is vital for optimizing patient care and healthcare outcomes. Virtual Oncology Nurse leaders serve as experts in the field and must find creative ways to engage their remote nurse teams, standardize procedures, and consistently measure productivity and quality of nursing care. Developing and integrating a standardized system to measure the care provided by remote oncology nurses offers many benefits for the healthcare organization, staff nurses, and patients. By consistently measuring and monitoring care quality, virtual leaders can identify areas for improvement and take corrective action promptly, leading to better patient outcomes. Employee engagement and trust are also improved when transparent communication, expectations, and real-time feedback are discussed. Interventions included:

- Regionalized Virtual Nurse Leadership across the state (Texas) to support approximately 15 direct reports per leader.
- Established standards around Virtual Nurse Leader communication to increase regular feedback to virtual staff: daily huddles with all staff on camera to increase engagement, structured quality one on one meetings with nurses, monthly virtual all team huddles by director and manager discussing updates, weekly newsletter for virtual staff incorporating recognition, updates, and staff spotlights, leadership holds open office hours via Microsoft Teams, live call observations of staff nurses for quality assurance and feedback.
- Developed clear productivity goals: standardized metrics reporting, up front goal setting with nursing staff, regular chart audits.

The virtual leaders serve as experts and provide coaching in areas that require improvement. Leading remote nursing teams presents many unique challenges. Clear and consistent operations by virtual nurse leadership offers many significant benefits. When equipped with the appropriate quality metric tools and communication processes nurse leaders can actively seek ways to enhance care delivered. Virtual Oncology Nurse Leaders, when supported by robust measurement of success, quality metrics, and consistent feedback mechanisms, play a pivotal role in advancing oncology nursing care. Their significance lies in ensuring standardized, high-quality care for cancer patients, fostering a culture of improvement, and leveraging technology to make expert guidance accessible across geographic boundaries.

**P193**

**ON FIRE FOR PATIENT CARE AND THE PRACTICE ENVIRONMENT: IGNITING INTERPROFESSIONAL SHARED GOVERNANCE IN RADIATION ONCOLOGY**

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Professional Development

Often, Shared Governance (SG) structures in ambulatory settings are extensions of nursing models from acute care settings, which include mostly nurses, and may fall short of realizing the power of Interprofessional SG. SG is “structure and processes by which professionals direct, control, and regulate goal-oriented efforts of one another” (Hess, 2017 & 2019). It
is a Magnet® Recognition Program requirement. Magnet® organizations have been linked to better nurse and patient outcomes. The purpose was to implement Interprofessional SG in one ambulatory radiation oncology setting including nursing, radiation therapists, physicians, physicists, dosimetrists, and clerical staff. The project was IRB acknowledged as QI in nature and not subject to IRB oversight. The leadership intervention is Interprofessional SG. The sample included -55 interprofessional radiation oncology teammates. Work began in fall 2020, including:

- Staff education on basic SG concepts
- Each discipline identified representatives to participate
- Developed a council charter, established goals, and monthly meetings
- Mentored SG council leaders to form agendas, run meetings, and follow up on action item
- Tracked progress on goals, shared data
- Establish communication in and out of council

The Index of Professional Governance 3.0 (IPG) (Hess, 1994) was used with permission to measure intervention effectiveness. IPG 3.0 measures staff perceived governance on a spectrum between staff led and management/administration led. Baseline (Aug 2020) = 62% participation (n=34). Post (Feb 2022) = 60% participation (n=34). Total scores increased 80.5 to 92.9 (P=0.0159). Each of the 6 subscales increased. 5/6 revealed statistically significant change. Satisfaction with Professional Practice increased 3.79 to 4.09. This council (led by co-chairs: RN & Medical Physicist) is on fire for excellence in patient care and the practice environment. They received the hospital-wide SG award, twice (2021 & 2022). Teammate engagement is among the highest in the organization (GLINT); YTD 2023 is 86 (up from 72 in 2022). YTD vacancy for the department is 8.5% (nursing vacancy is zero). Patient satisfaction (Medallia) YTD 2023 Overall Clinical Team 97%, Top 2 Box (outperforming mean of all outpatient areas in organization). Patient satisfaction outperformed national means on all questions (related to nursing care) since 2021. The setting may be innovative. SG is powerful. For us, skillful application beyond nursing is yielding amazing results.

**P194 APPLYING MAGNET STANDARDS IN AMBULATORY ONCOLOGY SETTINGS**

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**Professional Development**

As competition to attract and retain nursing talent in oncology continues a top priority, oncology leaders in outpatient settings may increasingly seek to apply evidence-based nursing leadership/American Nurse Credentialing Center (ANCC) Magnet® Recognition Program standards. Magnet®-designated organizations inclusive of ambulatory oncology settings are aware that the program is increasing ambulatory outcome requirements. The purpose was to share one organization’s (3 times Magnet® designated) experience with application of Magnet® standards in the ambulatory oncology setting. Ongoing interventions in outpatient oncology areas align with Magnet® model elements. Transformational Leadership work on leader development, standard alignment, leader advocacy for resources, and chief APRN Mentorship planning. Structural Empowerment work focused on professional development (education, certification and CoC standards), onboarding work via oncology transition to practice and new grads into outpatient oncology. Huge focus was given to recognition (including not limited to): clinical advancement and reward for oncology experience. Exemplary Professional Practice work included shared governance work, interprofessional collaboration, measuring nurse-sensitive indicators in all areas (including distress screening and oral chemo assessment) and nurse-patient collaboration in developing a patient care notebook. New Knowledge, Innovations and Improvements work included journal clubs, projects improving patient safety and nurse well-being, research on RN Perceptions of CAM Therapy in Oncology and research and innovation with patient navigation. Areas outperformed the national mean 91% of the time for ambulatory falls with injury (NDNQI, Q1 2020-Q4 2022). Chemotherapy extravasation rate with vesicants, irritants, and irritants with vesicant potential, using a published NCI consortium benchmark (Jackson-Rose, et al 2017) outperformed the published mean 78% (87.5%) quarters Q1 2021-Q4 2022. All areas outperformed the national mean for questions assessing patient satisfaction related to nursing care (Medallia, Q4 2020-Q1 2021). Nursing satisfaction outperformed the national mean (Press Ganey) in 2019 and (GLINT) in 2022 and YTD 2023. Outpatient oncology areas contributed to the facility’s recent 3rd designation. YTD nurse satisfaction and patient satisfaction are both outperforming the national mean and among the highest in our organization. Nursing vacancy is 6%. Nurse certification was 53.4% in 2022 in Magnet® designated areas. Nurses with BSN and higher is over 65%. Magnet®
standards are applicable in ambulatory oncology settings. While research on Magnet® hospitals to date is acute care, ambulatory oncology areas may benefit from application of Magnet® standards. For us, they are supporting better nurse and patient outcomes.

P195
MEETING OUR MISSION, DEVELOPING A PREMIER ONCOLOGY NURSING LEARNING EVENT
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Professional Development
“The Oncology Nursing Society is committed to promoting excellence in oncology nursing and transforming cancer care” (ONS Reason to Be). Following the Mission of promoting excellence in oncology nursing, we developed an annual event that brings world class education to Registered Nurses and Advanced Practice Nurses, at no cost to the nurses. Eight years ago, as part of the Chapter President’s goals, a large scale, easily accessible day of education that could be sustained was proposed. The board approved this endeavor. A subcommittee was formed including board members, Directors at Large, members, and led by the current President. A venue was secured, with an eye to perpetuity and growth. The Conference is supported by leverage relationships with industry and persistent targeted promotion via an email management service. Product breakfast and lunch theaters defray the cost of food. Nurses can receive 10 Nursing Continuing Professional Development (NCPD) points from a combination of world-class lectures, Learning Resource Center (LRC) participation, and posters. The chapter also provides prizes to incentivize and encourage attendance. Utilizing an online registration platform, nurses make paid reservations, minimizing the risk of “no shows.” Eligible nurses are also to receive a refund of their registration fee at the end of the day based on attendance. The initial event was hugely successful, with strong survey responses indicating satisfaction with the educational offerings. Subsequent events have grown in attendance and necessitated increasingly larger venues. Our most recent event attracted over 500 nurses, and we currently have over 300 nurses registered for 2024.

P196
EQUITABLE GENOMICALLY-INFORMED CANCER CARE: PREVENTION AND PRECISION FOR ALL
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Screening, Early Detection, and Genetic Risk
Oncology is leading the field in the application of genomics to inform prevention and treatment. Precision oncology and genomic testing have evolved over the past 25 years from targeted germline testing done after treatment completion for high-risk individuals to the call for universal germline testing in certain cancer types (e.g. all patients with colorectal cancer) and even into population based screening for germline cancer-associated pathogenic variants. Additionally, guideline-concordant tumor biomarker testing is recommended for many advanced cancer types and allows for best application of targeted therapies. This presentation will review oncology genomic advances with both germline and somatic applications across the cancer care continuum from prevention to treatment through long-term survival. This will be done through an equity lens to assure that genomic applications do not worsen health inequities. Recent data demonstrate that genomic testing for inherited pathogenic or likely pathogenic variants is clinically indicated for a variety of tumor types beyond breast, ovarian and colorectal cancers (e.g. prostate, pancreatic, endometrial etc.). Unfortunately, there is unacceptably low rates of
guideline-indicated uptake of germline genomic testing. For example, guidelines recommend that all women with ovarian cancer receive germline testing, yet recent data demonstrate that only 38% of women are tested. Testing rates for other cancers like pancreatic and prostate are much lower. Lack of germline testing represents missed opportunities for cancer prevention (for both patient and family) and optimal treatment. Similarly, guideline-concordant tumor biomarker testing in a variety of advanced cancers, most notably non-small cell lung cancer, impacts overall survival as this directs treatment selection. Underutilization of both germline and somatic testing in cancer disproportionally impacts minority and sociodemographic underserved populations contributing to health disparities. Genomic advances will continue to change cancer care in the next decade; moving into precision prevention and cancer interception. A focus on the equitable application of genomic advances in cancer care is crucial. Assuring that all groups benefit from the genomic advances in cancer prevention and treatment is an advocacy matter for all oncology nurses. The importance of genomics for cancer care and cancer prevention cannot be underestimated. Oncology nurses play an essential role in providing information for patients and their families regarding health promotion, risk reduction, increased surveillance, and empowering patients for improved cancer control.

**P197**

**SUPPORTING NURSES TRANSITIONING TO THE LIFE SCIENCES INDUSTRY**

Eva Gallagher, PhD, RN, ANP-BC, Agios, Boston, MA

**Professional Development**

A nursing degree provides a multitude of skills that are applicable across many career choices beyond clinical nursing. A transition to the pharmaceutical industry is an option that allows nurses to significantly impact patient care by utilizing their clinical knowledge, critical thinking, and skills around collaboration and teamwork. Exposure to career opportunities within the pharmaceutical industry and educational resources for nurses interested in this career path are lacking. A web search with the terms “nursing and pharmaceutical industry” identifies only a couple of articles on this topic. In order to fill this gap, I developed a multifaceted website to support nurses interested in transitioning into the pharmaceutical industry with comprehensive educational, networking, and coaching resources. The goal of this site is to ensure qualified nurses are aware of the opportunities available to them and provide a roadmap and the tools to successfully land their dream job in this industry. I reviewed all available resources on the internet and interviewed 10 nurses currently working in various roles in pharma to understand what resources are currently available. Given the paucity of information, a web-based resource (RN2Pharma.com) was selected as the most effective mechanism to reach as many nurses as possible and launched in July, 2023. Included on this site is an e-book, a blog, a networking forum, direct coaching and support. Since launching the site 2 months ago, there have been 829 site sessions, 623 unique visitors, 6 book downloads, and 2 consultations. The majority of interest has come from the northeast and southeast states. Traffic to the site has come from various social media sites including LinkedIn (372), direct (249), Facebook (129), Google (58), other (21). Feedback from users has been very positive. The overwhelming interest in this website suggests that this resource is filling a unique need and has the potential to impact nurses across the country. Oncology nurses have unique skills that make them ideally suited for successful careers in the pharmaceutical industry, particularly in roles such as medical writing, medical information, medical science liaisons, product safety, nurse navigators, nurse educators, patient advocacy and clinical operations. Transitioning from clinical nursing to the pharmaceutical industry presents the opportunity to have a long-lasting effect on healthcare beyond the patient care setting and to change healthcare for the better.

**P198**

**LEADER ROUNDING AND EMPLOYEE RETENTION**

Shawnette Graham, MS, RN, OCN, NE-BC, BSW, Dallas, TX

**Professional Development**

Retaining nurses is a challenge for many organizations but is essential for ensuring high levels of patient satisfaction, safety, and quality outcomes. By retaining seasoned nurses, organizations can maintain a culture of excellence that can be passed on to new nurses through training and professional development. Retaining new nurses trained to specialty populations is essential to continue these objectives. This not only benefits the nurse but also the organization and patients. The pandemic created an environment of uncertainty, rapid change, and opportunities for nurses to travel. We faced new challenges with retaining nursing staff in our Bone Marrow Transplant Unit, Oncology ICU, Apheresis, and Infusion clinics. To retain seasonal and novice nurses, we implemented a 90-day tool to be used for 1:1 staff rounding sessions in 2019. The tool has been...
modified over time and focused on direction provided by the nurse. The original format was connecting with the staff member with a focus on what they like about the unit and what frustrates them. It was modified to enhance communication and support a work life balance. The tool now focuses on professional development, setting goals, and providing resources to help nurses grow in their specialty. Our organization offers the opportunities to grow in research, education, quality, advanced practice, leadership, or legal routes. Leaders round with staff members every 90 days to follow up on goals or areas of focus that the nurse has identified. The tool is shared on Teams to ensure the nurse completes rounding with one of their leadership team members. Since June of 2019, we have retained 56% of nursing staff hired on our unit. 7% have been retained in our organization through career opportunities in other departments. Opportunities that were identified during rounds were transitioning to 60hr work schedules to maintain full time status, offering special assignment time for projects, creating the senior six set work schedule to ensure a senior staff member was on the unit each shift, and assisting with enrolling in continuing education opportunities. Staff surveyed on their satisfaction with the rounding experience was higher with nursing staff with 5 years or less experience. Implementing a tool that can be individualized to the employee and utilizing a team approach can assist in controllable retention of nursing staff.

**P199**

**DRASTIC TIMES CALL FOR A STABILIZING CHANGE - ONE UNIT’S LEADERSHIP MODEL REVISION**

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**Professional Development**

A 24-bed stem cell transplant unit within an 815-bed academic medical center was managed by a two-person leadership team. Staff engagement survey results repeatedly indicated the leaders’ inability to communicate adequately and meet the needs of their 50 Full Time Equivalent (FTE) nursing team. Through the pandemic, with the loss of staff members and the potential attrition of the unit leadership team, it was clear that the unit leadership structure needed revision. The goal of this nursing leader initiative was to implement and evaluate a 3-person leadership team with the addition of a Clinical Practice Leader to the existing Nurse Manager and Assistant Nurse Manager team. In doing so it was projected that staff engagement and retention would stabilize as a result of specific unit improvements. Following the Iowa Model®, all unit nursing staff were invited to complete a Qualtrics pre-survey. The unit leader responsibilities were divided and communicated to all team members and actioned by the unit leaders; then a 6-month post-impact Qualtrics survey occurred. The impact was assessed in the following areas: RN certification, class and conference attendance, shared governance engagement, regular staff inservices and staff meetings, and knowledge of The Foundation for the Accreditation of Cellular Therapies (FACT). Compared to the previous two years, class and conference registration increased from an average of 11 attendees, to 38 in 2023. Certification increased from 55% of those eligible, to 72%. Shared Governance engagement improved from 62% to 87%. Post-implementation, 92% of staff strongly agreed or somewhat agreed that leaders provided a sufficient number of inservices, compared to 78% pre-survey. FACT knowledge improved 32%. Staff nurse turnover stabilized from 43% to 22%. It is the conclusion that the unit leadership model revision was successful and made a significant positive impact on leading through the pandemic and beyond. It stabilized nurse turnover and improved staff engagement. It is the recommendation that a unit leadership model should consist of clearly delineated responsibilities per role, not overall shared responsibility. Furthermore, when determining an adequate unit leadership team, there should also be consideration of direct report FTE, not only bed count per unit.

**P200**

**FINDING JOY IN ONCOLOGY NURSING**

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**Oncology Nursing Practice**

Moral distress is a reaction to situations threatening one’s sense of right or wrong. When a person repeatedly experiences moral distress, it can lead to moral injury. Moral distress negatively affects oncology nurses. Nurses who perceive that their moral integrity is compromised may feel morally distressed and experience burnout, potentially leading them to change roles and leave their positions. Building resilience is crucial for all nurses, especially in the post-pandemic healthcare world. Resilience can be described as the ability to recover and recuperate quickly from a complex or challenging situation. For nurses to build on resilience,
they need to be able to take and stay in control of their hearts, mind, and body throughout the day. A study of over 900 nurses revealed that resilience is an important protective factor against emotional exhaustion. By adopting a resilience approach, nurses can prevent moral distress and maintain, enhance, and restore their moral integrity. Several studies have outlined strategies to promote and sustain moral resilience, including having conviction in one’s values and beliefs to courageously advocate with confidence in what is right. There is limited research on moral distress with oncology nurses, therefore, the study-based interventions for moral distress, burnout, and compassion fatigue are extrapolated from current data. The pandemic has made it difficult for nurses to build and maintain resilience. Oncology nurses (especially in acute care, and Palliative) often witness unprecedented suffering and deaths, often not allowing time for grief or recovery-depleting our resilience and causing moral distress. Consequences of Unresolved Ethical Dilemmas / Conflicts:

- Persistent moral discomfort/stress/distress.
- Crescendo effect of moral distress; moral residue.
- Affects all HCPs, especially nurses (time/space).
- Influences professional relationships, teamwork.
- Can lead to medical errors, and harmful decisions

This presentation will explore ethical issues that cause moral distress, moral injury, trauma, compassion fatigue, and, most important, burnout. A case study approach is based on a situation with an oncology nurse working with a CML patient. The presentation will give practical interventions for building moral and personal resilience, trauma-informed care, and the “real self-care.” Every oncology nurse can develop resilience and improve their emotional intelligence. Incorporating strategies to prevent or manage moral distress can strengthen resilience in managing ethical and moral dilemmas. Practicing self-care and using ethics committees and support systems may empower a resilience approach.

P201
EMERGING ROLES IN REMOTE ONCOLOGY NURSING

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Professional Development

The impact of the COVID-19 pandemic has revolutionized clinical care via telehealth, which has given rise to novel remote oncology nursing roles like those with innovative companies, like AccessHope (AH). AH is an employer-based benefit that provides individuals diagnosed with cancer access to experts at NCI-designated cancer centers who review cases and provide second opinions on diagnosis and treatment. AH aims to bridge potential cancer knowledge gaps to approximately 5 million members with the support of its diverse nursing workforce. To facilitate their various services, AH employs oncology nurses in a variety of roles, all of which are remote positions: oncology nurse abstractors, narrative writers, nurse navigators, cancer support line nurses, and quality assurance nurse practitioners. The purpose was to explore and define the various remote oncology nurse roles within AH; educate nurses on the options for professional and career development that allow them to make an impact in a remote setting while using their oncology knowledge; highlight the significance of evolving nursing roles in the context of care delivery, emphasizing the growing importance of remote nursing practices and their impact on patient outcomes. It will offer a glimpse into the trends, challenges, and opportunities associated with these emerging roles, thereby serving as a valuable introduction to the broader research or discussion on this topic. Interventions: Discussion of the different product lines at AH and how they are supported by oncology nurses, including Accountable Precision Medicine (APo), Expert Advisory Review (EAr), Onsite Expert Consultation (OEC), Cancer Support Team (CST). AH oncology nurses facilitated second opinion recommendations which, if adopted, were associated with improved clinical outcomes such as improved treatment efficacy, reduced toxicity, and enhanced quality of life. A peer-reviewed study found that AccessHope sub-specialists provided evidence-based treatment recommendations in 93% of cases, including significant changes in 28% of cases. Anecdotal feedback from members included gratitude, decreased anxiety, and improved emotional well-being after a second opinion consult facilitated by nurses. Emerging roles and positions in remote oncology nursing have the potential to improve patient outcomes and quality of life. Nurses can positively impact people throughout multiple engagement points during their cancer journey. We recommend further research in how remote oncology nurses perceive these new roles and their level of job satisfaction.

P202
“TEAM DAYS IN A BAG”

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Professional Development

Staff nurses applied to receive institutional funding to provide “joy” to staff. Due to the pandemic, in-person events such as professional development workshops had been placed on hold. The committee’s goal was to develop a way to bring “joy” to staff while also providing education and professional development. Cancer care continued throughout the pandemic and the committee wanted to recognize the staff for their efforts. The purpose of this idea was to develop and implement a project to promote joy, increase access to staff development, and provide meaningful recognition to nursing staff caring for cancer patients. A pre-survey was conducted to seek staff input related to topics of interest that would promote joy and provide educational opportunities. Survey questions focused on components in which the committee felt were essential to address which included:

- Level of Joy in the Workplace
- Burnout from Current Role
- What brings them joy?
- Health, wellness, and personal well-being
- Education topics of interest

The survey was used to develop educational content focused on the topics of interest that were identified. Institutional funds received were utilized to purchase backpacks that contained a journal, ice packs, snacks, pens, motivational stickers, “Seeds of Gratitude” packets, wellness resources, and a list of the educational sessions. Topics were presented virtually and recorded. At the conclusion of the project, staff were provided a post survey like the pre-survey and a free text space to provide feedback regarding their overall thoughts of the project. There was an overall positive response to the joy project. The staff expressed the project made them feel valued and that the project was a meaningful way to recognize hard work and dedication within the cancer care specialty. Survey results as indicated in the graph below demonstrated, an overall increase in joy at work and feeling happy and fulfilled at work. In the end the joy initiative proved to be an impactful project that combined recognition and education to improve professional development of staff and promote joy. Nursing involvement in shared governance and implementation of this project were vital to the success of this project. Committee members shared their successes with other nursing staff across our institution which has led to similar project ideas being implemented.

P203

LEADERSHIP PIPELINE DEVELOPMENT IN A BUSY NCI DESIGNATED AMBULATORY ONCOLOGY HOSPITAL

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Professional Development

There are many reasons nursing needs to invest in a leadership pipeline. The average age of the nursing workforce is rising, and many will be retiring soon. The rate of retirement increased during and post pandemic. The demand for healthcare professionals continues to rise. The US elderly population continues to increase as the Baby Boomer generation hits their 60’s, 70’s and 80’s with increasing numbers. Additionally, enrollment in nursing academic and training programs is on a downward trend. This creates a perfect storm of aging workforce, increased demand, and decreased supply, thus creating a deficit of available nursing leaders. How can we invest in our future nursing leaders on a budget? Staff development is often one of the first things to be cut from an operational budget. Nursing leaders are busy and stretched to the limit and often place their own professional development last on the never-ending “to do list”. Succession planning is important to determine the “who” for future leadership talent and is a topic unto itself. The “how” of leadership development can be accomplished through a spectrum of activities, many of which don’t hit the bottom line of the budget. The leadership team that runs operations for Imaging and Outpatient Procedures in a busy NCI designated ambulatory oncology hospital are not immune to the challenges of maintaining a leadership pipeline. To ensure we have the best opportunity to develop our team we created a leadership development framework that focuses on activities to develop new and future leaders as well as current experienced leaders. Activities ranged from one-on-one coaching, quarterly leadership training presentations with discussion and formal mentoring. Through our leadership development plan, we have been able to recruit several new formal leaders from our frontline staff. Turnover in our leadership team is at an all-time low. Staff satisfaction with their leaders and work environment is at an all-time high. Investing in future leaders is crucial to achieve operational efficiencies as well as maintaining staff and leader satisfaction. We have been able to effectively maintain our leadership pipeline. Our hope for the future is to extend this plan to the rest of our organization.
P204
LEADERSHIP INTERVENTIONS TO IMPROVE STAFFING, RETENTION, AND PRODUCTIVITY IN AN ONCOLOGY SETTING
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Professional Development
In the summer of 2021 a manager of a 10-exam room and 24-infusion chair Cancer Center, part of a large academic hospital system, was faced with multiple challenges. These included a 35% turnover rate, a 20% Infusion RN vacancy rate, 60% clinic staff vacancy rate, high traveler utilization to fill those gaps, and an onboarding process that was longer than necessary (12 weeks compared to 4-8 weeks at other centers within the system). Staff engagement was also low, as evidenced by a lack of participation in the 2019 Press Ganey Employee Engagement survey. This quality improvement abstract will identify key leadership strategies implemented to stabilize staffing (vacancy rate and traveler utilization), improve staff retention (turnover rate and employee engagement data) and decrease unnecessary orientation time which slowed operational growth. Three key approaches were taken to meet these needs: setting core operational structure, optimizing closed-loop communication from leadership, and utilizing existing organizational structures including UVA’s RN Clinical Ladder and advanced degree incentives. Operational structure projects included establishment of clear onboarding pathways, including essential oncology learnings, and regular check-ins with managers/preceptors to track progress. A core preceptor team and oncology Nursing Education Coordinator was established for the site. Additionally a first-ever infusion RN float pool stabilized staffing across four infusion locations. Closed-loop communication from leadership began with hard-wiring an effective, multidisciplinary team huddle at the start of each day in addition to Center-wide quarterly staff meetings and manager 1:1s with frontline staff. The nursing governance structure was utilized to foster experienced oncology RNs with the goal of retaining top talent. Advancement included BSN/MSN achievement and advancement on the clinical ladder. Finally, a multidisciplinary employee engagement committee was established on site. By summer of 2023, all key metrics had improved. Turnover decreased to 6%, current total vacancy rate is 3% (with open positions solely for growth, not replacement), and zero traveler utilization in over 6 months. Orientation time for experienced RNs has decreased to 4-8 weeks on average. Employee engagement is now ranked Tier 1 against national benchmarks through Press Ganey and the Nursing Engagement Survey beat the average scores from like institutions in all areas scored. This abstract demonstrates simple but effective leadership strategies taken to stabilize clinical staffing in an oncology setting, improve staff retention, and decrease time-wasting activities.

P205
WHAT’S YOUR SUPERPOWER? INFORMATICS AT THE POINT OF CARE
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Professional Development
Our health system is a National Cancer Institute (NCI)-designated cancer center serving oncology Patients across multiple sites in New York. Although the Electronic Medical Record (EMR) system is shared across the system, a need to standardize the use of our EMR documentation tools was identified. Attended by leadership only, the Oncology Nursing Informatics Committee (ONIC) aims to standardize the oncology nursing workflow and clinical documentation system-wide. However, nursing leadership recognized the importance of involving the end-users primarily impacted by changes. The unique configuration of our oncology-specific EMR required clinical nurses’ input. Additionally, including clinical nurses in this type of forum where they can share ideas and input is in alignment with Magnet principles, exemplary professional practice, structural empowerment, and new knowledge. Our goal was to create a forum where oncology staff nurses collaborate across eight hospitals to gain insight into their workflow, enhance nursing documentation, and improve patient care through technology. We aimed to gather input from end-users, the oncology staff nurses, to understand their needs, workflow challenges, and suggestions for optimizing the EMR system. Standardizing oncology nursing documentation across the healthcare system was another key objective. We initiated an informal trial project and proposed establishing an Oncology Staff Nursing Informatics Committee (OSNIC) comprised of oncology staff nurses across the system. The chairs of OSNIC report to the existing executive committee, ONIC, relaying staff nurses’ ideas, needs, and feedback on changes to nursing leadership. Executive sponsorship, co-chairs, an online platform, and monthly meetings with compensated attendance support this initiative. A QR code input collector was distributed to capture
insight from nurses unable to attend virtual and in-person meetings. Our efforts have enabled staff nurses to share ideas and workflows, facilitating mutual learning. Leadership gained a deeper understanding of nurses’ workflows and recognized the need for systemic changes to support them. Two dozen oncology nurses participated in the OSNIC meetings and proposed close to a dozen changes. Several items have been approved and built in our EMR, with more in progress, including IV assessment flowsheets, Infusion-reaction documentation, hematology referral orders, and others. Systematic changes in our EMR system, informed by oncology staff nurses, have enhanced clinical workflow and standardized nursing documentation. This project demonstrates the significance of staff nurses driving change and continuing to advancing their practice in a meaningful way.

P206
EXPLORING ROLES OF ONCOLOGY NURSES IN THE PHARMACEUTICAL INDUSTRY
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Professional Development
Oncology nurses are in demand with an estimated 18.1 million cancer survivors (5% of the population) in the United States. For improved patient outcomes, oncology nurses contribute to providing education about treatment options to oncology providers and patients. Oncology nurse roles in the pharmaceutical industry are growing, offering oncology nurses an opportunity to use their critical leadership skills and experience. Oncology nurses in the pharmaceutical industry impact the outcomes and experiences for patients with cancer, yet accessibility to gain knowledge of these roles is limited. There is a lack of literature available to nurses regarding oncology nurse roles in the pharmaceutical industry. There is a critical need to inform oncology nurses about opportunities in the pharmaceutical industry. The purpose was to explore oncology nurses in the pharmaceutical industry. A survey was developed and implemented to expand knowledge regarding oncology nurses currently working in the pharmaceutical industry. The survey contained 8 closed-ended questions that were focused on the professional background, experience, and impact of current pharmaceutical industry oncology nurses. The survey was distributed to oncology nurses in the pharmaceutical industry. It was available for 1 week, took approximately 5 minutes to complete and no incentives were provided to participating nurses. The survey was completed by 36 oncology nurses in the pharmaceutical industry. Most of those surveyed have advanced degrees, 10 or more years of experience and were oncology certified (69%, 64% and 67% respectively). While their employment settings varied, 78% indicated that their work impacts patients and health care professionals in areas of patient/provider education, medication access, adherence and cost support. Respondents endorsed areas of work setting (83%) work/life balance (92%), their impact on patients (86%), and impact on oncology nursing (75%) as sources of job satisfaction. Respondents endorsed perceptions of the pharmaceutical industry (97%) and adherence to guidelines (31%) as challenges. Survey findings indicate that oncology nurses in the pharmaceutical field are highly qualified and skilled, using leadership to impact outcomes through provider and patient education. Findings indicate that oncology nurses report greater satisfying aspects than challenges. Knowledge gained from this survey provides oncology nurses with information about innovative career opportunities which impact cancer care and delivery.

P207
LEVERAGING TECHNOLOGY TO EMPOWER CERTIFICATION
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Professional Development
Specialty certification is an achievement and professional milestone for nurses, however, barriers at both the organizational and individual level can limit nurses’ intent to certify. Study groups are a well-established preparation strategy, but shift work, cost of materials, and inflexible timelines have challenged participation at Allina Health. Allina Health’s Nursing Professional Development Practitioner (NPDP) and Allina Health Cancer Institute (AHCI)’s Clinical Nurse Specialist (CNS) partnered to design a study group that addressed identified barriers. The NPDP and CNS team embarked on a journey to reimagine and launch an OCN® study group in the Fall of 2023. Recognizing that a traditional lecture format would not overcome identified obstacles, they leveraged Microsoft Teams to create a virtual learning space. Following the OCN® test blueprint, the CNS provided the oncology content from various free sources. Utilizing the organization’s Library Services department, the Oncology Nursing Society (ONS), and other trusted internet resources, the team supplied content that appealed to multiple adult learning styles. The NPDP built a 13-week certification plan.
using Microsoft Teams and SharePoint Lists with weekly goals, content, practice questions, and a community forum. This plan was modeled after a pilot hybrid study group the NPDP created earlier in the year. Evaluation is ongoing, but initial results have been overwhelmingly positive. Participation far exceeded expectation with 20 nurses joining the first cohort. It was evident during the first welcome meeting that a virtual format was ideal in that participants were highly engaged in the chat, but not vocally. When examining format options, previous learnings from the pilot study group led to the creation of an exclusively virtual cohort with a more organized format. This learning was critical and supported buy-in to the chosen modality. Participants were able to access the certification plan and resources on their personal devices for flexible and accessible learning. The community forum created a space for nurses, ensuring they remain resilient and motivated as integral components of nursing practice. The purpose was to establish a Health and Wellness Center for emotional wellness. The nursing staff's response to the various events was overwhelmingly positive, with a particular highlight being the impactful mural that now graces the wall of the nursing unit. The various events provided a platform for nurses to come together and reflect on the importance of self-care. The nurses felt recognized, appreciated, and understood. A supported nurse is better equipped to provide the highest quality of care. It is a symbiotic relationship where the well-being of nurses and the well-being of patients are interconnected. As a nurse leader, providing meaningful recognition to our oncology nurses is crucial. They are not only devoted to their profession but also deeply invested in their personal well-being. As we navigate the complex landscape of healthcare today, it is imperative for nursing leaders to understand that their nurses require more than just acknowledgment for their time and effort. They need recognition for their dedication to their profession and commitment to maintaining a healthy work-life balance. This recognition, rooted in empathy and genuine concern for their well-being, elevates the nursing profession.

P208

NURTURING WELLNESS: RECOGNIZING AND SUPPORTING ONCOLOGY NURSING STAFF THROUGH MEANINGFUL RECOGNITION
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Oncology Nursing Practice
It takes an exceptional individual to be an Oncology Nurse. Their expertise and compassion provide hope and comfort for those facing the unimaginable. In the current landscape of the healthcare workforce, it has become increasingly vital to recognize and appreciate the unwavering commitment and dedication exhibited by our nurses. It entails fostering a workplace culture that values self-care, resilience, and mental well-being as integral components of nursing practice. The purpose was to foster a culture that values and supports nurses, ensuring they remain resilient and motivated in delivering the highest quality care to patients while maintaining their own well-being. We celebrated Oncology Nursing Week (May 22-26, 2023) with daily activities that promoted social, physical, intellectual, creative, and emotional well-being. These included a Coffee Chat for social wellness, a Nature Walk for physical wellness, a lunch and learn presentation by Radiation Oncology for intellectual wellness, a coloring mural for creative wellness, and guided meditation for emotional wellness. The nursing staff’s response to the various events was overwhelmingly positive, with a part...
Nursing Director is collaborating with Development and potential donors to secure funding which will allow this program to fund nursing positions, offer more modalities and increase hours of operation. The Nursing Director partnered with the integrative RN as a stakeholder to ensure that her input regarding planning the choice of modalities offered to patients is considered. Nurse involvement and patient satisfaction are vital to ensure that the environment of care is conducive to patient-centered care. Patient satisfaction “likelihood of recommending” was measured in Press Ganey prior to piloting the Health and Wellness center. Patient comments regarding the health and wellness pilot will be reviewed. Maximum integrative patient volume per treatment day is 6; continued patient volume can be measured and reviewed along with patient satisfaction scores to justify funding integrative nursing positions at our facility so that our program can be expanded. Nursing leadership should work collaboratively with integrative oncology nurses to introduce complementary modalities which will improve patient care and reduce patient symptom burden. Nursing leaders are the conduit for communication between integrative nurses and senior leadership in advocating on patients’ behalf with outside donors to secure services which can improve patients’ quality of life.

P210
THE NURSES ROLE IN HEALTH POLICY
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Professional Development
A partnership between nurses with lawmakers plays an important role in advocating for our patients. Lawmakers form health policy that directly affects the patients we care for daily, and the health policy of our country cannot be made without the input of those who care for patients. It is imperative that lawmakers hear directly from those who are on the frontlines of care delivery and access every day - in our case, oncology care. Our chapter, guided by leadership, decided that becoming more familiar with the process of policymaking at the local and federal levels was an important step to help our members be more comfortable using the proper channels for legislative advocacy. As a collective we decided to partner with organizations that were already advocating at the local level for cancer patients. This partnership evolved and eventually led to the passage of a law in 2022 that provided all citizens in the state access to procedures needed to create a personalized treatment plan. Through connections made at Capitol Hill Day, our chapter was able to partner with federal legislative leadership in the state. This legislator was invited to attend a chapter meeting and a chapter-sponsored event to help build a partnership for change. At a recent large-scale chapter conference, a panel comprised of a nurse, a legislator and a lobbyist addressed the topic of legislative advocacy and the importance of partnering for change for cancer patients. As a result of these connections, there is an avenue for our chapter and the legislator to partner. The nurses can provide insight for the legislator into how to best react to current policy and there is now an active partnership to help craft change at the federal level to provide comprehensive health care. Nurses in our chapter who previously felt intimidated by health care policy now have a better understanding and active channels to utilize when there is a need to advocate for better health care policy changes. By engaging with local and federal partners as a group, the barrier of intimidation was addressed. Chapter members felt more at ease participating in addressing policy with our legislative partners.

P211
STOP THE MADNESS: DECREASING THE NUMBER OF NEW PRODUCT TRIALS BASED ON EVIDENCE
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Oncology Nursing Practice
New products are introduced to healthcare on a daily basis. Clinicians are inundated with what they are told are the best products from vendors and manufacturers. With the ever-changing healthcare climate and the amount of change that clinicians are faced with, it is imperative to ensure that changes they are given are based on evidence and not the “latest and greatest”. The purpose of this project was to decrease the number of new products rolled out to clinicians. A secondary purpose was for staff to understand that when a product is introduced it is because it is best practice as supported by evidence. The nursing value analysis team (VAT) reviews all requests for new products. This team is made up of staff from supply chain and distribution as well as clinicians from key areas of the hospital. As Associate Director of Evidence-Based Practice, I was given a seat on the VAT. Recognizing that the number of requests being brought to the VAT to trial a new product was becoming overwhelming to the staff, changes were suggested. The supply chain group stopped allowing vendors to request product trials with all requests coming from the nursing staff. Second, we changed the
request form to include synthesis of evidence tables that showed the change was based on evidence that the new product was better than what we already had in place. Only those with sufficient evidence were implemented.

Since 2021, the VAT has been using the EBP process for new products. Prior to this, there was an average of 15 new product trials per month with an average of 15 a year actually being implemented. Since requiring evidence, the number of new products implemented has dropped to an average of 12 per year with no trials prior to implementation. With all of the unexpected changes occurring through and after the pandemic, nurses need to know that when they are being asked to change products or procedures it is based on evidence of best practice. Requiring evidence has successfully decreased the number of new products and makes the change more easily accepted by clinicians. Requiring evidence for any new product request is a new and innovative way to streamline the number of products being introduced and is one more way to ensure that the organization is evidence-based throughout.

P212 INTEGRATING EVIDENCE-BASED PRACTICE EDUCATION THROUGHOUT A LARGE ORGANIZATION: AN EBP LEADERSHIP INITIATIVE
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Professional Development

Patients should receive care based on evidence of best practices. Education regarding evidence-based practice (EBP) must be delivered to healthcare professionals to gain the knowledge required to provide best care. An organizational infrastructure supporting the delivery of EBP education is necessary. In a large organization with differing levels of understanding of EBP among different disciplines this can be daunting. The EBP leadership had a goal of providing EBP education in a variety of settings and modalities to reach staff throughout the organization. A variety of EBP educational opportunities were offered. A quarterly 4-hour virtual course on EBP is available to any staff. The nurse residency program incorporates EBP education that has been updated and revised based on feedback from participants. The APP fellowship program includes a 4-hour course on EBP along with a PICOT development workshop. A week-long immersion into EBP is offered that staff can attend and many EBP mentors help to facilitate. A leading EBP 2-day course is offered with facilitators from the organization. Two e-learnings are available on the learning management system that is required for all incoming nurses and available to any staff. A nurse manager professional development series includes a session on EBP focusing on nurse manager EBP competencies and leading EBP. There are quarterly educational meetings for all of the EBP mentors. An EBP webpage in available on the intranet that houses a variety of EBP resources including recorded sessions and toolkits. Each of the educational opportunities includes an evaluation process that incorporates feedback from participants. Changes and updates to the content are made based on the feedback or additional evidence. In the past year 65 attendees including nursing, PCA, imaging, epidemiology, quality and patient safety, and nutrition have attended the 4-hour course. Sixty-five nurse residents have attended the EBP course with 23 attending other EBP programs prior to the 4-hour course. Eighteen APP fellows attended their sessions. Thirteen interdisciplinary leaders attended the week-long course along with 6 nurse leaders and 5 facilitators. Four nurse leaders attended Leading EBP while 30 nurse mentors attended their educational sessions. It is imperative that EBP education is provided in a variety of modalities with a mix of opportunities. With the support a strong infrastructure this can be undertaken even in a large organization.

P213 INITIATING CHANGE IN A LARGE ORGANIZATION WITH AN ESTABLISHED PROCESS: HEPARIN VS SALINE
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Oncology Nursing Practice

There were two different discharge kits for disconnecting therapy at home when discharged with the central line still accessed. One contained heparin and the other saline. Heparin was to be used with implanted ports only. Our policy for flush and dwell indicated to use heparin for flushing and locking implanted ports while all other central lines used saline only. It was causing confusion. The primary purpose was to determine the evidence regarding flush and dwell of saline vs heparin in central lines. A secondary goal was to identify an established change management process for implementing major changes. A literature review was conducted regarding best practices for flushing and locking central lines. Fourteen articles were reviewed. Studies showed either positive outcomes or no change if flushed with saline only. Studies showed either no change or negative outcomes including Heparin induced
thrombocytopenia (HIT), inaccurate coagulation studies, iatrogenic hemorrhage, CLABSI, occlusion and duration of catheter when flushed with heparin. Recommendations were to stop using heparin to flush central lines.

Nursing collaborated with process engineering to determine best practice for major changes. It was decided to use the ADKAR process. The steps of ADKAR are Awareness of the need for change, Desire to participate in and support the change, Knowledge of how to change, Ability to change, and Reinforcement to sustain the change. A group of stakeholders were convened. The first step was to determine any additional stakeholders and list any potential barriers to the change. Subgroups were then developed with the barrier themes: Communication, Education, Policy/IT. All potential barriers were addressed with action plans by each subgroup. A final meeting of the entire group was conducted to report out and determine next steps. We plan to have a Kaizen-type event where all final steps can be determined and any additional issues addressed. We will measure outcomes based on the number of heparin doses ordered from pharmacy, the number of heparin doses supplied by pharmacy, the number of occlusions or adverse events in patients who no longer are receiving heparin and the number of TPA doses ordered for potential occlusions. Change is never easy and is more difficult when it affects a large number. Using an established change management process can alleviate barriers to acceptance of the change and sustainment over time.

P214
IMPROVING CARE COORDINATION FOR CANCER PATIENTS WITH AN ADVANCED PRACTICE PROVIDER-LED SERVICE EMBEDDED IN THE INFUSION SUITE
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Coordination of Care
Cancer patients receive multimodality therapy in a variety of settings and across many disciplines. As a result, coordination of care continues to be an operational challenge and is further heightened by the migration of cancer care out of the traditional hospital setting and into the ambulatory setting. Treatments are long, symptom management is complex, and the episodic nature of care creates challenges with care coordination and access to timely care. Data suggest that advanced practice provider (APP)-led clinical programs for patients with advanced cancer have excellent outcomes and that oncology APPs are integral to timely intervention and coordination of supportive care. In order to improve care coordination and delivery for leukemia patients receiving care in the infusion suite, the infusion leadership team partnered with oncology and cancer service line leadership in establishing an APP-led service embedded in the infusion suite. The APP would follow designated leukemia patients during a treatment cycle, providing more frequent assessments, trending lab results and symptoms closely, and coordinating supportive management. This project utilized a quality improvement study design following the Plan-Do-Study-Act method to guide implementation of embedding an APP in the infusion suite at a hospital-based, ambulatory cancer center. In order to assess for improvements in care coordination, the main outcome measures for this project were hold times, or appointment delay times, and provider satisfaction with their level of support in caring for these infusion patients. Pre-implementation, median hold times for lab results, orders, and order signatures was 24, 20, and 24 minutes respectively. Post-implementation, these hold times were eliminated for patients on the new service. 100% of participating providers reported that they now felt they had adequate support in caring for their patients. Pre-implementation, 66% of leukemia providers reported experiencing frequent interruptions from the infusion suite. Post-implementation, this was reduced to only 20% for participating providers. Embedding an APP-led service in the infusion suite was successful in improving care coordination for leukemia patients receiving treatment in the suite, as well as improving the primary oncology teams’ perception of support in caring for these patients. This model could easily be replicated by other disease teams where patients receiving infusion care may benefit from additional management. There may also be opportunities for this APP-led model to facilitate transitions from inpatient cancer care to outpatient cancer care.

P215
HARMONIZING FINANCE & NURSING LEADERSHIP: REMIX YOUR STAFFING WITH A 4-HOUR BEAT. HOW AN INNOVATIVE
REAL-TIME STAFFING ANALYSIS USING FOUR-HOUR ASSESSMENTS LED TO COLLABORATION AND PARTNERSHIP WITH THE DEPARTMENT OF NURSING AND CHIEF FINANCE OFFICER (CFO)
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Professional Development
Fluctuating patient needs, coupled with an ever-present nursing shortage, galvanize nurse leaders with creative staffing model challenges and budget variances, necessitate prompt evaluation to adapt to the organizational staffing needs. An innovative tool, created to conduct real-time variance analysis, has empowered frontline leaders with an ability to analyze as well as adjust the staffing matrix. The development of a staffing analysis workbook to capture current staffing plans, census data, and targeted nursing hours per patient days (HPPD) was designed to assess staffing decisions, incorporate nursing skill mix, patient acuity, and shift from the traditional 12-hour staffing paradigm. Assessing staffing in four-hour increments optimizes resource allocation thus adapting to patient throughput throughout the day and reduces unnecessary labor costs due to overstaffing during lower census periods. A comprehensive staffing analysis workbook afforded live input of staffing, census, and acuity data in four-hour intervals. The workbook was equipped with preset values for targeted RN HPPD and total HPPDs, facilitated the calculation of actual HPPDs, and initiated variance analyses. Color-coded indicators simplified budget assessments, aiding supervisors in decision-making during off peak hours pertaining to staff deployment. An enhanced ability to assess, evaluate, and promptly alter staffing decisions was established. Daily variances in staffing and budget discrepancies were reduced, contributing to improved fiscal accountability. Trends in hourly, daily, and weekly census were identified while considering patient acuity and promoting greater resource allocation and efficiency. Sharing with the finance team provided valuable insights into the fiscal impact of staffing decisions. This tool improved overall staffing practices and strengthened the relationship between nursing leadership and the finance team. Through a collaborative approach, a deeper understanding of the interplay between clinical and financial factors was fostered, resulting in informed and strategic decisions. The collaboration culminated into a biweekly meeting with the CFO to review positions, based on accurate assessment of operational needs. The initiative revolutionized the analysis of nursing staffing by transcending from the 12-hour staffing model to real-time assessments in four-hour increments. Improved utilization of resources was ensured through assessing the appropriate number of staff that is available at critical times. By enriching the financial acumen of frontline nursing leaders, a culture of fiscal accountability was formed, bolstering the partnership between nursing leadership and finance. The strengthened professional relationship exemplifies optimal changes across healthcare organizations.

P216
ELEVATING HOSPITAL OPERATIONS WITH THE DEVELOPMENT OF AN ELECTRONIC 24 HOUR NURSING SUPERVISOR SHIFT REPORT SYSTEM USING REDCAP WORKFLOW METHODOLOGY IN A 100 BED ONCOLOGY SPECIALTY HOSPITAL.
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Patient Education and Safety
Communicating information timely and efficiently is essential in ensuring high quality patient care in healthcare settings. Delayed reporting of information to leadership can hinder effective hospital operations management. Introducing an innovative electronic 24-hour shift report system developed for nursing shift supervisors, utilizing the secure web platform of REDCap (Research Electronic Data Capture). Having discreet fields in the REDCap report allows for the tailoring of vital information to be reported instantly to leadership in this electronic format. The primary objective is to optimize hospital operations by creating an electronic shift report system that automatically sends reports via email to hospital leadership for real-time notification. This approach aims to streamline communication, reduce response times, and enhance overall hospital efficiency. Additionally, this system includes rapid response and code notifications to the Critical Care Clinical Practice Lead for immediate audit of critical incidents and instantaneous zero harm event reporting for continuous quality improvement. We developed and implemented an electronic shift reporting system designed specifically for nursing shift supervisors using REDCap. Customized data fields were configured to capture essential information, including patient updates, staffing levels, incidents, oncologic emergencies, infrastructure failures and zero harm events. Automated email notifications were integrated to promptly inform
hospital leadership upon the completion of each shift report. Rapid response notifications were also set up to alert the Critical Care Clinical Practice Lead immediately in the event of critical incidents. Preliminary findings highlight significant improvements in response times to critical incidents, enhanced communication among healthcare teams, increased operational efficiency, and a robust system for zero harm event reporting. Real-time notifications have empowered hospital leadership to make timely decisions, allocate resources effectively, and proactively address emerging challenges. The inclusion of rapid response notifications and zero harm event reporting has facilitated immediate audits leading to improved incident management, education and continuous quality improvement.

Discussion: Hospital operations significantly improve with real-time notification increasing prompt leader responsiveness significantly advancing hospital operations management. It ensures that leadership gains immediate access to critical information and promotes a culture of safety and improvement. Moreover, the system minimizes the risks associated with paper-based reporting, simplifies data analysis for continuous quality improvement, and promotes transparency in healthcare operations specific to oncology care. Widespread adoption of this comprehensive system holds potential to drive enhancements in quality and overall hospital performance.

P217
BUILDING A CARDIOPULMONARY RESUSCITATION COURSE WITHIN THE ONCOLOGY SERVICE LINE TO SUPPORT CERTIFICATION REQUIREMENTS BY LEVERAGING CLINICAL NURSES EXPERTISE AND PROFESSIONAL DEVELOPMENT
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Professional Development
With consideration to requirement of nurses to hold a CPR Certification, nurses reported challenges signing up for hospital CPR Renewal sessions. Nurses reported an increase in anxiety related to the CPR recertification process. The hospital requires all nurses renew their CPR certificate every two years, specifically through the American Heart Association (AHA). An Oncology CPR Program was developed to provide easy access to attend CPR renewal courses from the care units. This was to meet the needs of clinical nurses, promote professional development and improve RN satisfaction.

The Oncology CPR Program was created to support nurses’ CPR renewal and promote professional development of clinical nurses who participated in the instructor certification course to lead the sessions. Collaboration with the Professional Development Department was instrumental to ensure a process, compliance and maintain regulatory requirements. A group of experienced oncology nurses was formed to attend the CPR Instructor course, with representation from all oncology units. Upon completion of the course, the nurses collaborated with professional development to shadow the hospital’s CPR session process to familiarize with regulatory requirements. A course calendar was put out on a bi-monthly month basis for all oncology nursing to attend. Extending to our partners in infusion, radiation, research, and apheresis. Course dates are determined well in advance and instructors sign up based upon their availability. The sessions are rotated through the oncology units in a conference room. Since the launch of this program in 2019, approximately 300 oncology staff have recertified through the Oncology CPR Program. The average overall evaluation of the course was a 4.9 out of 5. Feedback included nurses reporting a decreased level of anxiety related to the CPR renewal process. Nurses also shared an appreciation for the ability to recertify with a familiar face and in a comfortable location. With consideration to the ever-increasing requirements that an oncology nurse needs to complete and maintain for compliance and care in a complex patient population, a robust CPR Renewal Program that is easily accessible and can lessen the burden on nurses throughout their careers as well as promote the professional development and engagement for experienced nurses in the instructor program.

P218
WHAT’S LOVE GOT TO DO WITH IT? A RESPONSE FROM ‘80S MUSIC TO COMBAT NURSING INCIVILITY IN THE WORKPLACE
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Professional Development
The ‘80s music genre offers a twist on interpretation of themes that emerged from a descriptive phenomenological research study exploring the perceptions of peer-to-peer incivility in the nursing profession. This interactive session will engage the participants in reflection and explorations related to how their interpersonal communication skills impact their workplace and learn how to capitalize on strengths to ensure positive
colleague interactions to create a dynamic and healthy workplace. The purpose of this qualitative study was to explore registered nurses’ lived experiences of peer-to-peer incivility in the workplace. A study aim sought to understand the participants’ experiences of peer-to-peer incivility in the workplace, as well as its effect on patient safety, and ultimately nursing job satisfaction and retention. Based on the findings of this study, suggestions are offered for further research and required actions to elevate the work atmosphere of the nurse from uncivil to a healthy and professional workplace. Two themes and five subthemes emerged from the participants’ verbal descriptions. The participants revealed how their workplaces were highly competitive and that one had to fend for oneself to survive. Many of the participants verbalized that they did not feel supported by their peers. Participants chose words such as war, enemy, brutal and rival to describe their workplace. Experiences of competing and fighting with one another were shared and therefore, being in a warzone, became apparent. Participants described how incivility in their workplace prevented them from being able to provide adequate care to their patients. Additionally, the participants revealed emotional, physical, and social consequences that directly or indirectly had an impact on them. Feelings of rejection, disrespect, not treated with dignity, and treated unjustly feeling demoralized and humiliated were common themes shared from the participants’ experiences with peer-to-peer incivility in their workplace. The study findings have substantial implications for nursing education, practice, research, and science. This investigation provides novel information about experiences with uncivil peers and relates the experience to being in a warzone. Some participants shared their perceptions of the impact on safe patient care, retention of nurses, and medical costs. Finally, this study suggests what it is like to be a nurse who has experienced peer-to-peer incivility and how that experience has affected their decision to remain in their nursing position.

P219
CONTINUOUS LEARNING INTERVENTIONS TO IMPROVE NURSE PRACTITIONERS KNOWLEDGE AND CONFIDENCE IN MANAGING COMPLEX ONCOLOGY CARE SITUATIONS
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Oncology Nursing Practice
The Oncology Care Unit (OCU), is a Nurse Practitioner (NP) led urgent care clinic to reduce Emergency department visits, Inpatient admissions, and re-admissions. With the rising complexity of oncology treatments and symptom management, OCU NPs need extensive knowledge and skills to provide complex oncologic patient care. A patient safety incident occurred related to critical lab values being missed during the OCU visit, resulting in poor patient outcomes. A case review was performed to address the safety issue due to identified lack of knowledge from the NPs related to this event. Didactic educational sessions were implemented to provide the NPs with specialized knowledge and confidence on complex oncology patient care. The purpose was to promote a learning environment for Oncology Nurse Practitioners via didactic educational sessions with a goal of improving their knowledge and confidence in caring for the complex oncologic clinical needs of cancer patients, and reduce the incidents of safety events. Five full-time OCU NPs were surveyed in Redcap to identify the types of disease/treatments with low knowledge and confidence. Specialized NPs within the cancer center provided monthly live Zoom educational sessions to OCU NPs on the topics of interest. A post-intervention Redcap survey evaluated the effectiveness. Eight live zoom didactic educational sessions were provided on the diseases/treatments that were selected by the OCU NPs. As new highly complex treatments such as bi-specific antibodies and cellular therapies management have shifted from inpatient administration to outpatient, OCU NPs’ interest in care management for these treatments have rapidly increased. This resulted in more didactic sessions on these treatments than on conventional cancer treatments. The post-intervention survey results among the OCU NPs demonstrated increased confident levels in novel therapies and their side effect management. The results demonstrated that continuous learning opportunities for nurse practitioners improve knowledge and confidence when caring for patients receiving novel therapies. Providing live didactic education for OCU NPs who require broad knowledge to care for various types of oncologic emergencies and side effect management with novel therapies increases practitioners’ confidence levels. As cancer treatments become increasingly complex, it is meaningful to assess oncology nurse practitioners’ educational needs and confidence.

P220
OBJECTIVE SCORING TOOL TO PRIORITIZE PATIENTS DURING DRUG SHORTAGES
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Coordination of Care
Many patients can be impacted by drug shortages and recently, oncology drug shortages have been
substantial. Those patients impacted by these shortages suffer effects such as decreased control of disease and reduced length of survival. Prior to this intervention, each day patients would arrive and the patient who was here earliest would get the medication; those arriving later may not get treated solely because their appointment was later in the day when the limited supply of medication was already used. This process was modified with a weekly multidisciplinary meeting every Friday afternoon to evaluate the scheduled patients for the following week. Providers would negotiate with each other by describing their patients and why their patient should be treated over others. This left the providers frustrated with feelings of loss of control and guilt. The purpose of this project was to develop an Objective Scoring Tool (OST) to be used to compile clinical details for each patient to prioritize who would receive the medication when it became available. Additionally, our practice would be able to know in advance which patients would be treated and who would be postponed. Publications from American Society of Clinical Oncology (ASCO) would be utilized to identify clinical details specific for treating various diseases with either of three specific medications: Carboplatin, Cisplatin, and Fluorouracil. These clinical details were used to create an OST with a points-based system. The higher the tally of points, the higher priority the patient would be to receive treatment with the medication if it was available. The criteria for each specific medication would be collected for patients who are prescribed that medication. The more points, the higher the priority for that patient to receive the medication. The results showed that the weekly meeting to review schedules for the following week was no longer necessary. The pharmacy teams were able to communicate the amount of drug available and nursing could look at the OST for scheduled patients each week. This tool was essential to assist clinicians with determining which patients would be treated. This scoring tool removed the subjective criteria and emotional aspect of a process of compromise.

P221
WORKING TOGETHER TO WORK TOGETHER: ACP/RN SHARED WORKSPACE
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Coordination of Care
Ambulatory hematology/oncology safe patient care relies on effective Advanced Care Provider (ACP), Registered Nurse (RN) and Physician (MD) communication and collaboration. In a large ambulatory hematology/oncology patient care setting with 36 individual practice teams, this can be difficult to achieve. The disease specific physician practice team consists of the physician, ACP and RN. Previously, ACPs and RNs were cohorted within 10 work rooms without regard to their physician team or to their disease specialty. ACP and RN leadership identified an opportunity to reimagine the workrooms closing gaps in communication and creating disease specific team support. Press Ganey data regarding team collaboration and effective communication as well as employee engagement surveys were reviewed as part of the planning phase. Room capacity, team size and interpersonal relationships were also considered. Open staff meetings were held to discuss the goals of the initiative. Staff were given the opportunity to voice any questions or concerns. A schedule was created with operations and IT to facilitate the relocation of staff over approximately 4 weeks. It is now easier and more convenient for all staff to communicate with team members, addressing patient needs and planning safe, effective care. Three months after the relocation of staff was complete a staff meeting was held to discuss staff satisfaction and feedback on the initiative. Staff stated improved response time to patient needs, ease of access to clinicians and a newfound appreciation for interdisciplinary roles. Physicians also stated increased satisfaction with ease of communication and improved team morale. Press Ganey data and employee engagement survey results will be reviewed one year post implementation of this initiative. Open communication is important when implementing new processes and changes to the work environment. Staff are frequently asked to share their input related to the new work environment. The concept of team-based work-space will continue to be implemented as new staff are onboarded.

P222
UTILIZING ONCOLOGY NAVIGATION TO CLOSE THE CARE GAPS AFTER AN INCIDENTAL FINDING IN THE EMERGENCY DEPARTMENT
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Coordination of Care

Occasionally, patients presenting to the emergency department (ED) may have abnormal findings unrelated to their reason for testing. The literature refers to these findings as incidental, requiring further investigation by an oncologist. When healthcare options are limited, people frequently turn to the ED, causing a steady increase in usage and a failure to follow up in the ambulatory setting due to barriers and lack of resources. Lack of primary care, financial struggles, and limited options lead to more emergency visits. However, this approach can leave vulnerable patients with suspected cancer diagnoses without proper care. Post-emergency care can be challenging to navigate, causing some to miss crucial treatment. The quality improvement project uses oncology nurse navigation to guide vulnerable patients with incidental findings to oncology quickly. The goal is to help uninsured patients access the necessary resources, make timely appointments, and remove institutional barriers. Interventions: Develop a standardized protocol and referral process for ED patients and disseminate the information across the organization. The ED physician or care team will initiate the referral to the oncology care team and, sub-sequentially, to the Oncology Access Navigator. The ONN evaluates patients’ social determinants of health (SDOH) and care obstacles within 24 hours, guiding the patient’s next steps. The Navigator plays a central role for the patient, using a hub-and-spoke method to connect the patient to the next steps within seven days. One protocol was established for ED patients. Within six months, the program fast-tracked 122 ED patients to oncology. All patients were contacted within 24 hours of discharge and evaluated SDOH and barriers to care. Equity Patient Navigators addressed non-clinical practical issues such as the Charity Care application process for uninsured patients. Their assistance helped establish timely appointments, < 7 days, (98%) for a follow-up appointment. One effective way to assist patients with incidental findings during emergency room visits is by using a navigation program to guide them to oncology. Addressing institutional barriers, such as the lack of a standardized referral protocol for incidental findings, limited awareness of internal referral resources, and patients’ need to understand the next steps and available resources, can bridge the gap in care. Nurse Navigators working with Equity Patient Navigators are skilled at addressing clinical and practical barriers and providing resources and support.

P223
PROVIDING ACCESS TO ONCOLOGY SCREENING AND DIAGNOSTIC CARE IN HISTORICALLY MARGINALIZED COMMUNITIES: 10-YEARS OF LESSONS LEARNED FROM DANA-FARBER’S CANCER CARE EQUITY PROGRAM

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Coordination of Care

Dana-Farber Cancer Institute is one of many excellent hospitals that provide cancer care in Boston. Despite the availability of state of the art care, profound disparities exist in cancer mortality across all common cancers (breast, lung, colon and prostate) even though morbidity rates are similar across racial and ethnic lines in Boston. These data are well-documented and lead us to examine what happens to patients from historically marginalized communities after a cancer diagnosis and found that patients lingered in the diagnostic stage and ultimately were diagnosed in the ER. We thus founded the Cancer Care Equity Program in 2011 in order to address these disparities and provide a connection between community care and specialty cancer care via a unique co-location model. The purpose was to address well-documented disparities in access to cancer care we embedded DFCI staffed diagnostic clinics in Federally Qualified Health Centers (FQHCs) in Dana-Farber’s priority neighborhoods. We focus on Harold Freedman’s model of patient navigation and have patient navigators in our community clinic and at DFCI’s main campus. Patients get a warm hand-off which helps them gain trust with cancer specialists and has increased clinical trials enrollment in patients that come through our program. In 2011 we started partnering with FQHCs in Boston’s historically marginalized communities to work side by side with PCPs to connect patients to focused diagnostic and/or cancer care. We have approached these relationships with cultural humility and deep respect toward our patients and our clinical partners. Knowledge gained through these community connections has led us to start embedding Community-Focused Patient Navigators in DFCI disease centers, with an astute focus on the SDoH needs of our patients. Our evaluation methods include RedCap, Epic and Quickbase databases. We measure how long it took a patient’s clinical problem to become resolved, clinical trials enrollment, each PN touchpoint, barriers assessed and how each barrier was resolved as well as patient satisfaction across each program.
Disparities in access to focused diagnostic services and timely cancer care persist. Our co-location model within historically marginalized communities has proven effective and successful both in terms of concrete data, as well as trust earned and relationships built across diverse communities in Boston. Ten years of lessons learned have positioned our model as a exemplar to other cancer centers.

**P224**
**BUILDING SOLID FOUNDATIONS: DEVELOPING PRACTICE PATHWAYS FOR ONCOLOGY NURSE LEADERS**

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Professional Development

Within our organization, oncology nurses clearly identify a growing need for leadership development resources. Like other healthcare systems worldwide, Canada has experienced significant change since the COVID-19 pandemic, including health human resource shortages. Nurses are joining the workforce following interruptions in clinical placements and asked to step into unit-based leadership roles with less than one year experience. Nurses are advancing to formal leadership positions much earlier in their careers. With a rapidly growing incidence and prevalence of cancer, increased late diagnoses, exponential growth in expensive novel therapies, and complex ethical and equity considerations, nurse leaders in the specialty of oncology are faced with wicked problems daily. A solid leadership foundation can better prepare oncology nurses to influence change at the unit, organization, and system level. The goal of the project is to develop transition to practice pathways to support oncology nurses holding or pursuing informal and formal leadership roles. Building on the Learning Pathway for the Specialized Oncology Nurse, the Leadership Special Interest Group (SIG), in collaboration with the Education and Professional Practice Committee, will develop pathways aimed to provide education and support to oncology nurses as they build the leadership knowledge, skills and competencies required in contemporary chaotic practice environments and advance their professional development goals. The development of the leadership pathway will be informed by a workshop to further leverage the experience of members passionate about advancing oncology nursing leadership. A needs assessment is being collected using SurveyMonkey. Questions were developed by Leadership SIG members during virtual meetings. The survey is open for 4 weeks and the link disseminated to members through organizational communication channels. Survey results will be shared, and themes validated during a workshop using small and large group discussion, and an interactive digital platform. Themes will inform the prioritization of pathways. Amplifying the voices of valued and experienced oncology nurses is foundational to identify key strategic initiatives. Oncology nurses require support now more than ever in all domains of leadership, especially in the varying contexts of specialty and practice environments. We heard and we are responding in partnership with our members as we strive to ignite the Extraordinary to fulfill our mission to advance cancer care nursing to benefit of all Canadians and share our learning to strengthen oncology nursing globally.

**P225**
**IMPROVING WORK CULTURE AND STAFF WELLBEING WITH PRIMARY NURSING AND TRANSFORMATIONAL/SERVANT LEADERSHIP**

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Oncology Nursing Practice

Nurse-initiated survey identified that only 25% of the clinical staff were thriving in their workplace and role in the outpatient hematology oncology and blood and marrow transplant clinics which could potentially have a negative effect on patient outcomes and staff turnover. The purpose was to improve the overall wellbeing of the staff at the Blood Cancer Center and create a positive work culture. It was expected that implementation would improve the staff reported satisfaction rate on the following criteria: lunch breaks, work hours, work/life balance, schedule/assignments, belonging, and work culture. Interventions: Implementation of a primary nursing care model and renewed emphasis on a positive work culture including building a trusting relationship between staff and leadership, team goal setting, consistent staff recognition, promoting professional development, and implementation of improved staffing ratios. Post-implementation yielded an overall improvement in clinical staff wellbeing and work culture per staff reported survey results. Nursing leadership can improve the wellbeing of their staff and general work culture by following both a transformational and servant leadership style. Understanding what
motivates their staff, building trust, and including them in decision making can have a positive impact overall and can be easily replicated in other healthcare facilities and settings.

**P232**  
**CREATING AND IMPLEMENTING AN ONCOLOGY NURSE LEADER MENTORSHIP PROGRAM**  
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**Professional Development**  
At a large, academic cancer institute, the Chief of Oncology Nursing Services recognized that the Nurse Manager (NM) turnover rate was 31.9% for FY22, up from 7.5% in FY21. In addition, the onboarding for new NMs was non-existent. Without proper guidance and support in addition to clear objectives for learning, NMs were reportedly feeling unsupported and overwhelmed. The purpose was to create a program that would support the new oncology leader during their first year in a leadership position and improve nurse leader retention. The American Organization of Nurse Leaders (AONL) offers the Nurse Manager Learning Domain Framework and Nurse Manager competencies to outline the “knowledge, skills, and abilities associated with effective leadership” (AONL, 2023). This framework was used to develop the program. In October 2022, a pilot was initiated. A new nurse leader mentee was partnered with an experienced oncology nurse leader for a one-year program. They met bi-weekly for first 6 months and then once monthly for the last 6 months. Three sections of learning material was created that is customized to oncology nursing and the organization. Each section included learning objectives and tasks. A second cohort began in Spring 2023 and consisted of 3 new partnerships. Mentees were given pre-assessment surveys regarding their comfort and baseline knowledge of each objective. At the conclusion of the program, a post-assessment was performed to assess for changes. The pilot cohort had increased comfort with the core competencies of nurse leadership and understanding in who their resources are within the organization. Preliminary data also shows an initial reduction in NM turnover with an overall rate of 22.5% at the end of FY23. We know that a large number of nurses have left the bedside during COVID-19 due to stress and burnout. Mentorship is well documented in the literature as being a vital part of a successful retention plan (Raso, 2022; Vance, 2022; Tarver et al., 2023). Through the implementation of this program we were able to provide support for the professional development of the novice nurse leader, support and clarity in key aspects of their role, and create relationships through human connection which was lacking throughout the pandemic (Raso, 2022; Vance 2022). This work could easily be replicated in other organizations and in other specialties across the healthcare field.

**P226**  
**PROJECT MONITORING OF A STANDARDIZED TAXANE TITRATION PROTOCOL’S IMPACT ON HYPERSENSITIVITY RATES**  
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**Oncology Nursing Practice**  
In 2022, a nursing-led evidence-based practice pilot [EBPP] found that an initial three-step titration provided with first and second lifetime exposure Paclitaxel and Docetaxel infusions decreased the incidence of patient hypersensitivity reactions [HSR] and the need for drug desensitization referral. To minimize the risk of human error and to comply with USP-800 standards, it was necessary to standardize the approach to taxane titrations. Revision of this protocol and implementation across the Institute required significant involvement from nurse leaders [NL]. NL used a situational leadership approach to facilitate multidisciplinary meetings and collaborate on decision making. NL recognized benefit in ongoing monitoring to expand the sample size and ensure our standardized infusion rates remain efficacious in preventing HSR. Various NL collaborated with pharmacists, providers, allergists, and risk managers to determine the standardized rates and new associated workflows. Nursing Clinical Specialists [NCS] developed and delivered the interactive education with frontline staff and collaborated with pharmacy and analytics to develop a dashboard to capture patients scheduled to receive taxanes. NCS manually collected data by reviewing patient charts while closing data gaps via conversations with frontline staff. Data collection
focused on determining HSR frequency, grading of HSR, post-HSR same day rechallenge success rate, and percentage of patients needing allergy consultation and/or drug desensitization after noted HSR. NCS then partnered with NL Clinical Inquiry Specialists to further analyze the data. In the EBPP findings, compared with the non-titratable group (n=123), the titrated group (n=99) had significantly less HSR (19% v 7%). Comparable to these findings, the standardized titration rates (n=999) continue to have a significant impact on lowering overall HSR at 6%. Furthermore, 62.5% of those who noted HSR were successfully rechallenged on the same day while only 2.9% of all patients needed an allergy consultation. NL impacted this work by facilitating and collaborating on decision making but also by ensuring the monitoring stage of the project was not lost to competing priorities. Data was collected and analyzed on the long-term impact that titration has on HSR. Preventing Taxane HSR decreases patient time in infusion chairs, referrals to drug desensitization, and increases patient safety and satisfaction. Recognizing the benefits that this titration has on both institute and patient, and being able to disseminate such findings, is a true mark of our success as leaders.

P227 MEANINGFUL RECOGNITION TO BUILD TEAM SPIRIT: A BEE AWARD TO COMPLIMENT A DAISY AWARD®
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Professional Development
DAISY® is a national, evidence-based program that promotes meaningful recognition for nurses. DAISY® has successfully impacted healthcare organizations by contributing to a healthy work environment, nurse engagement, and retention. Our comprehensive cancer center has an active DAISY® program that frequently receives nominations for supportive staff. However, individual Daisy® awards are given only to nurses. Meaningful recognition for all staff members is essential and developing a recognition program for support staff promotes a healthy work environment for all team members and can serve as a strategy for retention. The purpose of this project is to develop a formal recognition for supportive staff at the comprehensive cancer center. The cancer center’s DAISY® coordinator teamed up with managers of an inpatient unit to pilot an award for supportive staff. Literature review found that the BEE award was utilized by different healthcare organizations, however, the focus and operationalization of the award varied. Our team developed guidelines for the BEE award process and worked with the hospital marketing department to design the award material and promote the BEE slogan: “Be Excellent Everyday”. Promotional materials were donated by the marketing department and includes a nomination form, a badge holder, and a unit banner. Nominations are scored using a new evaluation tool that focuses on excellence in care and aligns with the hospital’s mission to heal, to teach, and to discover. A BEE committee was formed to review blinded nominations each month. Winners will be celebrated monthly on the division and within the cancer center newsletter. Implementation of the BEE program rolled out September 2023 with low overhead cost. Staff have vocalized enthusiasm and excitement for the new award. The number of nominations, engagement, barriers and modifications to the program will be tracked and reported out six months post implementation. After modifications are made on the pilot unit the BEE award will be packaged into a tool kit and shared throughout the cancer center and with the audience at ONS Congress®. The BEE compliments the DAISY® program and as a “daisy cannot survive without a BEE”, nurses cannot survive without outstanding teamwork with their colleagues. Healthcare shortages go beyond nursing and meaningful recognition is crucial for all members of the team for retention of healthcare staff.

P228 DEVELOPMENT OF DEDICATED ONN CLINICAL SPECIALIST
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Professional Development
The role of nurse Clinical Specialist (CS) provides foundational support that positively impacts oncology nursing care. Historically this role has been applied to the inpatient setting and ambulatory infusion nursing but has not been directly applied to oncology nurse navigator (ONN) practice. The purpose was to create a CS position dedicated to ONN practice to meet the ongoing educational and competency needs of this dynamic nursing role. ONN leadership met with executive leadership at DFCI to advocate...
for the development of a dedicated ONN clinical specialist. Some of the responsibilities identified for the CS were: providing orientation to new ONNs, ongoing education on new anticancer therapies, coordination of care, documentation, and telephone triage. A business case was presented which highlighted the need for CS leadership. Some of the immediate needs included the development and maintenance of ONN competencies, updating and conceptualization of policies that directly impact ONN work, ongoing professional development for ONNs, and providing navigation resources. The position for a dedicated ONN CS was approved. ONN leadership engaged the ONN community in discussion about the vision of the role. Job description development was modeled after existing CS positions. Requirements included a master's degree in nursing, a minimum of 3-5 years' experience in oncology nursing, leadership and education experience, and clinical expertise in oncology nurse navigation. As a member of the ONN leadership team, the CS would focus on proactively identifying learning opportunities for ONNs, and in collaboration with ONNs and leadership, develop, implement, and evaluate ONN practice. The ONN CS would be an expert clinician and mentor to ONNs. Through advocacy and a comprehensive business case, executive leadership was able to understand the need to support ONNs with a dedicated clinical expert in navigation. Navigation is growing and the need to continually scope the role to support ONNs and patients is essential. Onboarding of the new CS has consisted of working with ONN leadership and existing CS within DFCI. The ONN CS position has immediately enabled the ONN nurse directors and manager to focus on ONN program development and their individual ONN direct reports' needs.

P229 Navigating Through Climate Disasters: The Role of the Oncology Nurse Navigator

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Coordinating of Care

Climate disasters are becoming more common and intense due to human-caused disruptions to the Earth's natural systems. People with cancer are especially vulnerable to the negative consequences of these disasters. Significant evidence documents the impact of climate disasters on people with cancer. These include delays in screening, interruptions in treatment and other supportive care, and worsened prognosis and survival. The oncology nurse navigator (ONN) is well positioned as a leader to mitigate these impacts through a competency-based approach to disaster preparedness and response. Using the ONS Oncology Nurse Navigator Core Competencies, the authors outlined the role of the ONN as it relates to climate disaster preparation and response. This project is aimed at defining the oncology nurse navigator's role in preparation and response to climate disasters guided by the ONS Oncology Nurse Navigator Core Competencies. The ONN competencies include Coordination of Care, Communication, Education, Professional Role, and Expert ONN. Within the competency of Coordination of Care, the ONN identifies regions of their service area that are most vulnerable, triages patient risk based on individual treatment plans, phase of care, and other clinical implications, proactively collaborates with community partners and the interdisciplinary team to ensure appropriate resources are available to patients before, during, and after a disaster. The competency of Communication ensures the ONN provides psychosocial support for patients, makes appropriate referrals to facilitate care, and opens critical communication pathways for patients, the interdisciplinary team and community partners. The ONN provides Education to patients on the necessary preventative/proactive means for disaster preparation, ways to mitigate complications during and after disasters, and ways to communicate with the care team. In the Professional and Expert roles, the ONN promotes learning of evidence-based approaches to disaster preparedness and response for the interdisciplinary team and community partners, leads within institutional and community disaster preparedness planning teams, and collaborates across organizations and professional networks to disseminate best practices. Authors outlined the aspects of disaster preparedness and response as they relate to the ONN core competencies. The ONN Core Competencies provide guidance for practice and serve as a resource to the professional oncology community. Incorporating the competencies within disaster preparedness enables the ONN to take a leadership role and proactively collaborate with colleagues to ensure continuity of care during and after a climate disaster.
P230
ONCOLOGY NURSES AT THE BEDSIDE: INCREASING CONFIDENCE IN PRACTICE
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Oncology Nursing Practice

Nursing education is vital to the clinical decision-making of bedside nurses and safe patient care. The oncology specialty is diverse and requires expansive knowledge of disease state and standards of care and acknowledgment of ever-changing innovation. Nurses’ understanding of foundational oncology, including Cancer Biology and Basics, Oncologic Emergencies, and Treatment Modalities, can positively affect bedside nurses’ clinical confidence and patient outcomes. At a tertiary care center providing specialized oncology care, an Inpatient Oncology Nurse Education Series was developed to provide essential foundational knowledge to bedside oncology nurses. A team of two oncology Clinical Nurse Specialists and a Nurse Manager collaborated to develop an in-person learning experience curriculum. Knowledge gaps were identified through a learning needs assessment completed by all inpatient oncology nurses. Necessary topics were identified and assembled into a 3-class series: Cancer Biology and Basics, Oncologic Emergencies, and Treatment Modalities. After each didactic presentation, case studies were completed as a class discussion to gauge participants’ understanding. A pre-survey and post-survey were utilized to validate the effectiveness of the class and conclude each class’s impact on nurse confidence and comfortability in oncology care. Essential foundational knowledge ensures that the nurse is equipped with the tools to provide qualified nursing care to a vulnerable population. A survey evaluating nurse confidence and comfortability in oncology care was completed before and after each class of the series. Pre-survey data concluded that 53.6% of fifty-seven participants felt confident in their oncology knowledge and clinical practice before completing the education series. Post-survey data concluded a positive increase to 90% of participants reporting confidence in oncology knowledge and practice. Utilizing case studies following didactic presentations is an effective tool to evaluate nurse comprehension and critical thinking. Creating an in-person Inpatient Oncology Nurse Series has increased nurse confidence in caring for complex oncology patients. A secondary positive outcome of the initiation of this course was the ability to utilize the education series as a positive recruitment tool.

P231
BMT BOOTCAMP: PREPARING OUR NEW-GRADUATE NURSES FOR COMPLEX CARE
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Oncology Nursing Practice

The expectation that nurses work in bedside medical-surgical units before transferring to specialties is over. Today’s nurses are entering bedside nursing in their preferred specialty immediately following graduation. With this culture change, new graduate nurses entering Bone Marrow Transplant (BMT) units require education to help guide them as they care for complex and vulnerable patients. The purpose was to provide nurses new to the Bone Marrow Transplant unit with multifocal educational and clinical experience to aid in the knowledge base of this very specialized and highly acute patient population. A team of a Clinical Nurse Specialist, a Clinical Manager, a BMT Coordinator, and two BMT Charge Nurses collaborated to develop a BMT Bootcamp curriculum. Topics identified for the didactic portion of the presentation were the Basics of BMT, the Transplant Process, Transplant Medications, Transplant Complications, and Roles in the BMT Department. In the simulation portion of the boot camp, neutropenic fever, hazardous drugs, infectious precautions, presenting in rounds, when to call the provider, transplant monitoring, and care interventions to manage transplant complications were reviewed. Thirteen nurses participated in the boot camp. A pre-survey and post-survey were completed to assess participants’ comfort level, knowledge, and confidence in the care of a transplant patient. Knowledge checks were completed periodically throughout the didactic portion to gauge participant’s understanding of the content. In the pre-survey, 23.1% of participants did not feel confident in their practice as a BMT nurse, 69.2% felt somewhat confident, and 7.7% felt confident. In the post-survey, 0% of participants did not feel confident, 14.3% felt somewhat confident, and 85.7% felt confident in their
practice as a BMT nurse. Caring for a BMT patient is fast-paced and complex. New graduate nurses entering the specialty must be equipped with the tools to manage their patients safely and effectively. The BMT Bootcamp didactic and simulation learning experience provides nurses with the educational and clinical tools to be confident and successful in their nursing practice.

P232
INCREASING GENOMIC CAPACITY OF APRNS ACROSS THE VETERANS HEALTH ADMINISTRATION: DEVELOPMENT OF A CANCER GENETICS NURSE TRAINING FELLOWSHIP
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Professional Development
While there are increasing numbers of patients for whom genetic testing is recommended by the National Cancer Care Network (NCCN), there is a critical shortage of genetics services providers in the United States, and in the Veterans Health Administration (VHA). We hypothesized that advanced practice registered nurses (APRNs) could augment the genetic workforce within the VHA by addressing the genetic testing and genetic care needs of cancer genetics referrals. The first step in the process was to provide genomic education to APRNs to prepare them for this role. A Veterans Affairs (VA) Nurse Genetics Fellowship program was developed along with a 10-month curriculum. The course was open to APRNs of all specialties within the VHA. Over 100 APRNs across the nation applied to the program. Of the 139 attendees, all VISNs were represented. Monthly lectures by national cancer genetics experts were provided, along with a monthly case conference, via a virtual format. The objectives of the program included to introduce clinical genetics focused on cancer genetics, provide background to prepare nurses to apply and participate in more intense courses or training in cancer genetics, and increase exposure of the VA nursing community to the practice of cancer genetics risk assessment. This presentation will provide information about the curriculum and national clinical outcomes of the genomic education program.

P233
LABS IN ROOM: ACCESSING OUTPATIENT ONCOLOGY PATIENTS AT THE POINT OF CARE
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Professional Development
Venipuncture and intravenous access are two of the most routinely performed procedures for oncology patients. They are also taught to nurses in school but not practiced during clinicals. Outpatient clinics have separate labs that patients visit before appointments for blood results to be available at the clinic visit with provider. Clinic nurses do not perform these services so they’re lacking in their skillset. While closing the lab in an NCI designated cancer center, the site established a new nursing model of bringing the care directly to the clinic patient with the expectation of the clinic nursing staff drawing labs in the exam room. The purpose was to provide venipuncture and IV training for inexperienced clinic nursing staff to align with the care model of bringing the care to the patient. A 2-hour live class was provided to each RN, LPN, and Medical Assistant on site, utilizing online modules, didactic lecture and return demonstration. Pre-class, the staff’s IV insertion and venipuncture skills were assessed and rated from novice to expert, as some nurses had existing experience from prior work in other areas. Any found below competent level was assigned for training. Post-class, each subject was paired up with an experienced nurse for check-off. Thirty-six staff members attended the class prior to their disease site care model go-live over an eight-month time frame. The data shows 100% increase in confidence at the end of each live class. Nursing reported comments of “I’m ready to try it”, “I know I can do this”, and “I don’t think it will be too hard”. Verbal reports of low confidence within two months after classes ended along with lack of skill experience due to the large number of nurses needing practice required additional planning. These nurses were scheduled within alternate areas that provided high levels of practical experience. Labs in Room allows the patients to have their blood drawn in the comfort of their exam room without requiring them to travel to a separate laboratory area within the building. It reduces barriers to care such as conflicting appointments and wayfinding. It also reduces overall costs and frees up resources of staffing and running a full laboratory. Training the nursing staff raises their overall skill level, furthering their professional development while also increasing patient satisfaction with the new care model.
WITH HIGH EMETIC POTENTIAL USING A WELL-KNOWN SONG.
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Patient Education and Safety

The number of emerging oncology therapies has created an abundance of learning opportunities for the oncology nurse. The development of strategies to engage staff in learning can be framed within a context of creativity and encouragement. Nurses must be able to recall chemotherapies with highest risk for emesis to preemptively prevent and manage nausea in their patients. The purpose was to provide a creative learning activity for nurses to improve recall of highly emetic agents by using a familiar song paired with the NCCN™ list of highly emetic agents. Using adult learning principles, the ambulatory clinical nurse specialist (CNS), issued a learning challenge for oncology infusion and clinic nurses to improve recall of highly emetic agents. Nurse-created lyrics were paired with the song, “If You’re Happy and You Know It”. Nurses song practiced 3-4 times a week prior to videotaping for approximately 2 weeks. Infusion nurses were recorded/videotaped by the organization’s Art in Medicine Institute. Recall was measured prior to process improvement challenge, after last song practice and one year after taping. Recall of highly emetic agents improved with paired NCCN list and a well known song. Prior to intervention, most nurses could identify 4-5 chemotherapies, after learning lyrics 88% of nurses could recall 8-12 chemotherapies, almost 1 year later 25% of nurses recalled 6-12 chemotherapies from NCCN list. One nurse reported recalling song during OCN test for two questions and was able to answer easily. Research has shown that music provides rhythm, rhyme and often, alliteration. This structure is the key to unlocking information stored in the brain—with music acting as a cue. During rounds, it was found that outpatient infusion nurses could not fully recall the NCCN’s list of highly emetic chemotherapies. Pairing music with the NCCN list provided a creative approach to engage staff to learn these agents. Learning can occur with self-activity and with other adult learners. Laughter, smiles and teamwork were evident during all song practices. While learning acquisition did occur during and after song practice, nursing recall of chemotherapy list decreased over time signifying the importance of regular review of these medications. Additionally, the song has been shared on social media and can potentially be used as a teaching tool for oncology nurses worldwide.

P235
ADVANCING THE ONBOARDING PROCESS FOR NEW GRADUATES FOR AN ADULT ONCOLOGY INPATIENT UNIT
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Professional Development

New graduate nurses assigned to a medical-surgical unit complete a network-wide onboarding program for eight-weeks. We found that the eight-week onboarding program was not enough time to allow the new nurses to gain confidence in caring for adult oncology patients on our 22-bed medical-surgical hematology/oncology unit. The purpose of this improvement project was to evaluate whether increasing the length of the onboarding program for new graduate nurses helps to enhance their knowledge and confidence in caring for adult oncology patients who are seriously ill and hospitalized. To build the new graduate’s knowledge and confidence to competently care for our adult oncology patients we increased the length of our onboarding program to ten weeks. The additional time on orientation allows the new nurse to attend our network oncology classes that will teach them basic pathophysiology of cancer and provide them with information about the different treatment modalities our patients may receive for managing their illness. Nurses participating in the courses learn how to manage the side effects patients might experience from their cancer treatments. Our Case Studies in Chemotherapy and Biotherapy Oncology Patient Management class helps the graduate nurse develop critical thinking skills for managing problems that are unique to the oncology patient. One tool that we can use to ensure that our updated orientation program is hitting the mark is to assess the new staff members’ knowledge in having the ability to care for adult oncology patients. We created a questionnaire using a Likert scale to appraise the new graduate nurse’s ease and confidence level as they adjust to caring for adult oncology patients on the inpatient unit. Another way to evaluate the effectiveness of onboarding is to monitor turnover rates in the department. If we continue to see high turnover rates, we will need to consider changing the process to better assist staff in learning their new role in the department. Providing our new graduate nurse staff with basic knowledge in caring for the adult cancer patient begin the journey towards helping them become expert oncology nurses. Improving our onboarding process will allow our oncology patients to receive excellent care during their hospitalization.
EMBRACING NEW HORIZONS FOR DEU STUDENTS TRANSITION TO PRACTICE

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Professional Development

A National Cancer Institute (NCI) designated Comprehensive Center has established a successful Dedicated Education Unit (DEU) for BSN Adult Health Clinical and Senior Practicum student rotations. Academic faculty are the didactic content and curriculum experts, and clinical faculty must be designated onsite for supervision of learning. National nursing school faculty shortages are a well-documented problem. DEUs are a proven modality for best practices in the clinical rotations for nursing students utilizing clinical staff as collaborative educators. A practicing oncology nurse served in the clinical instructor role which provided benefit to the oncology scope of practice and depth of clinical judgement. The purpose was to describe an innovative practice engaging practicing oncology nurses to serve in the clinical faculty role with students in DEU rotations and make recommendations for sustainability. An established oncology DEU identified opportunities to enhance learning for BSN nursing students. DEU roles are distinct and necessitate close communication and planning to maximize student theoretical knowledge application to clinical care, which develops clinical judgment and critical thinking. Oncology nursing is complex and challenging in content and acquisition of clinical expertise. An oncology trained clinical instructor faculty is essential in assuring optimal oncology comprehension expertise development for students. Collaboration across university faculty, the oncology center advance practice nurse educator, and the clinical staff has created strong student learning opportunities. The compensation for clinical instructors is where sustainability of the partnership is at risk. One important goal of the American Academy of Colleges of Nursing (AACN) 2023-2025 Strategic Plan is to “strengthen the nursing workforce and transform healthcare delivery” (2023). Increased policy and legislative support is needed to sustain and fund multimodal approaches. Investments must be made in funding allocations for academic nursing and clinical faculty salaries to provide support to educate competent, high quality nursing graduates, which will ultimately improve patient outcomes.

P237

STAFF EDUCATION TO INCREASE CONFIDENCE IN CARING FOR LGBTQI CANCER PATIENTS

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Oncology Nursing Practice

The purpose of this project was to provide education to promote a welcoming environment, increase staff knowledge and confidence in caring for LGBTQI cancer patients. LGBTQI cancer patients present with unique challenges that they state the healthcare team is often unprepared to address. Caring for LGBTQI cancer patients present challenges for healthcare providers given the limited knowledge reported related to their cancer risk, screening and care of this population. LGBTQI cancer patients come with their own barriers related to receiving healthcare including not feeling comfortable identifying their sexual orientation and/or gender identity as well as a fear of being offered different treatment options. An interactive education session was provided to address knowledge about LGBTQI cancer patient uniqueness and to increase the confidence of the staff caring for the patients. A pre- and post-test was administered to measure knowledge and care/confidence in caring for LGBTQI patients and comfort in discussing LGBTQI issues with coworkers. There was a 42% increase in staff responses to the importance of knowing about a patient’s sexual orientation to provide the best care from the pre- to post-test results. Knowledge about cancer issues related to LGBTQI population increased by 58% from pre- to post-test. After the educational session, there was a 39% increase in staff who agreed that they were more likely to intervene in a homophobic or transphobic interaction at work. Providing staff with an education session to address knowledge about LGBTQI cancer patient uniqueness can lead to increase staff perceived knowledge and confidence in effectively caring for LGBTQI patients.

P238

IMPROVEMENT UPON STAFF ENGAGEMENT WITH THE FIRST RESPONSE TEAM IN AN OUTPATIENT ONCOLOGY SETTING TO IMPROVE THE PATIENT’S QUALITY OUTCOME

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Oncology Nursing Practice

The First Response Team was developed for an outpatient setting to respond to emergent conditions. Conditions is another name for codes. Emergent situations require the responsibility of a response from staff who are certified and trained for emergent care situations to assess and stabilize the patient until the Rapid Response Team arrives from the inpatient-hospital setting. With the evolution of clinical studies and influx of new medications entering the market, the side effects can pose more reactions. Oncologic emergencies can be life threatening in cancer patients that can be related to malignancy or effects of the treatment. Utilizing a rapid response team during an emergent situation may improve the patient’s outcome. Recruiting staff can be challenging especially if staff are unaware of the specific roles and responsibilities required during an emergency, staff may feel intimidated thus not engaged to be involved with the response team. Engaging staff with appropriate training may increase the confidence and compliance to join the team. The method of this research is to engage more staff to build a robust rapid response team to improve the patient’s quality of outcome from an emergent situation. Engagement of staff includes attendance of educational programs such as mock codes, utilizing simulated manikins and hands on practices. Involving an initial training course introducing the responsibilities may increase competency of staff to sustain or involve other staff to join. Debriefing with the team, feedback and recognition of wins may motivate and recruit more staff to improve the quality of the code team and outcomes. Data collection using an attendance list with the development of the response team included 18 attendees in 2018. In 2023, with the restart of the committee meetings, increase educational programs, there was a notable increase of staff engagement to 25. Increasing the awareness and providing educational hands-on programs may help facilitate the engagement of staff to join the response team. Providing awareness for the need of more staff members to join the response team may allow for improved engagement, such as involvement with education and training. Collecting feedback from staff who leave the program to increase improvement of the program may be essential. Recognition of a well-organized team may increase the awareness of staff to join building a robust team to be patient focused and improve outcomes.

**P239**

**RN 4 PROJECT-CHEMOTHERAPY ADMINISTRATION DELAYS IN THE ACUTE CARE**

**SETTING FOR HEMATOLOGIC AND SOLID TUMOR PATIENTS PHASE 1: BENCHMARKING BARRIERS**

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Oncology Nursing Practice

In 2019, elective patients were admitted at 0830 on the day of chemotherapy administration. The protocol was not initiated for at least two shifts. Administration delays in the acute care setting impacted the length of stay, chemotherapy administration staffing, and patient and physician satisfaction. The literature reflected the primary delays occurring in the ambulatory settings due to Physician orders and Pharmacy preparation. This presentation focuses on benchmarking chemotherapy administration barriers in the acute care setting identifying chemotherapy protocols, and baseline turnaround times (tat) from admission to completion. The initial phase of data collection occurred from 2019-2020 focusing predominately on High Dose Methotrexate, then expanded to 2020-2022 for incorporation of a greater variety of protocols. A qualitative tool was designed to collect data that included identification of chemotherapy protocols, admission times, time chemotherapy ordered, when started end time, and the delays/barriers. The tracking tool involved multiple RNs per patient chemotherapy protocol over 3 shifts. The project coordinator educated staff on the use of the data collection tool.

- **Barriers:** A total of 23 barriers were identified. Examples include Orders not released, Awaiting MD, VAD placement, Urine output, Premedication, Diagnostic tests, Patient education, Room not ready, Hydration-bicarb-pH, Transfusions, Unstable, Out of ratio/Chemo RN/ Verifier, Pharmacy chemo delivery, Lab Processes, Pharmacy staffing, Patient not ready, Equipment missing/malfunctioning, Short staffing, Locating Solid Tumor MD, Admission or transfer processes, Shift change- need to change chemotherapy timing, and No Delay.

- **Drug protocols:** HD MTR +/- Ibrutinib, Carbo Desensitization, Decitabine + Venetoclax, ICE+R, R-HyperCVAD, DA-REPOCH, R-CHOP, MAP, Cytarabine, HIDAC, R-MAXI CHOP, Carbo-Vp16, 7+3, GCLAC, EA, Blincyto , Azacytidine+ Venetoclax CALGN 1043 , ATG +CsC+ E1tromibopag, Vyxeos.

- **Four Categories of Chemo Administration:** Elective admission, Interhospital transfer, Inhouse
transfer, Chemo Administered by Chemo RN off of the oncology unit.

- Timeframes: The timeframes for completion of chemotherapy administration range: 8 hours-33.5 hours; Wait time range: 2.3-9.5 hours, wait time average: 5.38 hours
- Themes: Identified themes included 1-MD 2-Pharmacy 3-Nursing Leadership 4-Patient 5-RN and 6-EVS

The findings highlight the complexity of chemotherapy administration in the acute care setting and the multifaceted nature of the barriers contributing to delays.

**P240**

**ONCOLOGY RESOURCE NURSE ROLE EXPLORED THROUGH SHIFT SURVEY DATA**

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**Oncology Nursing Practice**

To support an oncology service line at a large academic medical center, a designated Oncology Resource Nurse (ORN) role was created. To serve as ORN, the nurse must have worked in oncology for one year and have a minimum of two years working as a nurse in acute care. Throughout the pandemic and subsequent nursing shortage, the ORN role has proven to be invaluable in supporting 170 oncology beds, 370 oncology nurses and off-service chemotherapy needs. To capture the work of the ORN, a survey was created and completed each shift by the ORN. Since the survey was implemented, 690 surveys on the work of the ORN have been completed. Survey data entered by the ORNs has helped to better understand how the role is being utilized, including how often they are asked to administer chemotherapy off-service or return into staffing. Review of the data allows leadership to optimize the use of the role. The survey was developed in collaboration with nursing leadership and the ORNs. Multiselect questions include tasks completed, whether and where off-service chemotherapy administration was required, and if they were needed in staffing. Free text questions allowed the ORNs to detail any non-routine tasks, issues that required escalation, or other information that they would like their nurse leaders to know.

Completion of the survey was required at the end of each ORN shift. In reviewing the survey data (n=690), we learned that high frequency tasks for ORNs were usually related to acuity, including passing medications (n=502), reviewing policy (n=480), and helping with ADLs (n=480). Notably, the next most common tasks were oncology specific tasks such as assisting in administering chemotherapy (n=362) and reviewing chemotherapy orders (n=477). The ORNs’ oncology expertise and availability has allowed new oncology RNs in the service to feel confident in verifying and administering chemotherapy. The survey also showed that ORNs were needed to administer chemotherapy on non-oncology units 24.7% (n=170) of the overall shifts worked. Prior to implementing the shift survey, feedback around the ORN role was simply anecdotal and it was difficult to quantify the work that was being done. Now, the data speaks to the need for a dedicated, at-the-elbow resource with oncology expertise who is available to the nurses in the service and the oncology patients on non-oncology units.

**P241**

**UTILIZING AN ADVANCED PRACTICE NURSE ROLE TO ALIGN NURSING CARE ACROSS COMMUNITY SITES**

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**Oncology Nursing Practice**

Large cancer centers have expanded to community sites to broaden their geographic reach for care delivery as oncology care continues to transition from inpatient to outpatient. At an NCI-designated comprehensive cancer center, five community clinics in diverse geographic locations serve 13,000 patients annually. It is essential to assure that oncology nursing practice is equitable in provision of treatment with optimal care modalities. Comprehensive engagement of key collaborators across all sites is critical for oversight of evidence-based clinical practice and education. An assessment was conducted of all clinics and gaps were identified in the processes of care provision, standards, policy, and evaluation of quality metrics. The purpose was to describe the steps in building alignment and assurance of equitable quality nursing care across diverse oncology sites of care. An organizational analysis demonstrated a vital need for a dedicated role across the community clinics. An advanced practice nurse (APN) role was implemented and became pivotal in serving as liaison between all sites. Responsibilities of this role include clinical expertise, state-of-the-science oncology education, facilitation of clinical com-
petence, and leadership for project development, implementation, and dissemination at an organizational, local, and national level. The role was designed with a dual-reporting relationship through Community Sites leadership and Education and Practice leadership to ensure dedication to Community Sites while maintaining alignment with main campus. Recognition of the unique nature of community sites’ populations and barriers to care was key to achieving optimal oncology outcomes. Community nurses are now actively involved in quality improvement projects and are presenting results for local and national dissemination (e.g., 2022 ONS Congress – 4 posters and 1 podium, 2023 ONS Congress – 1 poster and 1 podium). They participate in local and organization-wide practice committees. The APN has developed and mentored a network of staff nurses that serve as clinic-specific professional practice coordinators (PPCs) to fully engage their own clinic’s nursing team. The APN intentionally collaborated with the PPCs to assure alignment in assessment, planning, and implementation of education and clinical competencies. The leadership of the community APN has benefited the entire oncology center and all five community sites. Ongoing evaluation continues and recommendations for expanding from one APN and partial FTE allocation for each clinic-specific PPC to a team of dedicated full-time PPCs led by the APN is under consideration.

**P242**

**“SHAPING THE FUTURE OF ONCOLOGY NURSING THROUGH SPECIALTY CONTENT AND RESILIENCE BUILDING:” AN ONCOLOGY NURSE RESIDENCY PILOT PROGRAM**

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Professional Development

A hospital system in New England has embraced a graduate nurse residency program. The content is global and does not contain clinically focused education for nurses working on specialty units. There is a high percentage of turnover within this group of first-year nurses with national rates within the first year at 53% (Sherman, 2023). Conservative estimates for turnover within the organization for nurses with less than 1 year of service are 28%. Review of initial graduate nurse orientation evaluations identified a need for more oncologic specialty education. The purpose of this project is to provide specialized oncology nursing education and resiliency interventions to explore the effect on professional quality of life and retention rates among graduate nurse residents. Residents meet once a month for three hours virtually. These sessions are taught and facilitated by members of the oncology professional development team as well as clinical experts. Ten sessions were planned over the course of a year. Participants are within their first year of acute care oncology nursing from across the hospital system. Each session is broken into three parts: reflection, oncology-focused educational content, and a resiliency toolkit intervention. Participants completed a CD-RISC and ProQOL scale, which measure resiliency and professional quality of life. The surveys were completed at the start of the program and will be repeated at the end. Regular feedback is also solicited at the end of each session from participants. Initial ProQOL results showed participants started with an average of a moderate-high compassion satisfaction and low-moderate burnout risk. Initial results from the CD-RISC showed an average score of 75 on a scale of 0-100, demonstrating fairly high resiliency scores. Feedback surveys have also been completed and have shown primarily positive responses. Negative comments have been related to issues with timing and difficulties with virtual learning. Preliminary results from this pilot have been positive. Data suggests enhanced specialty knowledge and resiliency interventions can contribute to increased retention rates and professional quality of life. At this time, only two of the initial 28 participants have left to pursue alternative employment.

**P243**

**USING PRAYER TO DECREASE NURSES’ STRESS LEVELS AND IMPROVE PATIENT OUTCOMES**

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Psychosocial Dimensions of Care

Spiritual practices and religious beliefs influence overall health and well-being (Eckerd, 2019; Bowie, 2021). Nursing itself is a stressful profession. The political, social, and healthcare effects of the COVID-19 Pandemic, a merger between two healthcare organizations, racial tensions in the United States, and the RaDonda Vaught verdict also impacted nurses’ stress levels. This DNP project aims to determine if thrice weekly prayer would help decrease nurses’ stress levels, resulting in a decrease in nurse call-ins and turnover rate and reducing
the number of patient falls. Prayers can offer comfort, hope, and contribute to positive feelings (Cannon et al., 2019). There has been numerous research to determine the impact of prayer on patients, but limited research on how prayer impacts nurses. This DNP project was conducted using a quasi-experimental design consisting of a one-group pre/post-test design. The outcome (nurses’ stress levels) was measured at the beginning and after the exposure to the intervention (thrice weekly prayer). The nurses’ stress levels were assessed using the Nursing Stress Scale with a 4-point Likert scale. In nurses at a metropolitan acute care hospital, (P) how does thrice weekly prayer provided to nurses (I) compared to no daily prayer (C) affect nurses’ stress levels (O) within five weeks (T)? Decreasing nurses’ stress and improving their well-being has positive implications for healthcare organizations. Positive implications include but are not limited to a decrease in nurses’ call-ins and turnover rates and a reduction in patient falls. Results of the project were as follows: Twenty nurses consented and completed the Pre-Nursing Stress Scale survey. The mean score for the nurses was 40.9. Eight nurses accessed the thrice weekly prayers at least once. Two nurses accessed the thrice weekly prayers and completed the Post-Nursing Stress Scale survey. The mean score was 28.5. Unable to determine if thrice weekly prayer had any effect on the nurses’ stress levels, nurse call-ins and retention levels, and patient falls.

P244
IMPLEMENTING A STANDARDISED, CULTURALLY APPROPRIATE CANCER NURSE EDUCATION PROGRAM FOR A COMPANY WITH AN INTERNATIONAL FOOTPRINT.
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Professional Development
With the expansion of a cancer care organisation across Australia, New Zealand, Hong Kong, China and into the ASEAN region, innovative and flexible strategies were required to support the professional development of existing staff and orientate novice cancer nurses. With a large number of staff to teach across multiple sites and multiple countries, a clinical education framework was designed to enable the development of a nursing team that are capable, clinically competent and working to the top of their scope. The purpose was to provide equitable access to a standardised, culturally appropriate cancer nurse education program regardless of geographical location. Direct clinical observation was undertaken at existing sites to systematically observe the delivery of clinical care. The goal of the observation was to identify gaps in knowledge and skills, discover language and cultural differences of staff and patients and explore training delivery models that would meet the local clinical context. Analysis of the findings helped to inform education content and highlighted the need for staff education resources to be bilingual where relevant. Additional findings identified that all education needed to be offered virtually to enable equitable access and induction programs needed to be standardized and individualized. To assist the centralised nurse education team to deliver their education activities, a local trainer was established at each site and advanced technology in form of ‘wearable’ devices was introduced to assist with mentoring and training evaluations in the form of audits. To guide the development and foundation of the education program a Cancer Nurse Education Framework was developed. The outcomes of the direct clinical observation have ensured 100% of staff have equitable access to all education. 100% of face-to-face programs have been redesigned to be delivered virtually and all sessions are recorded and uploaded onto the organisation’s learning management system. Each site has a successful local training model and uptake of education has increased. Since the inception of the Cancer Nurse Education Framework, cancer nurse education is standardised and culturally appropriate. Staff from different countries are able to access education at a time that is suitable to their clinical context and have a local trainer to support their learning needs if required.
and competence of the new graduate nurses by facilitating a change in education during the onboarding/orientation process. To gain support and avoid barriers, we collaborated with key stakeholders: nursing leadership, staff nurses, and NGN. After a review of the literature and utilization of the constructivism learning theory, a two-day course was created to enhance assessment skills using shadow experiences, gaming, and simulation with debriefing. The NGN completed a pre-survey and post-survey. The results revealed that sixty percent of nurses expressed confidence in assessing the various body systems, compared to one hundred percent in the post-survey. During the course, NGNs participated in discussions, simulations, and on-unit performance to assess their ability to complete the assessment practice gap. The utilization of various engagement methodologies facilitated the application of constructivist theory, leading to the program’s success. Constant communication with stakeholders has mitigated potential barriers. Feedback from stakeholders has been positive. Nursing leadership continues to support the program and has expressed the value it brings to orientation and easing the load of the preceptors. Recent nursing graduates have shared increased confidence in their nursing skills following completion of the course. This course plays a pivotal role in enhancing patient safety since nurses must develop proficient assessment skills to promptly identify when to escalate care.

P246
HYBRID TWO DAY CHEMOTHERAPY COURSE
Brittany Callahan, MSN, RN, BMTCN, TriHealth, Cincinnati, OH; Crystal Schmidt, MSN, RN-BC, CMSRN, OCN, TriHealth, Cincinnati, OH
Professional Development
In the past, our organization offered the chemotherapy administration certification process as an in-person 4-day class and then as an entirely online class, to help better keep up with new medications and evidence-based practice changes. Barriers included staffing challenges and keeping materials updated in the in-person class, and lack of support and motivation in the online class. With increasing numbers of nurses unable to complete the course or failing the course we designed a 2-day hybrid course that blends online and in-person modalities to increase successful learning of safe handling and administration of chemotherapy and immunotherapies. On day one, nurses arrive to the computer lab and the educators assist them with signing up for the online course and provide study materials. The learners complete the online course with educators present to assist with questions in real time. On day two, nurses arrive at the computer lab to complete the online exam independently. Following successful completion of the exam, the educators provide in-person organization-specific instruction on safe handling of antineoplastics, PPE, oncologic emergencies, and common treatment plans used by the organization. Combining the online content with in-person instruction provides content using all four learning styles. Prior to initiating this hybrid chemotherapy course, approximately 36% of nurses held a ONS/ONCC chemotherapy immunotherapy certificate. After implementation, 74% of nurses held the certificate (see graph). Additionally, since implementation, no nurses have failed the course, and all have successfully completed the course. Through this new process, we have increased accountability, pass rate and overall number of nurses holding a certificate in chemotherapy and immunotherapy administration. In addition, we have seen increased provider and patient satisfaction related to timely administration of treatment. Satisfaction of the course is also high with the nurses who have been able to participate in this new formatting. We will continue to use this hybrid process to train our oncology nurses to administer chemotherapy and immunotherapy.

P247
OUTCOMES OF AN AUTOLOGOUS STEM CELL TRANSPLANT NURSE EDUCATION PROGRAM
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Oncology Nursing Practice
The inpatient medical oncology and hematology unit at a level I tertiary care facility in the Northeast was approved by the Department of Health for an outpatient-to-inpatient autologous stem cell transplantation program in June 2022. This program allows patients to receive an autologous transplant in-state, with their primary care team, as opposed to the previous process, which referred patients out-of-state. A knowledge gap was identified for this new patient population, which recognized that hematology/oncology inpatient nurses had little knowledge regarding stem cell transplants. The aim of the educational program was to increase knowledge and competence in caring for the autologous stem cell patient population. Evidence-based formal education and new hospital policies and procedures were designed and implemented. Twenty-six nurses attended a two-hour didactic education session inclusive of the outpatient pre-transplant process, the conditioning regimens, common side effects, re-infusion of cells, potential reactions, documentation, patient education, Hickman catheter management,
engraftment, discharge criteria and other transplant considerations was developed. A pre- and post-self-knowledge assessment was completed by all nurses to measure program effectiveness. Nurses scored themselves on a scale of one to four before and after the education on the following topics: purpose of a stem cell transplant, conditioning regimens, nurse’s role, cell engraftment, associated complications, and patient education. All knowledge categories demonstrated improvements after the education program. Participants reported an 80.7% knowledge level increase in understanding of the purpose of a transplant. For conditioning regimens, 92% of nurses reported a knowledge level increase, while 88% reported a gain in knowledge related to associated complications. Finally, for the nurse’s role, engraftment of cells and patient education, 96% of nurses reported a knowledge level increase. The remaining nurses felt their knowledge remained the same post-education, reporting they maintained a basic or proficient level of knowledge. The findings of the pre vs. post-test in this autologous transplant education in hematology/oncology nurses was found to be effective. Following this program, three patients have been successfully transplanted without significant adverse effects during their hospitalizations. The nurses were able to competently administer conditioning regimens, reinfuse stem cells, assess for infusion reactions, monitor for side effects, and identify engraftment. Questions did arise throughout all patient admissions which prompted follow-up education and clarification. Overall, this was a successful education program for this new patient population.

P248
IMPLEMENTATION OF A NEW-TO ONCOLOGY NURSE FELLOWSHIP PROGRAM
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Professional Development
Our comprehensive, multi-campus cancer center located in a metropolitan city has been experiencing ongoing vacancies in hiring oncology-trained nurses and onboarding experienced nurses with little to no oncology experience. These presented multiple challenges in training, staff satisfaction and retention. Our institution lacked a structured and standardized pathway for onboarding oncology nurses into the outpatient infusion and clinic roles. An innovative Nurse Fellowship Program was developed, piloting at our largest campus and eventually expanding to outpatient infusion centers and clinics at all four cancer center locations. The purpose was to develop a standardized and sustainable training program accessible to all four cancer center campuses for new-to-oncology nurses hired in the ambulatory infusion and clinic roles. An assessment was completed on current state onboarding practices and gaps including a literature search for existing program models and framework. Vetting of program vision and support was conducted with leadership and clinical staff. Multi-disciplinary collaboration was incorporated. A 16-week hybrid program was developed utilizing weekly didactic classes, Oncology Nursing Society (ONS) and other online modules, subject matter expert presentations, skills lab, high-fidelity simulation lab, educational gaming, unit-based training, formal check-ins, introduction to process improvement development and interdepartmental shadowing. A dedicated SharePoint portal was developed for centralized communication and training resources. The fellowship program has been reduced to 12 weeks, expanding across all four outpatient campuses. Five cohorts have participated in the program, training 21 infusion nurses, three clinic nurses, and one research nurse. Since the fall of 2021, 23 of the 25 fellows have continued employment at the cancer center, one returned to inpatient, and one left the institution. The fellowship program has created a robust, sustainable, and standardized pathway to address identified gaps in training and support for new-to-oncology hires at all the outpatient oncology campuses. Feedback and evaluation from previous cohorts have guided structured changes to fellowship programming, maximizing efficiency and improving the nurse fellow experience. Successful staff retention of Nurse Fellows suggests improvement in outcomes of onboarding strategies. In turn, staff satisfaction with onboarding practices for new-to-oncology hires has improved. Future considerations include expanding support to fellows and preceptors, and evolving content to reflect ongoing best practices. The potential to use fellowship program framework in building an outpatient oncology nurse residency program at the cancer center is up for consideration.

P249
WOULD YOU RECOGNIZE LATERAL VIOLENCE IF IT PUNCHED YOU IN THE NOSE?
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BSN, OCN, RN, Roswell Park Comprehensive Cancer Center, Buffalo, NY

Oncology Nursing Practice

Workplace Violence (WPV) escalated during the COVID-19 pandemic prompting regulations and legislation to address the violence and aggression experienced by healthcare workers. Lateral Violence (LV) has been tolerated in nursing for perpetuity. Studies have reported the prevalence of LV by nurses to be as high as 85% in the United States, yet it is a behavior that is tolerated as, “that’s just the way it is.” LV is costly as it leads to turnover and attrition. LV compromises the quality and safety of patient care when nurses are afraid to ask questions or speak up, and it causes stress and long-term psychological damage to its victims. The purpose of this poster presentation is to provide education on the overt and covert behaviors of LV. LV, incivility and bullying will be discerned along with strategies to eradicate these behaviors from the workplace. The results of an internal nursing survey about the prevalence and type of ruinous behaviors will also be reported. Inpatient RN nursing staff were provided with the definitions of LV, incivility and bullying and invited to participate in a confidential survey about their personal experiences with these behaviors. Open ended questions were also included to allow staff to share other behaviors they may have confronted that could be deemed as LV, incivility or bullying. Some demographic and explicatory questions (did you report the behavior(s) and if not why) were also included to identify behaviors not addressed and barriers to reporting any rude or discourteous behaviors. The survey is currently in process, but the goals of the survey are to identify the type and prevalence of these behaviors among inpatient nurses at our cancer center; to distinguish any noticeable trends; to take steps to address these behaviors through education and the development of zero tolerance policies for LV, incivility, bullying and other intimidating and rude behaviors. In the midst of a worldwide nursing shortage, retention of nurses is integral to maintaining an adequate nursing workforce. For too long nurses have tolerated “nurses eating their young” as a rite of passage that comes with being a nurse. Lateral violence, incivility, bullying and, intimidating tactics have been tolerated by nurses but the reaction to these rude and disruptive behaviors needs to stop.

P250

EMPOWERING EXCELLENCE: ADVANCING ONCOLOGY NURSING WITH THE IMPLEMENTATION AND EVALUATION OF A TRIPARTITE

INNOVATIVE EDUCATION INITIATIVE IN AN NCI-DESIGNATED CANCER PROGRAM

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Professional Development

In 2020, the American College of Surgeons Commission on Cancer (CoC) Accreditation Program released Standard 4.2 requiring policy and procedures that describe how oncology nursing competencies will be evaluated annually (CoC, 2020). In recent years, there has been a lack of easy access to oncology nurse education, limited free educational offerings, and associated financial stress with the cost of certification study materials. The purpose was to implement and evaluate an oncology nurse education program supporting oncology nurse certification and CoC Standard 4.2. In September 2022, a tripartite approach was initiated to over 500 oncology nurses, consisting of education in a monthly newsletter following the Oncology Certified Nurse (OCN®) exam blueprint, a monthly virtual Oncology Nurse Grand Rounds (ONGR) lecture, and an oncology nurse symposium offering continuing education credits. The program was sponsored by the University of Kentucky College of Nursing, the University of Kentucky Markey Cancer Center, and the Markey Cancer Center Affiliate Network (MCCAN). The education was made available to nurses at the University of Kentucky Chandler Medical Center, Markey Cancer Center, and across the MCCAN affiliate sites. MCCAN, which launched in 2006, consists of 19 community hospitals located across Kentucky. MCCAN was established with the purpose of reducing the burden of cancer and its impact by offering access to high-quality cancer services and programs through collaboration with community hospitals. MCCAN’s vision is for Kentuckians and those from surrounding states to have access to excellent cancer care close to home. The MCCAN Quality Team (three coordinators with nursing experience) assists member cancer programs in achieving and maintaining Commission on Cancer (CoC) accreditation, recognizing hospitals for achieving high-quality, comprehensive and multidisciplinary cancer care. The Quality Team uses a framework of
communication and support intended to guide compliance with CoC quality standards through education and ongoing technical assistance. Cancer-specific education and training programs for community doctors and nurses help ensure the most up-to-date cancer information is available to providers. In 2022, MCCAN collaborated with Dr. Holly Chitwood, from the UK College of Nursing, to implement this education program for oncology nurses. Findings, Discussion, and Implications: The Kentucky Oncology Nurse Education Symposium was one of the first in-person events coming out of the Covid-19 pandemic and was successful in bringing together over 100 nurses from Markey and the affiliate network. Further evaluation pending survey responses Fall/Winter 2023-2024.

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INCREASING INFUSION RN CONFIDENCE, KNOWLEDGE, AND SKILLS THROUGH BI-WEEKLY CLINICAL CASE REVIEWS
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Professional Development
Oncology care in the outpatient setting has increased over the years; ambulatory nursing practice is growing and nurses in ambulatory oncology infusion outpatient settings need additional rationale to boost their confidence, skills, knowledge, and critical thinking. The purpose of this project is to improve outpatient ambulatory infusion nurses’ self-confidence, knowledge, nursing skills, critical thinking, and collaboration with APPs, providers, and clinical pharmacists regarding oncology and supportive care practice. A self-assessment survey of infusion RNs using a Likert-scale was conducted before starting bi-weekly clinical case review (CCR) meetings in an ambulatory outpatient infusion center with 42 chairs and 10 beds. Survey questions were created after literature review with Nursing Infusion Director. A gap analysis was conducted to pinpoint areas of greatest need or areas of least confidence. Implementation of bi-weekly CCRs included collaboration with stakeholders, including APPs who rotate on the unit, clinical pharmacists, the nursing director, and infusion and education staff. Experts (APPs, clinical pharmacist, specialty RN, and CPES) were asked to speak at different times for each case review, according to the topic of discussion; this segued into additional questions and conversation between experts and infusion nurses. Brief synopsis printouts were provided at each meeting for reference or with information about the cases such as labs, history, progress notes, plans, and up-to-date best practices. Qualitative review of nursing comments with quantitative results from a evaluation survey using the same self-assessment questions from the initial survey were completed. There was a noted increase in staff participation submitting cases, and noted eagerness to learn, willingness to participate, and the one-hour format was sufficient for full review. Creating a formal clinical case review bi-weekly meeting has engaged staff in continued learning, understanding, and collaborative practices in the ambulatory outpatient infusion setting. Limitations to this format include not all staff available to participate since only offered to those staff on the calendar for set meeting days and times, time constraints for staff on the floor with patients, and limited variety of experts available during meeting times. CCR with nurses can increase self-confidence, knowledge, nursing skills, critical thinking, and collaboration with clinical providers. Implementing this across the enterprise can positively impact nursing satisfaction with opportunities to learn, engage, collaborate, stay current with best practices, and increase patient safety.

P252
SAFE HANDLING: FROM FORGOTTEN TO FUN
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Oncology Nursing Practice
Safe handling of hazardous drugs is an essential part of an oncology clinic due to staff exposure risk. Mandatory staff education and training is done within our hospitals, however clinical observations of staff behavior have indicated compliance is an issue. Staff perception of risks and lack of knowledge of equipment and processes when handling hazardous drugs lead to improper protective measures. Staff lacked familiarity in finding policies to guide with chemotherapy spills. Previous annual safe handling education lacked staff engagement and enthusiasm. Innovative staff education utilizing gaming strategies has been shown to be effective. The purpose of this project was to design, implement, and evaluate an educational program that incorporated gaming strategies for safe handling of hazardous drugs. First, an interdisciplinary team including a chemical safety officer, medical safety officer, and nurse educators developed a quick pocket reference and step-by-step instruction guide based on institutional policy. The guides were distributed to 4 inpatient units and 16 ambulatory sites. Second, weekly
voluntary safe handling challenges were designed for the month of March, titled “March Madness for your Safety.” Fun learning activities such as crossword puzzles and matching games engaged the staff. Third, gamification strategy was used to create an escape room on safe handling that reflected a scenario for both inpatient and outpatient areas. Staff were required to identify the right piece of equipment needed per specific situations then discuss rationale. Positive feedback was received from staff about all three strategies. Sixteen ambulatory sites (70%) and four inpatient units (5%) representing nurses and unlicensed assistive personnel (UAP) participated in the March weekly activities. All nursing and UAP staff in the cancer center attended the escape room as part of their mandatory annual review. Staff appreciated and enjoyed this unique approach to learning. The readily available resource guides were essential for managing a chemotherapy spill. Utilizing gaming strategies was effective in engaging staff in retraining about safe handling of hazardous drugs. A primary barrier was the inability of inpatient staff to participate in the March weekly activities. Possible explanations for this include a high percentage of travel nurses, high acuity patient load, and lack of manager endorsement. Future educational activities will build on this program to strengthen the culture of safety and behavior towards safe handling.

P253
AN INTEGRATIVE REVIEW: IMPROVING NURSES’S PERCEPTION OF INCIVILITY THROUGH COGNITIVE REHEARSAL
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Oncology Nursing Practice
The future of nursing relies heavily on organizations, nurse leaders, and educators who insist on trusting, healthy workplace environments. Sadly, incivility within nursing is a menacing problem that has existed since the profession’s inception. Many professional nursing organizations and the Joint Commission have posited that healthcare organizations and nurses are responsible for sustaining a healthy workplace culture to reduce incivility. This integrative review examined nurses’ experience of workplace incivility and an evidence-based intervention of cognitive rehearsal to reduce incidences of incivility. An integrative review was conducted, beginning with a search identifying the problem of nursing incivility and an intervention of cognitive rehearsal. Two hundred and thirteen abstracts were evaluated. Using the Johns Hopkins Research Evidence Appraisal tool, the final analysis included twenty-four peer-reviewed articles appraised for quality from multiple databases. The evidence revealed similar themes of definitions, causes, effects, and interventions to address incivility and the use of cognitive rehearsal as an effective intervention. The themes included incivility negatively impacts nurses, patient safety, and healthcare organizations. The existing studies demonstrate that incivility in nursing continues, and cognitive rehearsal is a well-represented method to mitigate incivility. Future studies may want to focus on incivility within nursing leadership as there appears to be a gap in the literature. Leading a culture of civility should be a standard within nursing practice.

P254
BIO-HAZARDOUS DRUGS
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Treatment Modalities
The anticipated implementation of United States Pharmacopeia (USP) 800 in healthcare created a new resolve to conduct thorough risk assessments of healthcare formularies. The role of this assessment was to identify the hazards posed by these drugs, to evaluate the exposure risks associated with these hazards, and to determine the potential health consequences of both acute and chronic exposure. Most healthcare facilities that conducted these risk assessments utilized a risk matrix that incorporated criteria commonly used in toxicology to evaluate the exposure to chemicals. As the pharmaceutical industry is quickly turning to novel biologics to treat and/or correct disease, a risk assessment of the biological hazards associated with these novel biologics is warranted. This presentation will provide information on these biologics; will explore the known and anticipated biological properties of each; will discuss the potential for these biologics to cause infections, to be shed, to contaminate the environment, and to be transmitted to other; and will cover the pertinent controls needed to contain these biologics, to prevent inadvertent exposure to these material, to remove them from the environment, and to ensure staff and patients are educated on the methods to prevent transmission to family and other care givers.

P255
COME TOGETHER: TRANSITION TO PRACTICE SEMINARS FOR NEW GRADUATE ONCOLOGY NURSE RESIDENTS
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Professional Development
An NCI designated comprehensive cancer center ambulatory clinic has a well-established nurse residency program. The residency orientation utilizes several modalities including didactic education, hands-on practicum experiences for skill acquisition, dedicated shadow experiences, and a 12-week preceptorship. Although the center’s residency onboarding and orientation is well insulated with educational support and frequent check-ins for each resident, following orientation, successful integration of new nurses in their transition to independent practice can be challenging. After an influx in new graduate resident cohorts in size and frequency, a nurse educator overseeing the nurse residency program identified an opportunity to complement the existing orientation by bringing multiple cohorts together for a three-part seminar series. The purpose was to provide an educational series to new graduate nurses that aims to facilitate successful transition to practice and enhance camaraderie across cohorts and nursing roles. Education partnered with unit leaders to ensure feasibility of nursing attendance to monthly seminars. Content for the seminars was taught by invited cancer center multi-disciplinary staff. Topics included oncology specific content around blood transfusions and pharmacological considerations for hypersensitivity reactions, in addition to topics that centered around self-compassion and mindfulness, professional development pathways, and an interactive panel with former nurse residents in various educational and leadership roles. Evaluations were collected after each seminar session. Seminar participants included various roles: infusion nurses, clinical nurse coordinators, a bone marrow transplant nurse, procedural suite nurse, and an apheresis nurse. 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Seminar participants included various roles: infusion nurses, clinical nurse coordinators, a bone marrow transplant nurse, procedural suite nurse, and an apheresis nurse. 100% of evaluation responses (n=28) indicated participants were satisfied or extremely satisfied with the seminar and frequent check-ins for each resident, following orientation, successful integration of new nurses in their transition to independent practice can be challenging. After an influx in new graduate resident cohorts in size and frequency, a nurse educator overseeing the nurse residency program identified an opportunity to complement the existing orientation by bringing multiple cohorts together for a three-part seminar series. The purpose was to provide an educational series to new graduate nurses that aims to facilitate successful transition to practice and enhance camaraderie across cohorts and nursing roles. 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Comments that represent the general attitudes of the learners include: “I really appreciate these continuous presentations throughout residency/post residency,” “This seminar was so inspiring and reassuring! I’m learning today feeling less alone and more confident,” and “Keep up with these meetings, they are so helpful, I always learn something and it’s great to re-unite with my cohort.” Evaluations reveal that the addition of seminars supplementing nurse residency orientation timelines has added value to increasing confidence and facilitated the building of relationships for mentoring and cultivating oncology practice. Bringing novice nurses together through continued dedicated seminars for new nurses will be instrumental in inspiring oncology care that supports best care outcomes and successful transition to practice.

P256
THE NIGHTINGALES: INTEGRATING ONCOLOGY-SPECIFIC PATIENTS INTO AN EMR TRAINING ENVIRONMENT
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Oncology Nursing Practice

An NCI-designated ambulatory cancer center implemented a new nursing care model that required NPD (nursing professional development) practitioners to become creative as they were tasked with cross-training clinic nurses into a unique dual role of clinic and infusion nurse. The new medical record (EMR) system that was implemented by the system months prior did not contain oncology-specific learning modules. Simulating complete workflows was challenging without practice oncology patients in the EMR training environment. The purpose was to develop test oncology patients in the EMR training environment to allow NPD practitioners to create simulations for common workflows that can be used during all facets of oncology nursing education and training. The NPD practitioner worked collaboratively with the EMR Oncology Applications Specialist and developed an oncology simulation environment. Nine patient profiles were created and affectionally named “The Nightingales,” with each Nightingale having a cancer diagnosis with an attached oncology treatment plan utilized by oncologists within the system. Each Nightingale patient profile had vital signs, lab results, height, weight, BSA, and medication administration records. The Applications Specialist created multiple profiles for the Nightingales, allowing the same profile to be used simultaneously by several nurses participating in one-on-one or independent training across campuses. Sixteen nurse log-ins were designed to permit classroom-style teaching and hands-on practice, releasing and documenting medication, two nurse verifications, and reporting patient education and hypersensitivity reactions. Since their integration, The Nightingales have been used to cross-train over thirty oncology clinic nurses. NPD Practitioners have utilized the Nightingales in three training simulations which include creating care coordination episodes, two nurse pre-chemotherapy checks, and EMR orientation during the Oncology Nurse Residency Program. Simulation-style training creates a safe space for nurses to think critically through complex patient situations without the pressures of time constraints and fear of patient harm. In the upcoming months, The
Nightingales, will become an integral part of the new Chemotherapy Basics-Oncology Class, allowing new nurses in inpatient and outpatient settings to practice the workflows before, during, and after administering treatments.

**P257**

**WORKING SMARTER NOT HARDER BEGINS WITH ORIENTATION. IMPLEMENTING AN ELECTRONIC ORIENTATION PROGRESSION PLAN AND SCHEDULE**

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**Oncology Nursing Practice**

According to Keil (2020), voluntary turnover during the first year at healthcare organizations averages 27.1%. Orientation and onboarding are the cornerstone of integrating new employees into a department. An effective orientation is structured and provides a smooth transition for new employees. When a department’s orientation lacks structure, communication can become challenging, making it difficult to see the new employee’s strengths and learning needs, ultimately causing them to miss opportunities to learn critical concepts (Keil, 2020). The purpose was to create an electronic orientation progression plan and schedule based on assessment findings from past orientation experiences of clinical members working at an NCI-designated comprehensive cancer center. A survey was e-mailed to registered nurses and medical assistants from the NPD (nursing professional development) practitioner across three oncology specialty clinics. Recipients were given two weeks to respond—the survey aimed to assess the employee’s orientation experience. Forty-nine out of ninety staff members responded. Participants were required to answer seven Likert scale-style questions and two yes or no questions. Based on the results, the NPD practitioner created an electronic orientation progression plan and schedule (OPPS) tool. The OPPS would allow all members involved in the new employee orientation to access current accomplished goals, needs, progression, and weekly focus areas. When asked, “How organized was your orientation/onboarding?” 35% of respondents reported somewhat, while only 5% stated that their orientation was extremely organized. Twenty-eight percent of respondents reported they often showed up to work not knowing their assignment for the day, 18% stated often, and 10% stated very often. Lastly, 41% of registered nurse respondents reported that starting their orientation by working three to four weeks in the clinic would have helped them learn phone triage. Suggestions for improving orientation in the future included mapping out orientation ahead of time, providing focus weeks, and having a weekly schedule. After evaluating the results, the NPD Practitioner created an electronic tool to provide structure and improve orientation. She started an Orientation Improvement Committee of stakeholders across the specialty clinics who reviewed the tool and gave feedback on the timing of goals and focus areas. The Orientation Improvement Committee included unit charge nurses, preceptors, unit nurse educators, and a senior manager. After receiving nurse leadership approval, the tool is set to go live in October 2023.

**P258**

**KEEP CALM AND INJECT ON: AN INTERVENTION TO INCREASE INJECTION KNOWLEDGE AND CONFIDENCE**

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**Oncology Nursing Practice**

Injections can be intimidating for both the administering nurse and the patient. The complex nature of oncology injections in a fast-paced, outpatient oncology setting has caused significant anxiety for new and experienced staff. An initial survey of staff showed a lack of knowledge and confidence related to ventrogluteal (VG) administration, confusion surrounding proper personal protective equipment (PPE) use, and a need for standardized resources. The purpose of this project was to increase knowledge and confidence of specialty injections by utilizing visual and kinesthetic learning opportunities in a supportive and no-risk setting. To address a multitude of injection-related educational opportunities, “Injection Fest” was born. During this skills fair, subject matter experts staffed a general intramuscular and subcutaneous injection booth, focused on general administration techniques. Realistic models that provided real-time feedback of accuracy were utilized to provide hands-on practice for staff. Pharmaceutical representatives were recruited to provide drug-specific education, specifically focused on their drug’s unique components of preparation and administration. A post-survey was completed by attendees to evaluate the effectiveness of this educational intervention. 100% of the 31 total attendees found value in attendance, with 68% finding it extremely valuable. Confidence in landmarking ventrogluteal injections increased by 30.5% post education. Staff knowledge of...
the use of eye protection while administering hazardous drugs improved from 17.8% to 90.3%. By providing staff with an educational opportunity to see, discuss, and practice injections, we were able to increase confidence in administering VG injections and improve knowledge of the proper PPE required to protect our staff. The success of this intervention has ignited a passion for ongoing injection-specific education, including future offerings of Injection Fest. Other organizations may find value in adapting this education modality to a unique, oncology nursing challenge.

P259
PReOMITTING NURSING EXCELLENCE: CULTIVATING SCHOLARSHIP AND EVIDENCE-BASED PRACTICE THROUGH IMPLEMENTATION OF A NURSING JOURNAL CLUB
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Professional Development
Oncology nurses are expected to remain current with evidence-based practice and nursing research. Nursing Journal Clubs (NJC) provide a forum for nurses to critically examine nursing research while fostering knowledge sharing, critical thinking, and education on research methods. NJCs provide nurses with opportunities to consider how evidence-based care might be integrated into their practice setting. Given the benefits of NJCs, our Magnet® recognized and NCI-designated comprehensive cancer care center sought to establish a NJC. The purpose of this project was to evaluate the feasibility of establishing a NJC and to evaluate the impact of the NJC on nurses’ confidence in critiquing, summarizing, and applying research findings to practice. A NJC work group within Nursing Council was established to organize each meeting. Research articles chosen for NJC were based on salient issues identified in local nursing practice. A research article critique guide was created and distributed to participants prior to meetings. Subject matter experts introduced each topic. Meetings were one hour and offered virtually to allow participants across eleven practice locations to attend. Pre and post-meeting questionnaires assessing participants’ confidence in critiquing, summarizing, and applying research findings to practice were completed. Participants received one Nursing Continuing Professional Development credit for participation. Six NJC sessions were held on a bi-monthly basis over one year. An average of 26 participants registered for each NJC, with an average of nine participants attending each session, resulting in a 33% attendance rate. The majority of participants were clinical nurses (63%), had > 10 years of nursing experience (78%), with 58% not having had prior journal club experience (Table 1). Pre and post-meeting questionnaires revealed an overall increase in confidence across all three domains: critiquing nursing research (78%/100%); summarizing findings (91%/94%); and applying research findings to practice (82%/91%) (Figure 1). The formation, implementation, and evaluation of a NJC at a Magnet® recognized and NCI-designated comprehensive cancer care center was shown to be feasible with a positive impact on nurses’ confidence in critiquing, summarizing, and applying research findings to practice. Implementing NJCs may benefit other oncology nursing practices by promoting nursing scholarship and utilization of best evidence in practice. Future work to increase attendance, expand diversity in participants’ professional experience and role, and establish a long-term program structure to ensure sustainability of this program is needed.

P260
INFUSION NURSE ONBOARDING TO NEW CARE NEIGHBORHOOD UNITS
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Oncology Nursing Practice
An expanding NCI designated Comprehensive Cancer Center needed to hire, onboard, train, and precept nurses to work in the center’s expansion building, adding three floors of care neighborhood (CN) clinics. In CNs, all care is brought to the patient’s room: specimen collection, provider visits, infusion therapy, support staff visits and procedures, assuring an efficient, patient-centered care experience. Integrating Team-STEPPS from the Agency for Healthcare Research and Quality, the cancer center is committed to ensure reliable, safe, high performing and effective cancer care delivery. The expansion of services into three floors of new CNs required an innovative approach for orienting complex infusion clinical expertise and acquisition of oncology knowledge, while maintaining the highest quality care and standards. The purpose was to provide an overview of the design and implementation process for onboarding and precepting of 20 new staff prior to opening of three new floors of CNs. In the months prior to the scheduled opening,
Seven residents/new to specialty nurses were precepted in existing CNs clinics. During the opening of the new clinics, these seven new staff members, along with two experienced oncology hires and eleven travelers, were assigned to one of the three floors. The staffing mix was determined to include nurse travelers and so a concurrent orientation system was designed utilizing an experienced Immunotherapy (IMTX) CN nurse preceptor to precept and orient these staff members. The goal of this approach is linking the information presented in onboarding to solidification of skills and knowledge during the precepting phase, and ultimately the safe transition to independent care during orientation at unit opening. Linking quality improvement efforts to the onboarding of staff promotes proficiency and efficiency. Utilization of center-specific policy and procedure standards incorporates safety practices and event reporting. Demonstrating the AHRQ principles of safety and best health care delivery with accountability for ongoing quality improvement, the preceptor builds clinical judgement and expert oncology acumen.

Discussion: The subtleties of time management and interdisciplinary communication that are unique to the CN model are essential. This orientation process creates a soft landing for staff, emmeshing them into the CN model and whether any delays in staff responding to their call bells were experienced. This modification increased satisfaction by 16.25% in one quarter from FY23Q4 to FY24Q1. Perception is reality. Patients greeted in person after they rang their call bell, perceived a timelier response of their needs being met. Providing patients with one’s name and title fosters trust between the patient and care team, even when the colleague who responds to the call bell is not able to directly assist the patient due scope of role, they are able to help by communicating the needs to a colleague who is able.

P261 WHEN “WAIT” BECOMES A 4-LETTER WORD FOR ONCOLOGY PATIENTS
Elizabeth Dailey, MSN, RN, OCN, NEA-BC, Fox Chase Cancer Center, Philadelphia, PA; Maggie Erb, MSN, RN, Fox Chase Cancer Center, Philadelphia, PA
Patient Education and Safety
Wait times for cancer patients have been studied extensively. From time spent in waiting rooms, time from diagnosis to appointment to the startup of treatment. The oncology inpatient setting received reports of patient dissatisfaction in timeliness in having their needs met. Patient experience surveys in the third and fourth quarters of fiscal year (FY) 2023, yielded less than optimal scores for staff responsiveness and nurses responding to concerns, with a mean score of 62.75%. Staff and leaders were alarmed by these scores as their perception of timely response time was converse to that of their patients’ perceptions. The team was determined to improve the patients’ overall perceived experience. In the oncology patient population, wait becomes a 4-letter word, due to the fact that while waiting, they face another 4-letter word, time. These patients do not want to waste any amount of precious time. An initiative aimed at increasing patient satisfaction regarding wait times for their needs to be met was implemented on a 34-bed inpatient medical oncology unit. Unit leadership shared patient experience survey results with staff and discussed patients’ perception of timeliness in having their needs met. Collectively, the decision was made to eliminate answering call bells via the intercom system and to respond to patient call bells in person. This afforded staff the opportunity to introduce themselves by name and title, acknowledge that they saw that the call bell was activated, and ask how they were able to assist the patient. Progress was measured via surveying the patients about their experience. Additionally, during nurse leader rounding, patients were asked how well their needs were being met and whether any delays in staff responding to their call bells were experienced. This modification increased satisfaction by 16.25% in one quarter from FY23Q4 to FY24Q1. Perception is reality. Patients greeted in person after they rang their call bell, perceived a timelier response of their needs being met. Providing patients with one’s name and title fosters trust between the patient and care team, even when the colleague who responds to the call bell is not able to directly assist the patient due scope of role, they are able to help by communicating the needs to a colleague who is able.

P262 IS IT POSSIBLE TO IMPROVE ONCOLOGY NURSES EDUCATION THROUGH SOCIAL MEDIA?
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Professional Development
Social media are widely used all over the world. In Latin America, Brazil is the country where social media is most consumed and it is in the third place in the world. Since the COVID-19 pandemic, education has become a topic more commonly found online. During graduation, oncology is not usually a topic discussed with students. In addition, postgraduate courses with good quality tend to be expensive, costing around 5 to 6 times the monthly salary of a nurse. Therefore, why not use Instagram, a free social media and one of the most used in Brazil, to share content about oncology education for everyone? Purpose: Considering that access to high quality education in Brazil can be very costly, using a free social media to share educational content in oncology can be useful for those who have gaps in knowledge, as well as doubts about the role of oncologist nurses. Interventions: Creation of an Instagram
page constantly updated with content about oncology using all the tools that Instagram makes available: Story, Feed, Reels and Lives. All publications are accompanied by study references, emphasizing the importance of evidence-based learning. In this way, in addition to using a platform that has an immense reach, it is possible to interact with professionals from all over the country, find out what the main doubts, discuss experiences and different practices in each state and emphasize the importance of shared learning. Discussion: Technological update is becoming faster and faster and this brings the demand to use new tools to seek better results in different segments, including education. The social media is a free tool used worldwide, with Brazil being one of the countries that most use it daily. Therefore, social media can be used as one of the strategies to increase the educational level of professionals.

P263
MITIGATING FINANCIAL TOXICITY BY EDUCATING NURSES & OTHER PROVIDERS ABOUT CANCER-RELATED LEGAL ISSUES
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Survivorship
After a diagnosis, individuals are faced with a variety of legal and financial issues. Individuals diagnosed with cancer and their caregivers often have complex questions about insurance coverage, accessing government benefits, and employment. Without accurate information, individuals are unable to make educated decisions and may suffer the financial consequences of losing their job, insurance, or even their home. Financial toxicity is directly connected to lower quality of life and reduced treatment compliance, so it is imperative individuals have access to resources to mitigate financial burden. In order to mitigate financial toxicity, it is crucial individuals diagnosed with cancer and their caregivers have access to the resources needed to make informed decisions about legal and practical matters. Health care providers (HCPs), including nurses, are uniquely qualified to connect individuals with relevant resources; however, there is a gap in formal training around these topics. With the proper information, HCPs can help guide patients through decisions around health insurance, employment, navigating finances, and more. Triage Cancer® created the free Insurance & Finance Intensive to educate HCPs about cancer-related legal issues, so they have the necessary tools to help their patients reduce the financial burden of a cancer diagnosis. The Intensive educates HCPs about how to identify cancer-related legal issues and which resources their patients may find helpful in navigating their situation to mitigate financial toxicity. The Intensive provides an overview of the US health care system; individual, employer-sponsored, and government health insurance; employment; disability insurance; and managing finances. The interactive format, including case studies, exercises, and frequently updated information, allows HCPs to develop a foundational understanding of the material. Since 2017, the Intensive has been provided 45 times to 2,446 HCPs in 49 states and Washington D.C. Respondents to the follow-up survey reported:
- Adjusting their approach based on what they learned at the training (96%)
- Knowledge retention six months later (80%)
- Sharing information learned in the training with patients (89%)
- Agreed or strongly agreed that the information provided by the training improved the quality of life of their patients and families (93%)

The Intensive provides critical education to HCPs about cancer-related legal issues. This training enables HCPs to support their patients and their families with accurate information and referrals to resources, in order to mitigate financial toxicity and improve their quality of life.

P264
A JOURNEY TO INCREASING CERTIFICATION RATES IN AMBULATORY CANCER SERVICES
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Professional Development
The Commission on Cancer (CoC) implemented a new Nursing Standard 4.2 which requires oncology nurses to either hold active oncology certification or complete 36 hours of cancer-related continuing education hours per 3-year accreditation cycle. The purpose was to increase ambulatory oncology nursing certification rates. Goal is to increase volume of certified nurses to 35% in year 1 (n=27 new certifications), 40% in year 2 (n=26), and 50% in year 3 (n=49). These targets assume 7% increase in FTE per year. Interventions: Conducted survey to identify barriers to certification and gauge interest in attaining oncology certification. The survey revealed that 98 respondents were interested. The primary barrier identified was financial hardship related to certification review courses, study materials, and the examination fee. Successfully advocated for:
- Funds to contract with an external company to provide OCN, BMTCN, and AOCNP review courses to our nursing workforce at no cost to the employee.
Enrollment in ONCC FreeTake, and
Funding to cover the cost of the examination should the nurse pass.
137 nurses attended our free OCN and BMTCN review course in August 2022, and a total of 68 Nurse Practitioners attended our free AOCNP review course in July 2023. Out of the 62 attendees who answered the post-OCN/BMTCN course evaluation question “I would recommend this program”, all participants selected “Agree” or “Strongly Agree”. Out of the 53 attendees who answered the same question for the AOCNP review course, 76% (n=40) selected “Agree” or “Strongly Agree”, 14% (n=7) “Neutral”, and 10% (n=5) “Disagree” or “Strongly Disagree”. In FY23, a total of 32 unique nurses sat for their ONCC exam using ONCC FreeTake. 13 failed their first attempt, 19 passed their first attempt, and 1 passed on the second attempt. Our target for year 1 was 27 new certifications and we achieved 20; a variance of -7. One of the primary barriers is tracking nurses with existing certification as our organization doesn’t have this information centralized. However, for new certifications these interventions have been successful. The 12 nurses who failed their first attempt plan to re-test in FY24. In FY24 to date, we have had 6 nurses sit for the ONCC exam, all of whom passed on their first attempt. We are currently on track of meeting our year 2 target of 26 new certifications.

P265
NURSING ADMINISTRATORS CHAMPIONING GENOMICS TO CLOSE THE IMPLEMENTATION GAP
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Oncology Nursing Practice
Successful implementation of genomically-informed cancer care requires collaboration among all levels of oncology professionals. Frontline nursing staff must be knowledgeable about the role of genomics in guiding care. Additionally nursing administrators and leaders must value the application of genomics in cancer care and support educational and application efforts as a metric for quality cancer care. Oncology nurse administrators must serve as champions for successful genomic integration on multiple levels once foundational knowledge is mastered. National projects have developed resources (e.g., Method for Introducing a New Competency: Genomics (MINC), Oncology Nursing Society Genomics and Precision Medicine Learning Library) that nurse administrators can utilize to support the integration of genomics in cancer care.

P266
BE ALL YOU CAN BE. A COMPARATIVE ANALYSIS OF EXISTING RESILIENCE PROGRAMS IN THE MILITARY VERSUS NURSING AND THE IMPLICATION FOR ONCOLOGY NURSES
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Professional Development
The definition of resilience includes a statement on the capacity to withstand or to recover quickly from difficulties. Resilience training has been part of the training of the American military in some iteration since Post World War II. In the time since the pandemic, the importance of resilience on nurse retention and job satisfaction has gained attention. Specialty areas known for high levels of stress, demanding and expensive specialized training, and difficulties in nurse recruitment need to move toward emphasizing the importance of resilience training. Evaluating existing programs that are successful or have responded to unsuccessful attempts at resilience training, in another comparative occupations, like the military, offers an example of the work needed to cultivate the resilience movement in the oncology nursing profession. A survey of Oncology nurses was completed and the results display self-perceived high levels of resilience while likewise reporting no formal training on resilience. Research has shown that nurses exposed to high levels of stress have lower...
resiliency and are more likely to suffer burnout or leave their positions. This study compares resilience training that is currently available for nurses to the training military members receive. The implications of the differences are significant and discussed in this study. Oncology nurses need formal resilience training that addresses stressors they face in their profession. Strategies to enhance emotional resiliency, promote self-care, and develop effective coping mechanisms specific to oncology nursing practice are vital for the well-being of nurses and job fulfillment. This work evaluates similarities, differences, and the implications for Oncology nursing practice. By implementing effective resilience training programs, nursing organizations like Oncology Nursing Society, schools of nursing, and employers, can support nurses in facing the challenges of their occupation and ultimately improve patient outcomes and overall healthcare system resilience. Suggestions for timelines and approaches to formal resilience training will be addressed for nursing organizations to use in the future.

P267
“I DIDN’T KNOW WE HAD THAT?!?”: INTRODUCING RESOURCES TO THE NEW OUTPATIENT ONCOLOGY NURSE
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Oncology Nursing Practice

Being a novice in a new field of nursing can be overwhelming especially in oncology due to the complexity of patients and treatments. Newly-hired nurses are paired with an experienced preceptor during orientation who facilitates the onboarding process. Upon evaluation of orientation, an area that was identified as lacking was the new nurse’s knowledge of oncology resources and tools available. A class was developed by the infusion coordinator and educator to support the new nurse in outpatient oncology infusion and improve the orientation process. The purpose of the Outpatient RN Resources Overview class was to standardize the sharing of available resources/tools and key workflows. This course would help to mitigate the variability between preceptors and enhance the nurse’s ability to use resources during bedside care. A one-hour class was developed to review available resources and workflows with the new outpatient oncology orientee. Objectives of the class included how to interpret a treatment plan in the electronic medical record, the location and use of medication administration guides and pharmacy resources, how to send patients home on ambulatory pumps, a review of complex or unique chemotherapy regimens, and how to locate and use nursing protocols. A post survey was created to evaluate the class. Participants were asked how to rate their knowledge and comfort level about finding oncology resources before and after taking the class. Ten participants were sent the survey and nine responded. The average nursing experience was 3 years, with eight participants having previous oncology experience. The responses showed the nurses’ knowledge increased by 38% and confidence increased by 40% in finding cancer-specific resources after attending the class. An overview of available resources and workflows for all oncology infusion nurses was found to be beneficial regardless of experience. Sharing resources in a standardized way helps nurses demonstrate knowledge and confidence using available tools when caring for patients in the outpatient setting. Course frequency, timing and content is continuously evaluated and updated to meet the needs of preceptors, orientees and trends in oncology.

P268
MULTIDISCIPLINARY TEAM BUILDING AND EDUCATION FORUMS
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Professional Development

Nurses noted that there were clinical knowledge gaps that they wanted addressed by a providers but did not want to interrupt the busy clinic schedule to ask. Clinical staff and Nursing Professional Development Specialist (NPDS) came up with idea to have set aside time on the provider schedule where staff can “open forum” ask any questions they want. The purpose of this time is not only to help nurses understanding of complex patient situations but also was a team building opportunity for our multidisciplinary teams spread through multiple care sites to come together virtually. Working with our medical secretaries, our medical director, and providers, we blocked 30-minute time slots on one provider’s schedule once a month. Then a virtual meeting was set out with the prompts for questions for that provider. Approximately 1 week before the meeting, a list of questions was distributed to all participants so that it could be reviewed by the provider and nurses. Any further questions were then sent in to NPDS. After a few sessions it was approved to offer 1 CE credit for this time. In order to fill another 30 minutes of time for a full CE credit one nurse would be chosen to review
pertinent oncology nursing research topics for that month and prepare a discussion. Feedback was obtained via KeySurvey. 100% of participants reported that they were able to increase their knowledge. All comments were positive including, “Please continue this series”, “would love it more often”, “very informative, educational”. Feedback from this activity has been overwhelmingly positive. Nurses like the ability to connect with the providers about questions without feeling rushed. They also feel that it has increased their confidence when approaching providers. It has also become a forum for newer staff to introduce themselves and have their names with their face on camera. The providers appreciate that they have a much better idea of how much our nurses understand and explain to their patients. They also appreciate that they do not have to prepare a formal slide deck or written material, but just to attend the sessions and give their professional opinion.

P269
CANCER CONNECTION EDUCATIONAL NEWSLETTER: PROFESSIONAL DEVELOPMENT FOR THE ONCOLOGY NURSE
Katelyn Gomach, BSN, RN, OCN, ProMedica Cancer Institute, Sylvania, OH

Professional Development

Our goal was goal was, and is, educating the oncology nursing staff on oncology best practices and patient-centered quality oncology care while maintaining the nurse’s attention, providing CEs, enabling access to education from most locations, and encouraging engagement. Providing timely education for nurses can be challenging due to barriers such as lack of time and resources, staff turnover, inability to access the learning management system from home, and decreased orientation time for new hires. A monthly newsletter using Microsoft Sway® was developed to provide evidence-based education and best practice standards directly to the nursing staff. In addition, the newsletter offers free oncology continuing education hours as our institution has accreditation through the Commission on Cancer. We decided against utilizing our institution’s learning management system since accessing that from home is difficult for many nurses due to the Multifactor Authentication. The Sway® format is user-friendly and an aesthetically pleasing and attention-grabbing layout can be created. The newsletter is emailed monthly to all nurses within our cancer institute and is available on our closed Facebook group. A flyer is created with a QR code to be placed where nurses at each site gather for safety huddle. The number of newsletter views is available through the Sway® website. This number has increased significantly from about 27 for our initial newsletter in January 2022, to 614 for the July 2023 edition. Verbal feedback from the nursing staff has been positive stating the newsletter effectively provides beneficial information. In the future, the mode of newsletter format may evolve to include a newsletter evaluation and offering CEs. The implications for nursing practice include increased knowledge of general oncology information, monthly updates on practice and policy changes related to best practice recommendations, information on obtaining certification to increase the number of oncology certified nurses within the institution, updates on treatment regimens, drug-specific implications pertinent to the bedside/Chairside nurse and information on specific cancer diagnoses. All of these contribute to providing patient-centered, evidence-based care for the oncology patient population.

P270
IMPROVING AMBULATORY ONCOLOGY PATIENT EXPERIENCE METRICS THROUGH STAFF EDUCATION
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Oncology Nursing Practice

In March of 2022, the ambulatory infusion center recognized that they needed to improve their delivery of care impacting the ‘Likelihood of Recommending’ patient experience score. In March, the score was in the 43rd percentile, well below the benchmark, with a mean composite score of 94.44. The purpose was to increase the ambulatory patient experience metric for the outpatient oncology infusion department related to Likelihood to Recommend. In February of 2022, the patient experience department began a weekly ambulatory patient experience work group that would focus on identifying opportunities for improvement and sharing evidence-based tools and strategies. The nurse leader representatives for the outpatient cancer center utilized the toolkit containing resources and professional development opportunities to tailor interventions to the oncology department. Each staff member within the outpatient oncology infusion department participated in the implementation of a Caring with Concern Toolkit. The toolkit provided EBP methods for successful improvements in patient experience domains. Each staff member completed an electronic professional development module that earned them CEU credits after completion. The education module consisted of content developed to increase awareness and
understanding of the AIDET (acknowledge, introduce, duration, explanation, thank you) communication method, the warm welcome process, and key words at key times that staff can use to convey empathy and concern when communicating with patients. At completion of the professional development module, each staff member was required to successfully demonstrate competence through validation and check-off. Additionally, quick reference guides and reminders were posted in key areas within the department to continue for “at a glance” education and quick reminders. The department increased their composite score from 94.44 in March of 2022 to a composite score of 95 in May, 100 in June, and 100 in July of 2022 which successfully put the department above the national benchmark (see outcome graph). The Kirby Glen outpatient oncology infusion center successfully increased their Likelihood to Recommend domain. This was due to the staff participation in the professional development learning module that gave them evidence-based strategies to help make the patient experience better.

P271
FAIR HIRING AND INCLUSIVE INTERVIEWS
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Professional Development
A diverse, equitable, and inclusive workplace is a priority for our National Cancer Institute-designated comprehensive cancer center. An oncology research nurse recognized the opportunity to help achieve this goal by improving departmental hiring practices, utilizing best available evidence to minimize conscious and unconscious bias in the hiring process. Available literature suggests that unstructured interviews can be unreliable job performance indicators and increase the risk of evaluating characteristics beyond a candidate’s experience and abilities. Our purpose is to create a framework that produces a more inclusive, transparent, and defendable interviewing process. The goal is to eliminate avenues for bias and prejudice, while emphasizing candidate qualifications based on position description requirements as opposed to undefined concepts such as ‘fit.’ We helped form a committee, which met bi-weekly and comprised representatives from multiple research groups, tasked with redesigning the hiring process. Position descriptions were deemed foundational, each were mined for required qualifications, key responsibilities and core competencies. Standard role-based question sets were created based solely on our thorough review of each position description and the available evidence regarding fair interview questions. An interview question response grading tool was created, utilizing the Qualtrics platform, to numerically score responses in real time and eliminate post-interview group discussion and reflection on unevaluable concepts such as ‘gut feel’ or ‘fit’. Guidelines were created to help standardize communication with candidates, interview structure, numeric scoring of responses, and the resulting translation of overall score into the hiring decision process. Finally, we consolidated our work into a best practices document and piloted our new framework within two research groups, presenting the resulting feedback to department leadership. This process has been implemented in two groups within the department thus far. Qualitative feedback was solicited in several planned sessions, including both the interviewers and interviewees. The feedback received has been overall very positive, with respondents appreciating both the efficient method and the expeditious process for providing and receiving feedback. This will be a continuous process improvement, with changes over time as we continue to receive feedback based upon expanded implementation. It is our goal that a hiring process that is more disciplined, standardized, and evidenced-based will ultimately be more equitable and allow us to draw a more diverse and highly-skilled workforce.

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INTERPROFESSIONAL APPROACH TO MANAGING BISPECIFIC ANTIBODY INDUCED CYTOKINE RELEASE SYNDROME
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Coordination of Care
Bispecific antibodies (BsAbs) are a type of immunotherapy used to fight cancer by helping the body’s immune system detect and target malignant cells. Bispecific antibodies have the potential to induce the release of proinflammatory cytokines. This can result in a condition known as cytokine release syndrome (CRS). Hallmark symptoms of CRS include fever, hypotension, hypoxia, and possible multi-organ failure. As more of these medications are transitioned to the outpatient oncology setting, institutions must prepare staff members to care for patients receiving BsAbs and manage...
CRS reactions. An interdisciplinary approach should be prioritized to align evidenced-based practices and staff education on these topics. The purpose was to optimize the ambulatory interdisciplinary cancer care team’s competence and confidence in caring for patients receiving BsAbs with the risk of CRS development by providing staff education, resources, and treatment order sets. An interdisciplinary workgroup was formed to prioritize staff needs in the identification, assessment, and treatment of patients at risk for BsAb-related CRS in an ambulatory oncology clinic. The workgroup consisted of physicians, pharmacists, nurse directors, clinical specialists, and nursing informaticists. The workgroup met monthly to review current practices, staff and patient needs, safety events related to CRS interventions, and evidence-based information. Gaps identified included nursing education regarding the grading and management of patients experiencing CRS in the outpatient setting, patient education materials related to CRS signs and symptoms, and providers’ ability to order evidence-based interventions for patients experiencing CRS. An order panel was approved in the electronic health record to enhance and standardize symptom management. A multi-modal nursing education plan was developed. In person and on-line unit-based education and in person high fidelity simulation was conducted with nursing staff members. A one-page education reference was distributed to staff members to enhance interdisciplinary education. An interdisciplinary workgroup can successfully create, implement, and use standardized, evidence-based approaches to BsAbs induced CRS management and education. Nursing collaboration with the team was essential to improving patient outcomes and propelling nursing practice forward. Continued safety report monitoring will identify if these interventions have improved patient outcomes and sustained interdisciplinary collaboration.

P273
NURSE TECHNICIANS AND CREATIVE BEGINNINGS IN NURSING
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Professional Development
Building pathways in clinical care often is seen in academic rotations of students gaining their mandatory clinical hours in dedicated education units (DEU). Another model pathway development involves integrating Nurse Technicians (NTs) in paid support staff positions where clinical experience, knowledge & relationships can be cultivated. An NCI designated Comprehensive Cancer Center in a large ambulatory infusion unit (n=175 patients daily) was challenged in staffing coverage for high acuity oncology patients. Current patient volumes are expected to increase therefore a need exists to enhance future nurse recruitment. The purpose was to describe a change in the program for recruitment & orientation of NTs for improvement of current patient/staff ratios & to concurrently supplement future workforce recruitment into oncology nursing. An Infusion leader identified a gap in clinical support staff & collaborated with the education department to design a program for off-cycle hiring of NTs, in spring & summer (“A nurse technician is a nursing student preparing to get an RN” RCW 18.79.340). Infusion department educators & supervisors coordinated special orientation sessions as well as worked with the new NTs’ schedules to create shifts that worked with their school schedules & unit capacity. The program modification to have two cohorts of NTs (spring n=4) (summer n=7) provided an overall increase of 35% in support staff. Accommodating NTs’ orientation while still in school allowed for an increase of available people to work in the infusion center, which was immediately beneficial while also providing additional time for the NTs to build relationships & develop oncology clinical knowledge. Oncology nursing is complex & early engagement with students allows for cultivation of clinical skills for care delivery. The DEU has a residency program for which many of the NTs are currently hoping to apply following graduation. The innovative collaborative program successfully bridged the staffing shortage gap while introducing potential new nurses to a career in oncology care.

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EFFECTIVENESS OF CROSS-PLATFORM ONLINE ACTIVITIES TO REINFORCE NURSE COMPETENCE IN ESOPHAGOGASTRIC CANCER CARE PLANNING
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Professional Development
Esophagogastric cancers are aggressive and have varying clinical, pathologic, and molecular/genetic features. Patients are often diagnosed with advanced disease and suffer from uncontrolled symptoms that impair their daily lifestyle. Rapid advances in treatment and supportive care make it difficult for clinicians to stay
Shared decision making (SDM) is the process by which clinicians and patients make health decisions together, thereby promoting patient-centered care. The SDM process involves an exchange between the patient, who provides insight into their goals, values, and preferences, and members of the multidisciplinary team, who outline the benefits, risks, and uncertainties of care options based on their experience and knowledge of the best available research and guideline recommendations. Despite growing evidence of the advantages of SDM, implementing this process in routine practice has proven challenging. Oncology nurses are integral to SDM in cancer care. Nurses act as a reliable source of information, represent patients’ interests, assess their willingness to participate in decision making, and support patients in nearly all aspects of their care. The purpose of this study is to gain insight into oncology nurses’ experiences of SDM, including challenges of the process and what resources could enhance implementation. Oncology nurses complete a short survey, administered by i3 Health, about SDM in their clinical practice. Data collection and analysis are ongoing. Survey data from 505 attendees at the 2023 Oncology Nursing Society (ONS) Congress and the 2023 Greater Los Angeles ONS (GLAONS) Oncology Care Summit showcased awareness among respondents regarding SDM in oncology practice (Table 1). The majority of nurses (80%) were familiar with SDM and almost all (92%) employed SDM in their current practice. Time constraints were the most commonly cited challenge to implementing SDM, and decision aids/tools were the most frequently cited needed resource (Table 1). In addition, 74% of nurses surveyed would be interested in receiving education on training about SDM.

Nurses are at the frontline of care for patients with cancer. They are pivotal in determining and accommodating patients’ preferences while providing supportive care and have largely adopted the SDM approach. However, oncology nurses and nurse practitioners still face barriers to employing SDM, including time constraints and lack of resources and training in SDM. To encourage the successful adoption of SDM in oncology practice, increased initiatives such as training programs and innovative tools, as well as additional support from organizations and health care systems, should be implemented. Oncology nurses must equip themselves with the essential knowledge, skills, and resources to empower patients to make informed decisions and enhance their quality of life.
TIP SHEETS FOR NEW PATIENT EDUCATION, GI ONCOLOGY INFUSION

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Patient Education and Safety

On the first day of treatment, patients diagnosed with gastrointestinal cancers are often overwhelmed by the amount of information they receive from their oncology team. The complexities associated with this diagnosis contribute to a sense of confusion, distress, and decreased potential for learning. Additionally, infusion nurses underutilize patient education resources. The purpose was to create a multimedia document to enhance infusion nurses’ understanding of best practices for addressing patient learning needs. A survey was distributed to assess feelings of confidence related to accessing and providing patient education using a five-point Likert scale. A team of advanced practice providers, infusion nurses, clinical nurse educators, and dieticians collaborated to review available resources and develop a collection of tip sheets. Topics included safety orientation, documentation of patient education, promoting chemotherapy safety at home, reporting and managing side-effects, and preventing infections. Priority items that must be reviewed during the initial visit were identified along with what topics can be safely deferred to future visits. The tip sheets were distributed electronically and reviewed with the nurses at weekly meetings to ensure understanding of the tip sheets’ contents and the purpose of the project. Nurses would review the tip sheets prior to a new patient encounter or bring the tip sheets to the education session to guide the conversation. This document also provided a directory of available patient education resources. After implementation of the tip sheets, a post-intervention survey was distributed to the nursing staff to determine if the implementation of the tip sheets improved levels of confidence in the same domains as the pre-intervention survey. The survey identified an average increase of 1.44 points across all six questions, raising the initial overall score from 3.18 to 4.62, with the majority reporting feeling “extremely confident.” Information related to patient education resources available through the hospital system was considered very helpful. More work needs to be done to assess patient perceptions of the education they receive and to develop a standardized patient education curriculum that spans the entire cancer care continuum.

FOSTERING EFFECTIVE ORGANIZATIONAL COLLABORATION TO ESTABLISH AN ONCOLOGY TRANSITION TO PRACTICE (OTP) PROGRAM

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Professional Development

Oncology nursing is a rapidly growing specialty in acute care, requiring strong foundational knowledge not often taught in school. In fact, there are significant disparities in such education and clinical training in nursing curricula which illuminates a need for organizations to bridge the gap. To create and sustain a strong Oncology Transition to Practice (OTP) program, teamwork and collaboration must exist between operations, education, and practice experts. In 2019, the institution increased from 2 dedicated oncology units to 6, with a 133% increase in patient capacity. Inpatient oncology units struggle to fill vacant clinical positions, and significant variations in inboarding and training highlight the need for a standardized transition to practice program. An intraprofessional oncology workgroup was established to collaborate and implement an OTP Program to meet the needs of novice oncology nurses. The workgroup included Oncology Operations (i.e., directors and managers), professional practice (i.e., Clinical Nurse Specialists (CNSs) and Unit Educators (UEs)), and education (i.e., Nursing Professional Development Specialists (NPDSs)). A gap analysis was conducted, and the workgroup met on a cadence to identify program outcomes, content, implementation plan, and evaluation methods (January to July 2022). Roles and responsibilities were identified within the workgroup. NPDSs were tasked with facilitating the 9-month OTP Program. CNSs were tasked with providing expert opinions on the structure and methods used in the program. Operational leadership coordinated staff schedules and provided feedback on individual needs. Post-OTP pilot implementation, the NPDSs conducted evaluations with operational leadership to assess the program’s feasibility and effectiveness; 13/16 managers responded. 100% agreed or strongly agreed that the overall program was sufficient to support nurses’ transition into oncology nursing, was well organized, and consisted of an appropriate amount of work. 100%
also agreed or strongly agreed that the NPDSs were approachable and effectively facilitated the program. The implementation of an OTP program necessitates the need for organizational support and collaboration between oncology operations, education, and practice. The workgroup will continue to review the content annually to keep topics current and evidence-based. With program implementation, evaluations from both nurse participants and workgroup leaders will be collected.

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CREATING A PIPELINE OF ONCOLOGY NURSES: USING A TRANSITION TO PRACTICE MODEL
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Professional Development

Oncology nursing is a specialty requiring education beyond academic preparation and acute care experience. Creating and sustaining an oncology nursing workforce has limitations, especially the lack of oncology-trained nurses. Solutions include innovative recruitment and retention strategies such as continuing education programs. An Oncology Transition to Practice Program (OTPP) featuring an Oncology Class Series (OCS) and Chemotherapy Simulation Class (CSC) was developed in August 2022. This project aims to create a sustainable, standardized transition to practice program to build a pipeline of empowered oncology nurses. The OTPP targets novice inpatient oncology nurses, including experienced nurses and new graduate nurses. Elements of the OTPP include an OCS and a CSC to standardize didactic and skill training. The OTPP is led by Oncology Nursing Professional Development Specialists (NPDS). The curriculum was created based on learning needs and stakeholder recommendations, including Clinical Nurse Specialists (CNS) and Unit Educators (UEs). Faculty includes Advanced Practice Providers, CNS, Clinical Nurses, Chemotherapy SuperUsers, and UEs. The OCS occurs bi-annually and is divided into 2 pathways: Hematology/Oncology and Bone Marrow Transplant / Cancer Cellular Therapy nursing. To promote sustainability and accessibility, sessions are available On-Demand and open to all nurses in the organization. Contact hours are offered for each session to incentivize nurses. The CSC provides a safe learning environment for computer and hands-on skills training for hazardous drug administration. Practice experts verify skills by return demonstration. Pre and post-tests are conducted to assess learning. The OTPP creates a pipeline for nurses interested in furthering oncology education. 79 nurses have successfully completed the OTPP. To date, the annual retention rate of OTPP participants is 96%. To date, the OCS has had 316 learners attend the live classes and 276 learners access it on-demand for a total of 592 learning events. Participants who attended the CSC demonstrated an 11% increase in post-test scores. 98% of learners were engaged and reported the class would contribute to their future success. The OTPP provides a sustainable and standardized approach to delivering oncology nursing education. Future plans for the OCS and CSC include gamification of learning activities and increased fidelity simulation. The next steps for the OTPP is to seek accreditation per the ANCC Practice Transition Accreditation Program standards.

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EDUCATION 101-KNOWLEDGE IS POWER
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Professional Development

Since the COVID-19 pandemic there has been a high turnover rate of nursing staff in the outpatient cancer center infusion area. This has led to the hiring of nurses with no oncology experience. From March 2020 to March 2023, there were 10 nurses hired that had infusion experience but no oncology experience. Due to hiring these non-experienced oncology nurses, the nurses within the clinics experienced an increased workload to an increased number of calls from the infusion center and patients. This increase in workload was brought to the attention of management with a proposal for educational sessions to increase the knowledge and confidence of the new nursing staff. The purpose of this project was to provide all staff with educational opportunities to increase knowledge and confidence in caring for oncology patients. An experienced oncology nurse and management created an education plan to be rolled out to all nursing staff and non-nursing staff. Educational sessions were held live monthly and offered via Microsoft teams for offsite members. The slides were provided for those attending the live session and then emailed to all staff after the presentation. The educational sessions were conducted by different oncology staff members including physicians. To gain the most participation the educational sessions were...
capped at thirty minutes to allow staff time to attend. As a result of the educational sessions the clinic nurses have noticed a decrease in the infusion staff calling to request information. Infusion staff have shown an increase in knowledge and confidence in caring for oncology patients. Individuals with little or no oncology experience comes with great responsibility to make sure these individuals are not only trained for their job but also knowledgeable about the unique care of oncology patients. Oncology nurses need to be equipped and able to competently respond to a patient’s question about side effects, drug information, and/or disease status. Providing educational sessions for all nurses in the clinic about disease types, oncologic emergencies, and basic overview of radiation therapy provided the nurses with the seed for critical thinking related to oncology patient care. Support from advance practice providers and physicians by attending the session and providing education helped enhance the teamwork within the clinic and increase the confidence levels of the staff.

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EDUCATING NON-ONCOLOGY NURSES ABOUT ANTINEOPLASTIC DRUGS AND SAFE HANDLING: A VITAL INVESTMENT FOR PROTECTING HEALTHCARE WORKERS AND PATIENTS

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Oncology Nursing Practice

Antineoplastic drugs are a diverse group of medications that help treat various cancers and other diseases, including autoimmune disorders, ectopic pregnancy, and post-transplant rejection. As the use of antineoplastic drugs has expanded beyond the oncology setting, non-oncology nurses are increasingly likely to encounter these medications in their practice. Non-oncology nurses who handle antineoplastic drugs are at risk of occupational exposure to these medications. Occupational exposure can occur through inhalation, skin contact, or ingestion. Exposure to antineoplastic drugs can have various health consequences, including cancer, reproductive problems, and congenital disabilities.

**Purpose:** Increase knowledge regarding the safe handling of antineoplastic drugs to reduce accidental exposure among non-oncology nurses. Make it a mandatory requirement to attend “antineoplastic therapy for Non-oncology” training before handling any antineoplastic drug among new and existing employees. Followed by annual online modules to maintain the competency and knowledge of Hazardous drug safe-handling guidelines. Antineoplastic drugs and safe handling training include:

- Didactic training, such as classes, workshops, and online courses.
- Hands-on training, such as simulations and mock chemo spill.
- Provision of educational resources, such as policies and procedures, safety guidelines, and patient education materials.

The effectiveness of educational interventions to improve knowledge and skills regarding the safe handling of antineoplastic drugs among non-oncology nurses was measured by collecting data on the number of participants. Data shows that around 350 non-oncology nurses attend this class every year. Data suggests that the educational interventions are well-attended and that there is a high level of interest among non-oncology nurses in learning about safe handling practices. However, more data is needed to assess the impact of educational interventions on nurses’ knowledge, skills, and practice. The oncology service line provides hazardous drug safe-handling training to non-oncology departments, and the course is well-received. Staffs have reported that the course is easy to understand and has improved their knowledge of safe-handling guidelines and the need for PPE to reduce exposure to antineoplastic drugs.

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OCN STUDY SESSIONS: PREPPING FOR CERTIFICATION SUCCESS

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**Professional Development**

The Nursing Professional Development (NPD) team coordinates a biannual Oncology Nurse Core Curriculum program as a preparation for the OCN certification. Based on program evaluations, the NPD team identified the need for individual studying support to further prepare for the exam. A nurse leader and NPD specialist, who both maintain their OCN certification, collaborated and formally surveyed all nursing staff, further validating the need for additional educational support. The study sessions promote the ongoing process of learning and colleague support, while also improving certification percentages. Certification enhances the knowledge and practice of the registered nurse, directly impacting patients across the care continuum. The study sessions provide an opportunity for professional growth development and clinical expertise. Acting as the nurse facilitators, the nurse leader and NPD specialist offered supplementary study sessions every...
other month. The study sessions, in addition to attending the Oncology Nurse Core Curriculum program, are unique opportunities to learn from the facilitators and fellow colleagues, while bringing questions in regard to the OCN content. Nursing Continuing Professional Development (NCPD) contact hours are also awarded to attendees. An online nursing forum was created for nurses who attend the study sessions to share information and support each other as a complimentary form of support. This forum allows for ongoing interaction, support, and feedback while preparing for certification. Since the implementation of the study sessions, two RNs have successfully achieved their OCN certification. In the study session program evaluations, attendees have stated that the sessions are valuable and have helped them further identify content areas in need of improvement. The majority of attendees have stated that they plan to sit for their certification exam within three to six months after attending. The study sessions and additional resources offer support with the goal of increasing staff certification by a minimum of five percent within a year of implementation. The nurse leader and NPD specialist saw value in supporting staff nurses who are looking to grow personally and professionally through certification. Oncology care is a complex evolution of new information and research, shifting of paradigms, and improving clinical practice. Certification empowers the oncology nurse and strengthens their proficiency and commitment to patient-centered care. Certification is the pathway to grow leaders within our organization, influencing and driving patient outcomes.

P282
CLINICAL DEBRIEFING: THE PRACTICE NURSES DIDN’T KNOW THEY NEEDED
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Oncology Nursing Practice
Due to rapidly changing hospital procedures and guidelines, today's high demand healthcare environment burdens its nursing staff with high acuity and low staffing. Through a review of the literature and an environmental scan of our facility, it has been identified that support must be given to nurses, in the form of self-care and clinical debriefing. It is important that nurses maintain a work life balance and the desire to practice oncology nursing, by incorporating debriefing into the workday. There are evidence-based interventions that can make a difference in a nurse's quality of life, both in the workplace setting and their personal life. Nurses have a crucial role in providing patient care, but little attention is given to their own health promotion, which directly impacts patient care. In collaboration with social work and a Psychiatric Mental Health Nurse Practitioner, two Nursing Professional Development Specialists implemented clinical debriefings with staff on inpatient oncology units. The clinical debriefings took place after a critical event or serious clinical situation identified by nursing department staff with a goal of positively impacting the staff’s stated well-being and job satisfaction. A facilitation guide was utilized to structure the clinical debriefing sessions. Participants were provided education and instruction on the purpose of clinical debriefing. All members of the nursing department had the opportunity to attend. Understanding that patient care demands at times prevented us from an immediate debriefing, a conference room was secured for a quiet environment post-shift. Two tools were utilized to individually measure stated well-being and job satisfaction. The tools were offered to the nursing department prior to implementation as an evaluation of their current state. After implementation, the evaluations were offered again, to measure impact. The aim of implementing clinical debriefing for members of the nursing department is to enable them to apply this skill, as needed, in practice. By guiding initial debriefings and offering a clinical debriefing tool to structure the activity, the nurses will be empowered to continue this practice on their own in our absence. Supporting nurses through debriefing offers them the individual skills to practice independently.

P283
USING A NURSE-DRIVEN ALGORITHM FOR ORTHOSTATIC VITAL SIGNS TO PREVENT FALLS IN THE HOSPITALIZED ONCOLOGY PATIENT.
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Oncology Nursing Practice
Orthostatic hypotension is a condition in which a patient’s blood pressure significantly decreases during standing. This drop in pressure can lead to patient falls. Evidence shows that oncology patients are at an increased risk of falls when hospitalized. Studies have also shown that they are at an increased risk of orthostatic hypotension. An inpatient oncology unit at a large academic cancer center, reviewed data surrounding patient falls on their unit. It was found post fall, many
of the patients were orthostatic positive. Interestingly, these patients were often rated a low to moderate falls risk before the event. These results triggered a review of process for obtaining orthostatic VS. Obtaining VS are within the nursing scope of practice and do not require a provider order. The purpose of this project was to develop and implement an algorithm, to be used by the RN, to determine who would benefit from daily orthostatic VS. By obtaining daily orthostatic VS, patients who are positive for orthostatic hypotension can be identified as a high falls risk with appropriate interventions. An interdisciplinary team comprised of nurses and advanced practice providers met to discuss the parameters for the RN driven algorithm. The algorithm incorporated patients who have received chemotherapy, febrile patients, and previously orthostatic positive patients. Those who fell within the algorithm would have orthostatic VS obtained for 48hrs. Staff education was provided during staff meetings and brief huddles. Education included a didactic portion and demonstration of proper technique. Written education was provided to patients regarding our initiative, and guides were placed within the nursing workroom and on the vital cart machines. Progress in this initiative was measured through daily audits. Audits identified if the algorithm was used correctly, and if the patient was orthostatic positive when vitals were obtained. Orthostatic positive patients were audited for fall precautions, and interventions placed. Early results show a decrease in falls when compared to a similar time period last year.

Discussion: This project demonstrates the importance of using the full scope of nursing practice and implementing new strategies in an attempt to prevent falls.

P284
SUPPORTING THE VOICE ON THE OTHER END OF THE LINE: CREATING AN EDUCATION SERIES TO MEET THE UNIQUE NEEDS OF ONCOLOGY TELEPHONE TRIAGE NURSES

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Professional Development

The continuing education offerings available to oncology nurses target those primarily caring for patients at the bed or chairside. No institution-specific options were available catering to the unique needs of dedicated telephone triage nurses caring for patients by phone. The purpose was to develop a regularly occurring continuing education series tailored to the identified learning needs of a centralized oncology registered nurse (RN) telephone triage team. Feedback from annual oncology nurse revalidation indicated a desire for educational offerings focused on managing symptoms by phone. The Clinical Educator and Clinical Nurse Specialist reviewed survey findings from previous learning needs assessment and filtered telephone triage responses only. Topics were compiled and matched with content experts and potential speakers. A standardized presentation template was created to help presenters organize content specific to telephone triage RNs’ workflow. This included assessment questions, “red flags”, problem identification, advice and disposition, documentation, and case studies. Educational sessions were held twice monthly during 1-hr lunch while phone line closed. Presentations were recorded and continuing education credit offered.

Eight different sessions occurred across four months. Sixteen triage RNs invited to complete baseline and post-intervention surveys. Seven participants completed the baseline surveys rating their knowledge level on various topics using Likert scales. Eight participants completed post-intervention surveys asking similar questions pertaining to the presentation topics to assess for level of self-reported knowledge. There was a decrease in comfortability of nurses current level of knowledge with neurological emergencies (Pre-intervention, 57.1% and 37.5% post-intervention), drain tube management (pre-intervention 85.7% to 37.5%), and wound vac (42.8% to 28.5%). However, participants reported increased comfortability post-intervention with current knowledge of cardio-oncology services (14.2% to 25%) and smoking cessation services (42.8% to 62.5%). 100% of participants rated sessions as very effective or extremely effective in meeting the specific needs of an oncology telephone triage nurse. Initial survey results measuring confidence in knowledge did not improve post-intervention, however, participants indicated the education series effectively met their specific needs. This possibly could be attributed to their feelings of inclusion, collaboration, and support fostered by a dedicated twice-monthly meeting with content experts. Going forward, baseline surveys will be conducted prior to each education session since the original pre-data was not recent. Post-surveys will continue following the education sessions to determine if the content and format meets their learning needs.

P285
IS SOMETHING BETTER THAN NOTHING? FOR ONCOLOGY NURSE RESIDENCY PROGRAMS, IT DEPENDS WHO YOU ASK

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Professional Development

Healthcare systems across the country are struggling with nursing retention. Transition to Practice (TTP) programs positively impact first year nursing retention. A Director of Nursing Education was hired to launch an Oncology Nurse Residency Program (ONRP) to support new oncology nurses at a multi-site comprehensive cancer center. Within three months, ten new oncology nurses were hired across the center. The comprehensive ONRP was not scheduled to launch for six months. To support the influx of new hires, the director led the Nursing Professional Development (NPD) team to implement an abbreviated version of the ONRP while continuing to build the full program. The purpose was to support the TTP of new oncology nurses hired prior to launching a comprehensive ONRP by providing a mini-ONRP. Within six weeks, the NPD team created a mini-ONRP consisting of three in-person, 4-hour classes to supplement online modules that were already being used to support orientation. Content included foundational information on cancer biology, treatment modalities and symptom management. Classes incorporated skills stations to practice competencies such as intravenous catheter insertions, venipuncture, central venous access device management, and safe administration of hazardous drugs. Content created for the mini-ONRP was designed to be incorporated into the comprehensive ONRP in the future. Class evaluations measured pre and post confidence levels related to oncology nursing competencies. Fourteen new oncology nurses, including seven new graduate nurses, participated in the mini-ONRP. First year turnover for participants in the mini-ONRP was 36%, compared with 33% for nurses across the healthcare system. Surveys showed increases in confidence levels for all competencies and participants reported at least a 50% increase in confidence for five competencies: use of a closed system transfer device (72%), responding to a chemotherapy spill (61%), navigating the chemotherapy administration policy (55%), providing patient education about treatment side effects (50%), and accessing an implanted port (50%). For stakeholders looking for an increase in first year nursing retention, the mini-ONRP did not meet expectations. However, participants reported significant increases in their confidence performing oncology nursing competencies, many of which are related to high risk nursing activities. Resources used to develop classes were well spent since the content has been incorporated into a comprehensive ONRP.

P286

EFFECT OF EDUCATION ON NURSES’ KNOWLEDGE AND USE OF PATIENT SUPPORT RESOURCES

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Coordination of Care

After facing a life-changing medical event, patients are often left emotionally distressed, requiring additional support. Unfortunately, these needs are often left unmet due to the lack of knowledge and utilization of inpatient support resources by nurses. Ensuring that patients have access to services like pastoral and palliative care, community groups, and other therapeutic resources is vital to improving patient outcomes and patient satisfaction. To increase the utilization of these resources, nurses need education on the available resources and how to access them. The goal of this project was to increase knowledge and utilization of inpatient support resources by nurses through the implementation of an easily accessible Patient Care Resource poster, outlining information on the available patient resources offered by Thomas Jefferson University Hospital (TJUH). A pre-implementation survey assessing nurses’ comfortability, knowledge, and the effectiveness of using patient care resources was conducted on three TJUH nursing units (Bone Marrow Transplant, Oncology, and Acute Stroke). Using this data, a Patient Care Resource poster was created outlining the available patient resources and the corresponding contact information. The poster was easily accessible and posted at each of the unit’s nurses’ stations. A final survey was conducted to evaluate the effectiveness of the Patient Care Resource poster. The collected nurse-reported data demonstrated that the Patient Care Resource poster effectively increased nurse’s knowledge and utilization of the services offered by TJUH. In the pre-implementation survey, 62.5% of nurses reported they felt knowledgeable of services offered. In the post-implementation survey 75% of nurses reported that they felt knowledgeable about the services offered. Providing nurses with the education and tools on what patient care resources are available and how to utilize them is...
vital to improving patient outcomes and satisfaction. Continuing to update the Patient Care Resource poster when new services are introduced or contact information changes is imperative to the long-term success of this project. A Patient Care Resource poster can easily be implemented and tailored to different institutions and patient care areas.

**P287**

**DEVELOPMENT OF WEB-BASED ENRICHMENT PROGRAM OF EGFR-TYROSINE KINASE INHIBITOR INDUCED CUTANEOUS TOXICITIES FOR ONCOLOGY NURSES IN TWO REGIONAL HOSPITALS OF HONG KONG**

**Sau Nok Law, RN (General), BHSc, MSc, PRCC (Oncology), United Christian Hospital, Hong Kong, Professional Development**

EGFR-tyrosine kinase inhibitors (EGFR-TKI) are developed to block the signal transduction cascades in EGFR which stop the tumor growth and is associated with cutaneous-related adverse events. According to the competency self-assessment survey conducted in oncology unit of two regional hospitals (United Christian Hospital, bed statistics: 1,174; Princess of Margaret Hospital, bed statistics: 1,700 beds), inadequate knowledge, feeling unfamiliar and unconfident, lack of nursing resources towards EGFR-TKI treatment are the main reasons for nurses to hesitate to perform nursing assessment proactively. An enrichment program in July – September 2022 have been designed to strengthen the knowledge of oncology nurses and equip them with skills on caring patients who are suffering from cutaneous toxicities induced by EGFR-TKI as well as demonstrate appropriate assessment and nursing care to the patient with cutaneous toxicities. The program is including an online lecture distributed by Nearpod (an online learning platform to integrate activities – multiple choice gamified quizzes and interactive video with content delivery and tracked records), pre-test and post-test questionnaire and evaluation interview. All the recruited nurses (n=51) completed the pre-test and post-test. The response rate is 100%. For the pre-test, the mean score is 40% and the scores ranged from 10% to 70%. Regarding the result of the post-test, the mean score is 92.9%. In an qualitative interview with nurses, they expressed that web-based learning represented more flexible learning approach. They are in full control and accountability for their learning and self-allocate time and place for their learning without affecting their job routine. Nurses are in the ideal position for the management of EGFR-TKI related cutaneous toxicities to maintain patients’ quality of life and promote treatment adherence.

**P288**

**BATTLING AN INCREASE IN ONCOLOGY SERVICE DEMAND: STRIVE FOR EXCELLENCE ON STAFF COMPETENCY**

**Sau Nok Law, RN (General), BHSc, MSc, PRCC (Oncology), United Christian Hospital, Hong Kong, Professional Development**

United Christian Hospital, a regional acute hospital in Hong Kong, is undergoing reconstruction to reinforce and expand oncology services. There are 5% growth in patients in total chemotherapy clinic attendances annually and turning out an increase in service demand. However, there are approximately 50% of new nurse comers who joined Department of Oncology with below 3 years seniority and had not been undergo specialty training. With insufficient skills and knowledge, it would affect clinical decision as well as patient safety. As a result, we designed an enhancement project aimed at improvement of staff competency and facilitation on nurse’ transition in Department of Oncology. Objectives were as follows:

- To enhance staffs’ knowledge and competency in handling oncology patients
- To equip newly-joined nurses with professional skills in delivering safe practices especially in high-risk procedures
- To facilitate smooth transition into work duties
- To increase sense of belongings

Training plan and materials have been developed. 28-days structured nurse training has been delivered for newcomers including lectures and hands-on workshops by various medical, nursing and allied health specialists, intra-hospital and inter-hospital visitations. The training domains consisted 7 parts: Chemotherapy and Hormonal Therapy Nursing, Biotherapy Nursing, Cancer Pain Management, Clinical Management of Major Cancers, Palliative Care, Radiological Nursing, Care of patient with Oncological Emergencies and Complications. Moreover, spillage management guideline has been redefined. Establishment of spillage workshop including spillage audit and care of central venous catheter workshop have been conducted to all nurses. An evaluation form was also contributed to nurses to collect feedback. All newcomers successfully completed in-service training and passed the post-training assessment. Newly-joined nurses agreed that the training equipped their clinical knowledge and competency and expressed more confident on handling oncological procedures (Mean score: 4.56 out of 5). Respondents
reported that the program achieved its stated objectives (Mean score: 4.94 out of 5). 100% compliance rate of nursing quality audits on spillage management and care of central venous catheter have been recorded. The enhancement project not only enhancing staffs’ competency, but also facilitating smooth transition into work duties. Trainings and audits are expected to provide yearly to monitor progress of competency and ensure quality and safety in oncology services.

P289
LET’S TALK ABOUT IT: ADDRESSING SEXUALITY & INTIMACY CONCERNS IN THE GERIATRIC AND PALLIATIVE CARE POPULATION.
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Professional Development
As palliative care providers, we are charged with providing holistic, person-centered care, with an emphasis on addressing and improving one’s quality of life. Utilizing a sex-positive lens, intimacy and sexuality are critical dimensions of the whole-person approach, yet these topics often go unaddressed with seriously ill adults. The research, albeit limited, highlights that patients living with serious illnesses want to discuss concerns around sexuality and intimacy and want education on how to manage side effects of cancer therapies that impact sexual functioning, but these concerns often go unaddressed if the patient is not prompted by a provider. As experts in addressing challenging topics with expert communication skills, PC providers are well-suited to addressing sexuality and intimacy topics in the palliative care encounter. We have experience working with adults living with cancer and we noticed a need for further assessment and education on how best to address sexuality and intimacy with our patients. Education session was provided on relevant terminology and literature (albeit limited) to highlight the significance of this topic through case studies from our adult practice. Identified tools to implement in clinic to assess all patient needs. The aim after this education session was to:
- Upon successful completion – participants will be able to implement a sexual and intimacy assessment into their clinic practice in order identify/discuss patient’s concerns.
- Identify access to resources to meet patients identified needs, including referrals to relevant services and support.
- Identify any quality improvement initiatives to improve patient care.
- Further education for providers and patients.

P290
UTILIZING THE ONCOLOGY NURSING SOCIETY’S ONCOLOGY NURSING PODCAST FOR SYSTEMWIDE ONCOLOGY EDUCATION
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Professional Development
In 2020, the Commission on Cancer (CoC) released a new standard requiring that nurses providing direct care to oncology patients hold an oncology specific certification or obtain oncology specific continuing education hours. The Allina Health Cancer Institute (AHCI) looked to its Oncology Nurse Leader Council (ONLC) for strategies to satisfy this new requirement. Under the direction of ONLC, the Care Task Force, comprised of frontline nurses, creatively met this need by developing recommendations for quarterly mandatory education bundles utilizing Elsevier’s Clinical Skills modules, a vendor already in place at Allina Health. However, the task force recognized that the oncology specific content in Clinical Skills would eventually run out requiring build of new content or a new source. The Oncology Nursing Society (ONS)’s Oncology Nursing Podcast (ONP) was incorporated as a component of the quarterly education bundle starting in Quarter 3, 2023 with plans to continue to use moving forward. The Clinical Nurse Specialist (CNS) for AHCI proposed utilizing the ONP in quarterly bundles to the Care Task Force. The group was supportive and developed recommendations for the first topic. After approval by ONLC, the CNS engaged with Allina’s Learning and Development Team to build the module. Evaluation is ongoing, but anecdotal results have been overwhelmingly positive. The CNS also engaged ONS leadership to track any metrics from their vantage point. To assist oncology nurses and their leaders with this innovative initiative, tip sheets and a video were developed to demonstrate setting-up a free ONS account and accessing the podcast and evaluation. Leaders were given the ordering numbers for headphones, so they were prepared when the bundle released. The ONP provides an alternative format to a traditional virtual module and exposes nurses to a wide variety of topics and speakers. Additionally, this approach serves the dual purpose of promoting and preparing nurses for certification. Utilizing the ONP also provides cost-savings to the organization by avoiding the need to develop and build content.
in-house. The ONP is an innovative approach to providing education to oncology nurses and as well as providing cutting-edge content and supporting certification.

**P291**  
**THE UTILIZATION OF FOCUSED EDUCATION IN EMERGENCY ONCOLOGY NURSING**  
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Oncology Nursing Practice  
In recent years, hospitals have experienced high turnover rates resulting in an influx of new graduate nurses, particularly in specialized areas, such as emergency rooms. While emergency orientation programs currently exist, they lack specific education on oncology care. New graduate nurses lack experience managing oncology patients, especially in an emergency setting. A need for a more thorough and specialized onboarding education was identified and led to the development of the Emergency Oncology Nursing 101 (EON101) course. The purpose of this project was to create a standardized onboarding curriculum focused on emergency oncology care to improve new nurses’ confidence and competence. A literature review was completed using keywords: nurse, emergency department, fellowship, residency, internship, onboarding, orientation, didactic, curriculum, knowledge, competence, preparedness, and confidence. Four databases generated 520 articles, and 12 were kept for review. The literature supported that specialty onboarding programs increase nursing confidence and competence, which in turn improves nursing retention. Collaboration between the Nurse Educator, Clinical Nurse Specialist, and registered nurses led to the development of a 3-month specialized onboarding program. Lesson plans were focused on oncologic complications and emergencies. Lessons included both instructor-led didactic content and hands-on simulation learning. Implementation of the first cohort of eight nurses was completed in Spring 2023. The two primary outcomes measured in this project were nurse competence and confidence. Competence was measured through completion of pre and post lesson tests measuring knowledge gain. Comparison of pre and post test scores showed an increase from an average score of 61% to 80%. Confidence levels were measured through a Likert scale and open response surveys completed after simulation days and at completion of the program. All 8 participants responded “agree” or “strongly agree” to feeling more confident managing oncologic emergencies. This program was inspired by the need for a more standardized onboarding education specific to managing oncologic emergencies. The results of the tests and surveys indicated the participants felt more confident and competent at completion of the program. In addition to the required departmental courses, EON101 has become part of our new graduate onboarding process. It is our recommendation that institutions should consider development of onboarding education specific to their patient populations to improve nurse confidence and competence.

**P292**  
**SPOTLIGHT ON ONCOLOGY CARE: ONE TEAM’S INTERDISCIPLINARY APPROACH TO EDUCATION**  
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**Treatment Modalities**  
Due to the complex and constantly changing nature of oncology practice, healthcare workers are challenged with maintaining knowledge of current treatment landscapes. Leaders are required to develop creative education methods to keep oncology practitioners current on literature, guidelines, and recommendations. The purpose was to enhance oncology practitioner understanding and comfort around cancer diagnoses, management and treatment modalities. A team of oncology practitioners consisting of pharmacists, nurses, and advance practice personnel (APP) met monthly to establish a “spotlight” on learning in the form of a poster. The spotlight focuses on the cancer type that is represented by the present cancer awareness month as specified by the American Cancer Society. Specific drug categories and hot topics in cancer care such as survivorship and LGBTQ considerations are highlighted. Accompanied by this are continuing education activities to reinforce learning. Educational videos are produced by the interdisciplinary team highlighting learning points in the form of music, dance, or skits and posted on the institution’s social media pages. The package of spotlight, CE, and videos are presented at all possible outlets such as shared governance councils.
and daily/weekly huddles and meetings. A survey was sent to oncology practitioners to assess effectiveness of communication and quality of content. Based on the survey results, the implementation of multiple education modalities resulted in improved staff engagement and awareness of oncology topics. Suggestions for future use are: to extend the opportunity for a variety of staff members to participate in the preparation of educational materials, and plan scheduled feedback from staff at a specific cadence. Further development of this activity could also include assessing understanding of information shared.

**P293**

**CHANGING PERCEPTION OF REMOTE TRIAGE**

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**Coordination of Care**

There is a perception that remote triage nurses, are not able to fulfill the patient/physicians needs that are typically met by the role of a traditional in-clinic triage nurse. The purpose was to educate Clinic staff and providers on the ability and benefit of managing triage remotely. Meeting 1: Zoom Meeting; Overview of Remote Triage Process and information gathering on clinic needs. The Staff Included in discussion: Regional Director, Office Manager, Assistant Office Manager, Clinical Nurse Manager. Follow up tasks: Begin to complete Physician preferences sheets. Communicating the importance of buy-in of physicians and staff members to support successful implementation of Remote Triage. Use of standardized templates to communicate with physicians. Meeting 2: Zoom Meeting; Go Live Meeting The Staff Included in discussion: Regional Director, Office Manager, Assistant Office Manager, Clinical Nurse Manager, any staff that is involved in triage daily. Confirmation of Clinic and Physician Preferences, confirmation of Go Live Date, discussion of prep work for Go-Live (cleanup of the triage report prior to Go Live). Addition of Staff to Teams Channel and Email groups. Introduction of team (remote and in office) in face-to-face meeting for benefit of cohesive teamwork. Meeting 3: Zoom Meeting; Post Go Live. The Staff Included in discussion: Regional Director, Office Manager, Assistant Office Manager, Clinical Nurse Manager. Discussion points: What is working? What is not? What can be done differently to successfully collaborate for greater success? Ongoing Meetings: Quarterly Follow-ups. The transition of Clinic Triage to Remote Triage began in Q 4 of 2021 with two clinics, due to a need to manage triages in a timelier manner and address nursing shortages. It is evident that proper education with leadership, physicians and clinic staff is essential. As Remote Triage was piloted in additional clinics, the educational material was adapted and refined to meet the need of the audience. Streamlined processes allowed the team to implement services in a shorter timeline, while maintaining quality care. There is now an appetite to expand this program practice wide.

**P294**

**EMPATHIC DISTRESS RECOGNITION IN ONCOLOGY CLINICAL CARE AND RESEARCH WORKFORCE MEMBERS**

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**Psychosocial Dimensions of Care**

Literature supports the high incidence and prevalence of empathic distress experienced by oncology clinical, scientific and support staff. Research has demonstrated empathic distress is a phenomenon which can result in loss of ability to care of self and others as well as burnout. Empathic distress implicitly affects staff retention. Neuro-science research confirms that empathic distress can be mitigated with compassion recognition and training. In a large NCI designated comprehensive cancer center ambulatory clinic empathic distress was identified as an essential workforce challenge to be acknowledged and addressed for increased staff satisfaction, workplace harmony and job retention. The purpose was to establish a program of empathic distress fatigue education for skill building experiences to promote awareness and engagement in self-compassion and mindfulness practices. An advance practice nurse (APN) educator convened an initial CE accredited program partnering with a Spiritual Health practitioner. Content was delivered via live webinar and recorded for on-demand viewing. Content review documented (n=147) views with feedback surveys (n=81). Content analysis of the feedback surveys confirmed evidence of the importance of the acknowledgement of empathic distress among oncology clinical practice. Feedback identified the need of continued engagement on empathic distress across interdisciplinary teams. Additional seminars were designed and delivered across dis-
Disciplines, (new graduate RN residency program, nursing students, unit staff meetings, and cancer information specialists). Oncology nurse educators facilitate building capacity for intentional addressing of mindfulness and fostering a shared acknowledgement of grief and suffering. Besides designing and offering formal classes on empathic distress APNs serve in consultative roles across the cancer center to encourage integration of this content to groups such as scientific animal research, cancer information services and administrative departments. Creating a community of shared dialogue and recognition of empathic distress allows individuals to increase job satisfaction and commitment to the workplace. Creating a system for ongoing seminars and course work on empathic distress is a priority to support oncology and scientific staff. Organizationally addressing empathic distress can effectively build a workplace where recruitment and retention are successfully attained, and best outcomes are realized in the care of oncology patients.

P295
BRINGING ONCOLOGY EDUCATION TO IN HOME URGENT CARE PLUS
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Coordination of Care
According to a study from JOCO, in the year after diagnosis; 71% of individuals with advanced cancer had at least one hospitalization, and 16% experienced three or more hospitalizations. 64.1% of these hospitalizations originated in the ED, which suggests that they were not part of the planned trajectory of care (Whitney et al., 2017). In April 2021, UPMC Hillman Cancer Center in collaboration with UPMC Health Plan created a novel nurse navigator position to decrease readmission rates in the Hematology/Oncology patient population. The nurse can refer patients to programs and services offered at both The UPMC Hillman Cancer Center and The UPMC Health Plan. In Home Urgent Care Plus (IHUC+), a team of advanced care paramedics connected to physician providers, who deploy to the homes of UPMC Health Plan members to help prevent unnecessary ED visits and related admissions, who require urgent assessment and treatment and available to take calls 24/7/365. Since the creation of the program, the nurse navigator collaborated with peers across the systems to bring various formalized oncology training to 19 advanced care paramedics. The medics were given access to 37.75 hours of onboarding education led by nurse educators through the Cancer Center education department. Topics included introduction to oncology for the healthcare provider, and five-part foundations to practice series which reviewed symptoms, emergencies, solid tumors, and hematology. The nurse navigator partnered with the nurse educator to train the medics on implanted ports via 2-hour classroom instruction and 2-hour clinical rotation. Both trainings included accessing, blood specimen collection, central line blood culture collection, and de-accessing an implanted port. Each medic was offered 4-hour clinical shadowing experience in the UPMC Shadyside Hospital oncology emergency department. In partnership with CarePath RX, medics most recently completed 2-hour classroom training on chemotherapy takedown when infused via CADD pump. This skill will be available through IHUC+ in times where the alternative would be for patients to go to ED in 2024 following completion of clinical rotation. Through this partnership it is estimated that each medic has completed over 47 hours of oncology specific training. From September, 2022-August, 2023 the medics received 51 oncology specific referrals resulting in 38 completed visits. Of the 38 (75%) completed visits 32 (84%) remained home who otherwise would have sought treatment in ED.

P296
EMPOWERING THE NEXT GENERATION OF ONCOLOGY NURSING: FINDING YOUR EXPERTISE, PASSION, AND IDENTITY
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Professional Development
A hospital network’s integrated community cancer center did not formally provide oncology nursing education. Historically, nurses obtained oncology-specific knowledge through on-the-job training and informal mentorships. These factors led to nursing staff lacking oncology knowledge and professional identification. Network nurses administering chemotherapy are required to hold an Oncology Nursing Society provider card. Provider course objectives focus on safe handling and administration of hazardous drugs. This course does not comprehensively address disease state, diagnosis, symptom/side effect management, or supportive care. Pre-licensure academic education does not
significantly address oncology care. Given the lack of formal educational opportunities, nurses working in oncology need baseline knowledge to care for the patient population. The purpose was to increase nurses’ foundational oncology knowledge while fostering identity as an oncology professional. A disease site-based curriculum was developed using evidence-based practices in oncology nursing. Subject matter experts contributed to the creation and delivery of nurse-centric content. The course was four classroom days. Each cohort consisted of 25-30 learners. Each learning module utilized a pre/post-test approach to assess for increasing oncology knowledge. Attendees completed a survey about their self-identity as an oncology nurse. An opinion survey was deployed and reviewed after each session. Education specialists adjusted content, handouts, and delivery methods to improve outcomes and for continuous quality improvement based on respondent input. Cumulative pre-test/post-test data comparisons for cohorts 1 through 4 showed a 24% increase in oncology nursing knowledge. In addition, 43% of attendees now strongly identify as oncology nurses compared to 18% before attending the Oncology Core Course (OCC). Financial considerations include 32 educational hours for each learner. The initial time for curriculum development was considerable for the clinical education specialists, but maintenance of the OCC requires less education team time. No-show rates and missing, incomplete, or unsuccessful pre/post-tests are areas for improvement. Classroom delivery has been adjusted for more learner engagement based on feedback. Over four cohorts, 90 nurses from inpatient and ambulatory settings have attended the OCC. This comprehensive, nursing-focused program has increased general oncology knowledge, as evidenced by increased post-test scores. The reported increase in self-identification as an oncology specialty nurse is just as meaningful. Providing this education will foster passion and increase the number of well-prepared oncology nurses within the network.

P297
END OF LIFE TRAINING THROUGH THE USE OF SIMULATION
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End of Life
Nurses often lack training on end-of-life (EOL) care which leads to increased anxiety, lack of confidence and may compromise patient and family supportive care. Simulation has been successfully used in nursing education to promote successful transition to practice; however, little is known about the outcomes of simulation for practicing nurses, and there is a paucity of literature about the outcomes of simulation for EOL oncology nursing care. Current practice at our institution was for nurses to learn EOL care experientially with preceptors. Recognizing unmet learning needs for new oncology nurses, we developed an EOL in oncology simulation in collaboration with experts from our state of the art-simulation center to improve nurse’s knowledge, confidence, and comfort with EOL in oncology care. The purpose was to provide new oncology nurses the opportunity to practice complex symptom management and family-focused communication strategies to promote supportive family engaged care at EOL. A high-fidelity simulation was developed with two scenarios in an inpatient simulation room using a high-fidelity mannequin and family member as a simulated participant. In scenario one, the patient has considerable respiratory distress and secretions. In scenario two, the patient is actively dying and the nurse must help the family through the EOL process. Each scenario embedded questions from the family member that were developed from the experiences of oncology nurses working with families at EOL. Debriefing is held by simulation trained oncology educators using the GAS (gather, analyze and summarize) model to promote learning and reflection on practice. Simulations to date (total of 3) have been held with 4 to 8 oncology nurses with 2 nurses as participants and others as active observers. The Comfort with Communication in Palliative and End-of-life Care (C-COPE), and educator developed questions on confidence and knowledge about oncology EOL were administered before the simulation, after the simulation, and three months post-simulation. To date knowledge increased by 100% and confidence by 84%. C-COPE analysis is pending. Discussion: We developed a novel strategy to improve EOL oncology care. Data collection is ongoing; however, formal evaluation and informal feedback is extremely positive. This EOL simulation is filling a critical transition to practice gap.

P298
EMPOWERING ONCOLOGY EXPERTISE: A FELLOWSHIP APPROACH TO NURSE ON-BOARDING
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According to the Oncology Nursing Society’s position statement on the impact of the national nursing shortage on quality cancer care, the nursing shortage will risk the future of quality cancer care. One of the proposed interventions includes innovative education programs to help resolve the nursing shortage. Within this organization, the cancer care service line had a large projected growth from 2021 to 2026 with a growing vacancy rate and longer position fill times. The organization was experiencing challenges in recruiting experienced oncology nurses into open positions as well as experienced nurses in other specialties found limited pathways to move into the oncology specialty. The fellowship program’s purpose was to help with recruitment and retention in the cancer care specialty. To support this growth, a team of nursing professional development practitioners developed a biannual cancer care fellowship. Using the Oncology Nursing Society’s Statement of Specialty, an 18-week nurse fellowship was created. The program focuses on foundational cancer care courses including chemotherapy/immunotherapy administration and the cellular therapy subspecialty. Rotations through inpatient and outpatient sites were incorporated to highlight all areas of cancer care and the trajectory of the patient treatment experience. During the fellowship, 100% of the participants passed the organization chemo test on the first attempt despite chemotherapy/immunotherapy administration being a new competency. Within 5-7 weeks of hire, fellows were chemotherapy certified according to organization requirements instead of waiting up to 12 months from hire in a more traditional orientation plan. At the completion of the first cohort, 100% of fellows stated they recommend the program to a colleague. Stakeholder feedback from nursing leadership and professional development practitioners stated that the fellowship program was preferred over the standard orientation plan. The stakeholders felt that the fellowship program produced well-rounded oncology nurses. For ongoing evaluation, retention within the cancer care specialty will be monitored for each cohort. The fellowship program gave nurses new to the cancer care specialty the opportunity to learn about oncology in a way that made them excited and eager to care for this population. By learning about the cancer care service line, the program developers hope to inspire a passion for the cancer care specialty and help fellows find meaning in their nursing practice.

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Oncology Nursing Practice

An NCI-designated comprehensive cancer center identified the need for standard onboarding of ambulatory clinic nurses across all departments and sites, including medical oncology, hematology, blood and marrow transplant, immunotherapy, surgery, radiation oncology, supportive care, prevention, and nurse navigation. Key drivers included: needing consistent onboarding experiences across the organization and decreasing preceptor burden by early introduction of role-related education and skills. The purpose was to outline the development and implementation of an organization-wide skills day with educational topics applicable to all clinic nursing roles. A project team was assembled, including an Advanced Practice Nurse, 3 Professional Practice Coordinators (unit-based clinical nurse experts), a Clinical Project Manager, subject matter experts from the areas above, and operational and educational leadership. Regulatory requirements, existing organizational policy, orientation standards, class curricula, and known orientation gaps identified by stakeholders were used to create a list of potential education topics, which were further narrowed by applicability to all clinic RN roles. The finalized skills day curriculum for all attendees included: Telephone Triage and Symptom Management, Oncologic Emergencies, and Patient and Family Education including the Teach Back Method. Clinic RN-specific curriculum included: Procedure Support, Needlestick Prevention, Hazardous Drug Safety, and Oxygen Skills. Oncology Nurse Navigator (ONN) role-specific curriculum focused on organizational role and resource utilization. Principles of adult learning were applied to increase engagement, including case scenarios, quiz games, and return demonstration of skills (including mannequin simulation). The organization initiated the Centralized Onboarding Program, with the first Clinic Nurse Skills Day on December 19, 2022. To date, 75 total clinic RNs have been trained over 17 sessions. Department onboarding for clinic RNs was shortened from 6 to 4 weeks. ONN role-specific curriculum was added on
August 24, 2023, and 2 ONNs have been trained. Orientees report an overall positive experience with the Clinic Nurse Skills day and direct feedback has informed curriculum modifications to better meet the orientees’ needs. Preceptors and leaders have expressed that clinic RNs, by reviewing role-specific skills in advance, can optimize department learning with fewer interruptions for training and classes. Lessons learned:

- There are common skills among clinic nurses to create a meaningful skills day, regardless of hiring department.
- In-person education is an important tool to maximize learning retention.
- Continual evaluation and modification of course curriculum is needed to ensure that orientation gaps are addressed.

**P300**

**HARMONIZING CARE ACROSS SITES OF CARE (SOC) WITHIN AN ONCOLOGY SERVICE LINE**

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**Coordination of Care**

Recent SOC changes with payors require that antineoplastic monoclonal antibodies for patients stable on monotherapy regimens and other oncology and supportive care medications move to non-hospital sites of care. Patients may be asked to move their care from a hospital-based infusion clinic to a non-hospital-based infusion clinic. The definitions of regulated (hospital-based) versus unregulated (non-hospital based) SOC are complicated and encompass sites of care, government regulations, and can also be insurance driven. These include behind-the-scenes decisions that can govern where the patient is treated. Oncology care should be evidence-based and harmonized across a system’s sites of care so that SOC issues are not a burden for the patient, caregiver, or oncology staff who provide care. The purpose of this quality improvement initiative was to develop a site of care workflow to assist with identification of patients who may need to be treated in a non-hospital-based infusion clinic while ensuring quality cancer care and a seamless transition for the patient and caregiver. This free-standing oncology clinic underwent numerous changes to adapt policies, procedures, workflows, equipment, and nursing competencies for alignment with the cancer service line. Nursing leadership partnered to implement new policies and workflows so that they are followed by all nursing staff at any outpatient site. For example, all outpatient sites have access to the same chemotherapy and vascular access website for reference, procedures, and nursing competencies. Nursing staff cross-trained at the main campus infusion center and gave input on how to implement new workflows and evidence into practice. These changes allowed staff to feel comfortable working at any site as acuity and staffing needs required. Patient satisfaction scores in this clinic are and staff feedback regarding the changes are positive and a number of nurses and staff have relocated from the main campus infusion clinic to this clinic. The infusion clinic nurse manager, pharmacy manager, and office practice manager report feeling supported and confident that they can provide quality evidence-based care that is harmonized across the cancer service line. Maintaining care for oncology patients within a clinic staffed with clinicians that specialize in oncology and follow evidence-based guidelines and workflows improves patient and staff satisfaction.

**P301**

**UTILIZING GAME THEORY TO ENHANCE LEARNER ENGAGEMENT IN BONE MARROW TRANSPLANT EDUCATION**

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**Oncology Nursing Practice**

A large teaching hospital in New York City, New York conducts a Bone Marrow Transplant (BMT) Education Day five times annually for newly hired nurses and advanced practice providers caring for patients receiving BMTs in the inpatient and outpatient settings. In 2022, 60 nurses and advanced practice providers attended the class, with an increase in attendance in 2023 due to the influx of newly hired staff members, the expansion of CAR-T cell therapy and BMT to the outpatient setting, and the conversion of a medical/oncology unit to a BMT unit, all requiring specialized BMT education. The BMT Education Day consists of a full-day of didactic lectures covering topics including but not limited to an overview of stem cell transplant, precision in research, and adverse events associated with CAR-T and bispecific agents. While the content covered in the lectures is vitally important to the attendees’ practice, facilitators have received feedback from attendees regarding the need for new methods to increase learner engagement and knowledge retention. The facilitators of the BMT Education Day utilized Ka-
hoot®, a game-based learning application, to review questions based on the lectures presented as a way to increase learner engagement and knowledge retention. Two Kahoot® games were created: one for a lecture on common medications used in transplant, and one as an overview of the content covered throughout the day. The transplant pharmacology lecture was chosen for a Kahoot® because the content is dense, and the learners have often reported difficulty in retaining information regarding the various medications utilized for the BMT patient. The Kahoot® as an overview of the lectures throughout the day was chosen as a way to summarize the content that was taught in an effort to improve overall knowledge retention. At the submission of this abstract, the Kahoot® games were utilized at one of the BMT Education Days with an overwhelmingly positive response. Attendees reported that the games helped with their engagement and with their retention and even requested that they be incorporated more throughout the day. Given that there was such positive feedback in response to the game-based applications during BMT day, we plan to continue to utilize Kahoot®, with plans to incorporate it into more of our educational initiatives both at the hospital and system level.

P302
LOCAL ALIGNMENT TO THE ONS MISSION – DEVELOPING REGIONAL EXCELLENCE ONCOLOGY NURSING
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Oncology Nursing Practice
Our professional responsibility as oncology nurses is built on the commitment to remaining up-to-date in the ever-changing field. Conferences and seminars are a robust option to obtain knowledge consistently. Unfortunately, most employers cannot support reimbursing multiple specialized nurses for travel and conference expenses. Apart from local chapter meetings, our local oncology community needed more options for oncology nurse education. This identified need led to the multi-hospital collaboration and structuring of a local oncology learning experience. The purpose was to implement a local ONS Chapter Education Symposium to increase local nursing education and networking opportunities. A committee of six oncology nurses planned and facilitated the symposium. The committee met monthly for 12 months. An assessment was performed to understand the learning needs and interests of the local nurses. Following the identification of learning needs/interests and translation into chosen topics, multidisciplinary speakers were chosen from multiple healthcare institutions in the area. Contact hours were approved through the state nurse’s association and the American Nurses Credentialing Center (ANCC). Individual learning needs assessment (ILNA) coding was purchased through ONS to provide points to certified nurses. External oncology-related vendors were invited to participate in an exhibit fair. Five student nurses interested in oncology were selected to participate in the symposium with a scholarship from the ONS local chapter. There were 44 participants in the 2023 symposium. Pre-survey was conducted to determine participant’s perceived knowledge of each scheduled topic. Options for response were limited, basic, proficient, advanced, and expert. A post-survey was completed following all presentations to track participants’ improvement in perceived knowledge. A learning needs assessment was conducted after the symposium to assess interests for the following year. Implementing a local Oncology Nursing Symposium was an excellent satisfied for oncology nurses local to the area. Participants perceived knowledge of oncology topics showed a significant increase following the symposium. Apart from providing nursing education, the symposium improved ONS local chapter involvement in multi-institution collaboration and provided multidisciplinary networking opportunities. The total profit acquired provides local chapter members with educational scholarships. The symposium positively affected participants’ knowledge and outlook on oncology care, improving patient care in the local area and committing to the mission of the Oncology Nursing Society.

P303
EXPERT TO NOVICE AND BACK: SUPPORTING STAFF DURING A CANCER CENTER RECONFIGURATION
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Oncology Nursing Practice
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Professional Development

In 2022, an NCI-designated cancer hospital underwent a reconfiguration of its largest location, resulting in 132 infusion nurses learning to care for patients in new disease groups. A team of educators, leaders, and clinical nurses came together to plan an extensive educational program to prepare the nurses for the change. The plan included digital learning, experiential learning, case study discussions, multiple job aids, and a real-time support structure. The education spanned five disease groups. Success was tracked using surveys of self-reported knowledge and confidence in caring for new populations. Surveys were conducted pre-intervention and at four time points post-intervention. After intervention and before go-live, every group of nurses surveyed reported increased knowledge and confidence. Additional “at-the-elbow” support was provided to accelerate learning and confidence. By three months post-go-live, 100% of nurses surveyed reported at least “some confidence” in their new disease groups. Over the course of the six months after go-live, confidence and knowledge for all disease groups showed substantial improvement. In designing the educational intervention for this change, the team focused on creating digestible content from multiple complex subjects in oncology. This required teaching critical thinking around drug regimens and symptoms, giving pathophysiology background, and identifying clinical pearls related to drug administration and patient assessment. Staff were active partners in their learning, despite the magnitude of change and competing demands of ongoing patient care. This presentation will address the successes and opportunities identified in this complex education project, with the intent that any cancer center going through a reconfiguration of resources might learn from this experience.

P304
INTENSIVE APPLICATION OF LEAN AND PEER MENTORSHIP RESOURCES TO SUPPORT ONCOLOGIC QUALITY AND PATIENT SAFETY
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Oncology Nursing Practice

A parenteral chemotherapy safety event prompted a review of workflows and cultural barriers within a newly acquired medical oncology practice. Following a comprehensive quality and safety assessment, numerous opportunities were identified to improve patient care, quality, and safety standards to align with current system practice. As a result, a process improvement rapid response team, along with clinical and operational mentors, were deployed to improve the culture of safety. The purpose of this quality improvement project was to demonstrate the durability of Lean process improvement principles, coupled with intensive on-site mentorship as a strategic management intervention in support of patient safety. In collaboration with our Performance Improvement department, Cancer Center operational and clinical workflows were evaluated. Using value-stream mapping, process steps were identified from the nursing perspective for a “critical to quality” safe chemotherapy infusion. Utilizing the define, measure, analyze, improve, and control (DMAIC) process of quality improvement, action plans were developed and implemented to improve both overall chemotherapy safety and nursing perceptions of safety within the Cancer Center. These action plans and clinical oversight were supported by the temporary re-assignment of nursing and operational mentors as identified by service line leadership. Data were gathered at baseline and at 12 weeks after implementation of our quality improvement project. At baseline, infusion nursing staff rated their perception of safety at an average of 3.85/5. The baseline chemotherapy “critical to quality” defect-free administration rate observed was 46%. Ninety days post-implementation of staff-identified projects, we observed a 10% improvement in infusion nursing ratings of safety, and a 12% increase in the defect-free rate of chemotherapy administrations. Intensive mentorship and a focus on lean process improvement has provided this team with the structure to improve overall chemotherapy safety. No chemotherapy safety events have been observed in the months following the rapid response intervention. This team now routinely self-identifies patient safety concerns and positively contributes to system “Heads Up Speak Up” initiatives. Our quality improvement project suggests that intensive mentorship, guided by a focus on Lean process improvement, is a viable strategy to support overall chemotherapy safety. Engagement and empowerment of front-line nursing staff has contributed to care transformation and alignment to current system practice.

P305
INTEGRATING THE ONCOLOGY NURSING SOCIETY’S (ONS) ONCOLOGY NURSE ORIENTATION PROGRAM INTO AMBULATORY NURSE ONBOARDING
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Professional Development

Nursing orientation plays an essential part in providing high quality care for complex oncology patients. Preparing novice oncology nurses with appropriate education and resources to achieve this care is vital. Finding cost effective and innovative ways to deliver evidence based oncology education is crucial. The purpose of this project is to implement and evaluate an evidence based program purchased through ONS into orientation in the ambulatory setting. The program is a 29.7 credit hour online interactive course that includes ONS standards and guidelines. A team of nursing educators and leaders implemented the ONS program as a mandatory requirement to be completed during orientation for any ambulatory nurses that were new to oncology. This program was assigned during week 2 of orientation. The nurses were given a schedule that outlined the expectation of completing the course by week 16, although they had access to the course for 6 months. Nurse educators met with each nurse 2 weeks after enrollment and then monthly until course completion. At week 8 and week 16, nurses completed surveys regarding the ONS program’s applicability to their clinical setting, and whether the course was supportive to their overall orientation. Barriers to orientation and satisfaction were also assessed. Since September 2022, 74 nurses have enrolled. At week 8, 100% (n=22) of survey respondents agreed or strongly agreed that the program was relevant to the setting. This dropped to 83.3% (n=6) at week 16. Ninety-five percent (n=22) of survey respondents at week 8 agreed or strongly agreed that they found the course supportive. This dropped to 83.3% (n=6) at week 16. Cognitive overload and time were the most common barriers reported. Only 3 nurses identified issues with navigating the course. The ONS oncology nurse orientation program provides asynchronous online learning. Utilizing this program provides didactic content at a nurses fingertips without having to hold a formal class expensing human resources and space. Incorporating this program into ambulatory orientation required active involvement from nursing leadership and educators. A clear outline for course completion and collaboration with nursing leadership are key facilitators of program success. Overall implementation of this program was adopted well by nursing staff and fulfilled the knowledge gap for novice oncology nurses.

P306 CROSS-TRAINING APERESIS AND BMT OUTPATIENT CLINIC STAFF

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Coordination of Care

Our BMT Apheresis and Outpatient Infusion Clinic are considered separate departments and are in different locations. With nursing shortages in both departments, management have worked together to cross-train staff. The purpose was to maintain safe patient to nurse ratios by increasing the flexibility of staffing to work in either department. We have trained the nurses from the BMT clinic to administer Autologous Stem Cell Infusions in our Apheresis Department. In return, our Apheresis Nurses have been trained to work in the BMT lab and Infusion at the clinic. We have noted improved nursing satisfaction as it has opened the nurses to learn new skills and experience a side of the patient’s treatment that they have otherwise never been able to see. Clinic nurses have enjoyed being a part of Day 0 and administering the patient’s stem cell. This is often a joyous day filled with hope for our patients and families. The clinic nurses have expressed gratitude for the opportunity to participate in this particular part of the patient journey as it is not something they normally are able to witness. Likewise, the Apheresis nurses enjoy working in clinic when needed and seeing patients months and sometimes years after their transplant. The nursing staff also appreciate leadership’s commitment and creativity in maintaining safe patient to nurse ratios. Our BMT Apheresis and Outpatient Infusion Clinics are located in different buildings about two miles apart. They are managed by different leaders and historically have never shared staffing. With nursing staff shortages experienced in both departments, leadership worked closely together to formerly cross-train nurses from both departments. The results have been very positive with both nurse and leader satisfaction as well as maintaining safe patient to staff ratios.

P307 ANTICOAGULATION MEDICATION ERROR
REDUCTION THROUGH EDUCATIONAL STRATEGIES

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Patient Education and Safety

Anticoagulation medications are the leading cause of acute serious drug events among hospitalized patients. Since 2008, reducing patient harm associated with the use of anticoagulation therapy has been a Joint Commission National Patient Safety Goal. An instance when a patient developed a pulmonary embolism after being discharged with an incorrect enoxaparin prescription for a new deep vein thrombosis prompted a review of current practices related to education for patients receiving anticoagulation therapy. A nurse-driven initiative was implemented to evaluate and improve the workflow for providers and nurses caring for patients receiving anticoagulation therapy and to update educational materials for patients and caregivers. A multidisciplinary group was convened; the root cause analysis (RCA) highlighted several educational and practice gaps including the ordering and prescribing of anticoagulation therapy and the understanding of the treatment and outpatient follow-up plans. Interventions were targeted to improve workflow, documentation, and promote a consistent approach to patient/family education. Following the RCA, five nurses (anticoagulation NP, program nurse, bedside RN, nurse manager and nursing professional development specialist) created patient/family anticoagulation educational resources with the goal of developing best-practice recommendations and consistent information. An Enoxaparin Safety Checklist was created to ensure that nurses understand what needs to be taught and demonstrated for a safe patient discharge and to reduce the variability in care and education. Dissemination and implementation of the teaching tools has occurred through unit in-services, department meetings and individual 1:1 teaching. The incidence of venous thromboembolism (VTE) is increasing due to advances in technology and medical care in the oncology population, especially patients with central venous catheters, patients receiving asparaginase therapy, and patients recovering from surgical procedures. Patients and families require extensive teaching to safely be discharged on anticoagulation therapy. To meet this need, nurses must be empowered with structured tools, such as checklists and evidence-based patient/family educational information, to provide standardized and consistent education for a patient’s successful discharge to home.

P308
AN EDUCATIONAL APPROACH TO SUPPORT CLINICAL TRIAL NURSES (CTNS) TO INCORPORATE PATIENT REPORTED OUTCOMES (PROS) IN CANCER CLINICAL TRIALS

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Oncology Nursing Practice

The value of PROs in cancer trials is increasingly recognized by regulators, clinicians, patients, and advocates to advance understanding of the clinical benefit & tolerability of cancer therapies. Integrating PROs into trials can be an important tool for patient-provider communication to facilitate patient care and standardized collection of disease-related symptoms and symptomatic toxicities of therapy, but requires education related to the use and implementation of these patient-centered approaches. By educating Clinical Trial Nurses (CTN), our goal is to develop buy-in and support for utilizing PROs during early-phase cancer trials to improve clinician understanding of patient symptoms, enhance communication with patients, and allow broader understanding of the impact of treatment. Staff within our office developed an educational plan for CTNs based on the nursing process. This includes a resources page containing an overview PowerPoint presentation, an SOP of the CTNs tasks, workflow, and study-specific PROs templates to help them better understand the key timepoints for PROs collection. We also developed scripted language resources when educating patients about PROs. During an initial meeting with each study team prior to launch of their protocol, we share and educate on the PROs collection process and share available resources. A second meeting is held to show the data visualization program for the PROs collected while on study, which allows study teams to understand patient burden in real time through their trial participation. Our team supports each study team throughout the process, including being present in clinic during consenting, as well as assisting with tracking of PROs completion. We plan to evaluate CTN understanding along with the effectiveness of our
implementation process through face-to-face discussions and development of a follow-up evaluation tool sent to assess understanding, ease of use, need for modifications, and satisfaction. We will modify our processes as necessary to strengthen and ensure success of this important program. PROs are important tools to better understand how our patients feel and function and can provide valuable information about clinical benefit and risk of new treatments. By developing a standardized approach to education on the use and utility of PROs, development of tools to reduce CTN and patient burden, we hope to facilitate use, improve satisfaction, and reduce data missingness in clinical trials.

P309
A NEW APPROACH TO ENGAGE NEW GRADUATE NURSES WITH EVIDENCE-BASED PRACTICE
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Professional Development
New graduate nurses understand the importance of evidence-based practice (EBP). However, some lack the knowledge and skills to integrate EBP into their practice. Providing EBP content during a nurse residency program (NRP) seminar will help support the integration of EBP into practice. New graduate nurses prefer interactive learning. Designing EBP content and facilitation methods to meet preferred learning styles is essential. The purpose of facilitating EBP content in the NRP is twofold. First, as a refresher from their academic education and second, to enculturate organizational EBP practices with new graduate nurses. Numerous iterations of facilitating EBP content in the NRP have been tried. These included requiring residents to complete an EBP project, an overview of EBP followed by short, focused sessions on specific EBP topics, and a four-hour didactic course. None met the overall learners’ needs, per evaluations and feedback. Knowing learners prefer hands-on activity-based learning, a new seminar was developed to emphasize each step of EBP process with content and a learning activity. Each cohort small group chooses one of three, pre-planned EBP scenarios. Each group, then develops a PICOT question, searches the literature, critically appraises an article, creates synthesis tables, makes evidence-based recommendations, and creates an implementation and dissemination plan. All participants complete an anonymous, pen and paper seminar evaluation. Pre/post seminar evaluations will be analyzed. Two cohorts' seminar evaluations of the four-hour didactic seminar (pre) will be compared to two cohorts’ seminar evaluations of the interactive learning seminar (post). A Likert scale will be used to evaluate questions pertaining to new, engaging, applicable EBP content and improved critical thinking. Open ended comments will also be considered. To ensure that learners will incorporate content into their practice, seminar design and content facilitation must align with learners preferred learning styles and expectations. Purposeful review of seminar and NRP evaluations should drive seminar changes.

P310
HOW TO STREAMLINE ONCOLOGY NURSE ONBOARDING AND TRAINING
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Professional Development
In a long term acute care hospital (LTACH) setting, we have a dedicated oncology unit with the ability to administer chemotherapy on-site. Many of our nurses are new grads. In an effort to improve oncology nurse confidence and knowledge and streamline overall program management, we analyzed our onboarding and training program. In response, we improved our new nurse training on the oncology unit to make it more interactive with learner-driven online gaming modules and hands-on training sessions. We developed this new program to meet the needs of a more tech-savvy generation of nurses who have not had as much hands-on experience as previous cohorts of new nurses. We also wanted to evaluate the best uses of our educators’ time with students in the classroom and see the impact on our facility’s budget and patient outcomes. To understand where we needed to make changes to training and onboarding education, we looked at the existing program. We implemented knowledge checks and qualitative surveys to measure the impact of different elements of training, like in-person chemo shadows, classroom sessions, and simulations. Then, we rolled out a new virtual gaming program with multimedia ways to learn. After reviewing data from the knowledge checks, qualitative surveys, a cost analysis of patient
care costs related to chemo administration, oncology nurse retention rates, and patient experience data, we determined that the new, more efficient oncology nurse training program has been successful. We’ve been able to onboard and train more nurses, save the facility costs that would be spent on transporting patients to chemo clinics, administer more chemotherapies, and improve patient quality of care. Nurses report more confidence and interest in working with chemotherapy patients. We believe that this new program has been extremely effective and beneficial to the facility as a whole. We are excited to continue our research and work to improve our education and ongoing training for oncology nurses with simulations and more gaming. We hope that other facilities will use our training modules and methodology as a template for their own new grad oncology nurse programs.

**P311 MEET AND GREET! IMPROVING THE ONBOARDING PROCESS IN THE OUTPATIENT SETTING**

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Oncology Nursing Practice

The transfer from inpatient nursing to outpatient nursing is markedly different, presenting challenges to the inpatient nurse transitioning to the outpatient setting. Nurses both new to oncology, and inpatient oncology nurses transitioning to outpatient centers face challenges of learning new antineoplastic and immunotherapy drugs, new processes and workflow, and the location of resources. UPMC Hillman Cancer Center (HCC) currently has 29 network sites, making consistent onboarding of both new and experienced nurses challenging. The nurse managers are often pulled into staffing, making it difficult to find the time to review the orientation book with the new nurses, thus creating inconsistencies in the ways that the nurses are onboarded. The purpose was to standardize the onboarding process for outpatient oncology nurses. The preceptor committee and the Clinical Education Specialists (CES) created and sent a survey to nurses who started at UPMC HCC from Jan 2022- December 2022. Based on the feedback of inconsistent onboarding, the committee worked to implement “Meet and Greet” sessions for new nurses. Using the current Oncology Nurse Orientation Book, the committee determined the content to be reviewed during weeks 1, 4, 8 of the sessions. The committee developed a standardized checklist to ensure consistent content review. The sessions are conducted virtually by a CES. A survey was sent to the nurses who participated in the meet and greet sessions (March 2023-July 2023) Thirteen surveys were sent, and three were returned. The participants responded that the sessions were helpful, however two of the respondents communicated that the sessions were difficult to attend during work time. A post implementation survey was sent to the nurse managers. Nineteen surveys were sent, and ten surveys were completed. Seven respondents had nurses attend the sessions. Managers reported that the sessions helped to provide consistent content and communication to the staff. Since implementation, barriers identified are: Providing a quiet space with a computer to ensure staff participation, attending the sessions during work hours is challenging, and decreased attendance occurs on week 8 of the sessions. Steps for improvement include: Rescheduling staff who have missed a session, working with the nurse managers to ensure a quiet space for attendees, and determining the best day and time for the sessions. Establishing a process for consistent content review during orientation provides improved nurse, preceptor, and manager satisfaction.

**P312 RISING, REBUILDING, AND REVITALIZING LOCAL CHAPTERS POST-PANDEMIC**

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Professional Development

Professional organizations play a crucial role in fostering community, providing resources, and advancing the interests of individuals within a specific profession or industry serving as a bridge between professionals, helping them connect, learn, and collectively address challenges and opportunities in their field. The Oncology Nursing Society is a pivotal platform for oncology nurses boosting over 200 local chapters. In one geographical locale are three chapters ranging from large to medium and small chapters, working collectively yet independently to advance the oncology nursing society’s vision of advancing oncology. The purpose of this abstract is to delve into the collective work of...
three chapters united in their mission to advance oncology to harness the strengths of each local chapter to achieve the broader objectives of the parent organization more effectively. By pooling resources, knowledge, and manpower, these chapters sought to create a more robust and impactful professional community within their region. These local chapters, representing oncology nurses within a large metropolitan area, recognized the urgent need to harness the oncology spirit, especially following the COVID-19 pandemic. They initiated a range of interventions and activities, including joint workshops, well-being programs, seminars, and legislative work that are nurses-friendly policies and regulations with agendas focused on safe staffing and work violence prevention at the local and regional levels and opportunities to embrace the oncology nurse’s spirit.

These events were strategically designed to cater to their local chapters’ unique needs and concerns while aligning with the overarching goals of the parent organization (ONS). The success of this collaborative endeavor was evaluated through multiple metrics, including attendance at joint events, participation in advocacy campaigns, and the impact of community outreach efforts.

- **10 Continuing Education and professional development activities**
- **Chapter’s growth by 15, 18 and 28% respectively**
- **6 Community work/participation**
- **Increased attendance at the chapter’s activities.**
- **5% increase in advocacy activities.**

This collaborative initiative among three local chapters has exemplified the profound impact that united, coordinated action can have on advancing the mission of a professional organization. In an era where localized challenges require tailored solutions, the collaborative model adopted by these chapters serves as a blueprint for other professional organizations and their local chapters. It highlights the need for continued efforts in building strong local communities that can collectively shape growth and foster positive change.

**P313**

**THE LEARNING NEVER ENDS: A NEW ONCOLOGY RN RETREAT**

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**Professional Development**

According to the article, “Perceived needs and coping resources of newly hired nurses” by Schmitt and Schiffman, the transition from nursing student to new graduate nurse (NGN) to the role of experienced nurse is challenging and long-lasting. The literature suggests that support from the hiring institution is essential if the newly hired nurse is to successfully transition to practice. In a large, academic medical center, the leukemia unit recognized the need for additional education among new oncology nurses outside their initial 12-week orientation. The unit-based council (UBC) wanted to bridge the gap with an educational retreat focused on advanced topics and skills. The purpose of the New Oncology Nurse Retreat is to increase new nurses’ knowledge and confidence through a full day of education. On May 15, 2023, the first retreat was held with 14 new inpatient and outpatient oncology nurses. A new nurse was defined as a nurse who has completed orientation but has less than one year experience. Based on the observed knowledge gap, the UBC and nurse educators collated an agenda for the 8-hour session with lecture and skills sessions. Presenters came from different areas of practice to help foster interdisciplinary relationships. The oncology presentations included nursing protocols, oncologic emergencies, nutrition, palliative care, rapid response, and interdisciplinary roles. The skills sessions focused on central line maintenance, drains and tube management. Attendees were given a pre and post-test to measure knowledge and confidence gained. The tests consisted of seventeen questions. Fifteen knowledge-based questions were taken from presented lectures. Two confidence-based questions were included regarding nursing and rapid response skills as defined by a five-point Likert scale. The results showed an overall 62% increase in knowledge. There was a 60% increase in nursing skill confidence and a 57% increase in rapid response skill confidence. Limitations include only one retreat has been held. The New Oncology Nurse Retreat has bridged the gap from NGN to experienced nurse. In the future, we plan to hold the retreat twice a year. The next sessions are scheduled for December and January to align with the influx of new nurses hired. By including peers and members of the interdisciplinary team, the retreat helps educate and build relationships across the oncology continuum which supports a successful transition to nursing practice.

**P314**

**EMPOWERING THE VOICES OF ONCOLOGY NURSES TO MEET COMPETENCY AND ACCREDITATION STANDARDS**

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ONCOLOGY NURSING FORUM MARCH 2024, VOL. 51, NO. 2 WWW.ONS.ORG/ONF

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Professional Development

Annual competency and education requirements for oncology nurses can feel like an added burden. Oncology nursing is ever changing, and systems need to be put into place to stay current. Our health system began requiring oncology nurses to have oncology certification or 36 hours of oncology education as part of the standard for accreditation as an Integrated Cancer Network Program (INCP). The nurse driven competency model we use for annual ongoing competencies is a well-established workflow in our organization. Oncology nurses provide care in diverse settings to holistically meet the needs of patients. Standardizing competency and education in a way that remains meaningful and relevant to all areas of oncology nursing is challenging. Tracking oncology specific continuing education for a multi-site INCP and providing support for oncology nurses with a variety of subspecialties can lead to confusion. We wanted to create a standardized approach to reduce the burden on staff, provide meaningful education and validate competency in caring for patients with cancer. A policy and procedure was created to guide annual ongoing oncology nurse competencies across the INCP. To minimize the burden on staff, existing workflows for nurse driven competency validation and annual performance evaluation processes were expanded to address educational needs. A high priority was placed on oncology nurse brainstorming, quality data, and error reporting to determine competency selection, validation methods and education. Oncology nursing classes were created to provide in-person live continuing education utilizing interdisciplinary speakers, simulation and interactive presentation software. This format permitted data collection and competency validation while education was being provided. Eighty-five percent of the oncology nurses participated in a four hour in-person class to expand their knowledge, develop interdisciplinary relationships with the care team and validate their competencies. Participants self-rated a 13-48% increase in competence in seven different aspects of foundational oncology nursing practices. A site review with the accreditation surveyors resulted in positive feedback and no deficiencies. Combining processes of nurse driven competencies with selection and tracking of oncology specific education, resulted in a streamlined approach, meeting needs of the nursing staff, quality care and standards of accreditation. Interactive software and live simulation made real-time data collection for competency validation feasible. The tracking of oncology continuing education was the most challenging portion, this has led to current work developing a tracking form.

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PROCESS DEVELOPMENT FOR NURSING EDUCATION FOR THE DELIVERY OF BISPECIFIC T-CELL ENGAGERS IN THE COMMUNITY OUTPATIENT ONCOLOGY SETTING

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Oncology Nursing Practice

Bispecific T-cell Engager (BiTE) therapy is a cutting-edge immunotherapy for patients diagnosed with certain hematologic malignancies. BiTE therapy provides additional treatment options for patients who have exhausted traditional therapies. Our organization’s mission to provide innovative cancer care in the community-based oncology setting ensures patients benefit from new therapies such as BiTEs in communities where they live. BiTE therapies pose specific complexities for education and care coordination in the outpatient setting due to complicated treatment regimens and potentially severe side effects. The care team must be educated on administration, assessments, toxicities, and management of medical emergencies. While introducing the first BiTE therapy in April 2023, a need was identified for a systematic process for training staff involved in the care and management of these patients. When developing a staff education plan, several elements were considered. A combination of electronic and in-person training modalities was used. Nurses, chemotherapy prep technicians, and triage staff receive drug-specific training. Drug-specific online modules were developed and assigned in the online management learning system. These modules review specific elements such as drug indications, mechanism of action, dosing and preparation, administration, and specific considerations for assessment and monitoring. Clinical educators collaborated with subject matter experts from the pharmaceutical company to conduct in-person staff training. Our team developed Immune Effector Cell Encephalopathy (ICE) assessment sheets and grading scales for the electronic medical record to standardize patient assessment. Another component of the educational plan involved patient education for at-home monitoring and recognition of cytokine...
release syndrome and neurotoxicity. Educators also coordinated education for staff in the emergency department and hospital inpatient units that would care for BiTE patients who experience acute toxicities. Our organization has five BiTE therapies approved for administration in the outpatient setting. Workflows have been established to facilitate the management of these patients. Workflows were also developed to facilitate inpatient observation periods. Staff are better prepared and empowered to safely care for patients receiving BiTE therapies. Patient satisfaction has also improved, knowing that staff are knowledgeable and adequately prepared to manage their care. Currently, BiTE therapies are administered at 4 of our 35 locations. With the continual rapid approval of new and innovative oncology therapies, education is critical in ensuring that clinical staff is competent for successful administration and patient management.

**P316**

**HERE WE GROW: INTEGRATING NURSING PRACTICE VIA ONCOLOGY NURSING GRAND ROUNDS**

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Oncology Nursing Practice

A healthcare system merger resulted in the need to begin integrating oncology nursing practices across approximately 40 acute and ambulatory oncology patient care areas. Nursing grand rounds (NGR) are well supported by literature to promote peer learning, acknowledge best practices, improve rapport across nursing staff, and promote professional development. The purpose was to remove geographical barriers, establish nursing relationships, and promote practice inquiry and learning across a merging health care system by implementing a quarterly virtual, live, and enduring oncology NGR program. A NGR team consisting of nursing leadership, nursing educators, and frontline nursing staff across the system began meeting to establish NGR topics, standardized content delivery, apply for continuing education hours, and develop evaluation methods. Special attention was given to ensure content applied to all nursing practice areas, involved actual patient case studies, included time for discussion to learn practice difference across the system, and involved frontline oncology nurses from content planning to delivery. A total of 3 NGR programs have been offered in 2023. To earn contact hours, nurses were required to evaluate overall learning, answer questions to assess learning, provide feedback, and ideas for future sessions. Over 206 total contact hours were earned for first and second quarter events. Enduring hours remain open for 3rd quarter and the 4th quarter event will be held in November. Over 80% of learners strongly agreed or agreed learning outcomes were met by NGR programs. Comments by attendees were positive and included representation from over 30 different sites. The first topic, led to a review of infusion reaction reporting and harmonization with emergency procedures and order sets. Other topics have included health literacy and system patient education and trauma informed care with a review of resources. While NGR is not a new concept, implementing an oncology NGR with the goal of integrating nursing practice across a merging health system, has proven to be effective. Delivery via numerous formats offered opportunities for nurses to network, learn from one another, advocate needs or concerns to integration leadership and is leading to efficiency and improved patient care through practice and resource alignment. Networking leading to policy, procedure, evidenced based practice standardization has accelerated as a result of NGR. NGR programs can be used by leaders to integrate oncology nursing practices during healthcare system mergers.

**P317**

**BRIDGING THE GAP: AN EDUCATIONAL APPROACH TO STANDARDIZE CHEMOTHERAPY ADMINISTRATION PRACTICES ACROSS IN-PATIENT ONCOLOGY UNITS AT A MULTI-SITE ACADEMIC MEDICAL CENTER.**

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Oncology Nursing Practice

Assessment of current oncology education determined a gap in standardized training for new chemotherapy nurses. Prior unit-based education created practice variance between preceptors and confusion for new nurses. Sustainability was hindered by a siloed approach to education. Oncology nursing learning needs survey determined chemotherapy training a primary concern for staff. Literature review supported blended-learning as an effective approach to improve...
learning outcomes and personalize instruction of diverse learners. System-wide surveys echoed evidence. Nurses reported e-learnings and skills sessions as preferred formats for education. The primary goal was to standardize antineoplastic administration practices in adult inpatient oncology units across a large academic health system. Based on multi-site oncology unit growth, and varied onboarding schedules, the secondary goal was to provide an asynchronous component supporting flexible delivery of training. The oncology nurse educator, staff nurses, and informatics collaborated to develop training around institutional policies and safe antineoplastic administration. An interactive e-learning was developed reviewing policies and resources. Multi-drug regimens, dosage verification, extravasation, IV site selection, and safety were among topics covered. Post e-learning, a hands-on class, incorporating ONS orientation preceptor tools™ and simulation, allows practice in technical skills associated with safe antineoplastic administration, documentation and spill management. Training begins with nurse validators, to standardize preceptor support of new nurses. Following validator training, the course will be implemented as required training for all inpatient oncology nurses prior to administering chemotherapy in their practice settings. Practice scenarios throughout asynchronous and in-person sessions assess understanding of course content. Return demonstrations assess competency, providing a forum for individualized guidance. Likert-type, pre/post surveys will assess nursing self-confidence in antineoplastic administration skills, whether course objectives were met, and preceptor intent to alter practice based on learning. Ongoing environmental scanning assessments and survey of new nurses 3-months post training will be used to evaluate the impact on standardization of practice across oncology units. Quality and safety of cancer care correlates to knowledge and practice. Sans formal learning opportunities, nurses rely primarily upon peers to guide professional competency. Standardizing antineoplastic administration practices within a large health system is a process towards improving technical skills, nursing confidence, competency, and patient safety. Blended-learning is an evidence-based pedagogic approach to education that supports flexible on-boarding, a diverse nursing workforce, and improved learning outcomes.

P319
EXPLORING THE POTENTIAL BARRIERS TO NURSING CERTIFICATION
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Professional Development

The United States has one of the largest pharmaceutical markets in the world. Despite this, the public remains uneducated on the importance of proper medication disposal. Improper disposal of medication and retention of unused or expired medications can lead to accidental exposure, substantial hazards and even fatal consequences. These substances include but are not limited to analgesics, sedatives, antidepressants, antihistamines, narcotics, oncology drugs, and various vitamins and supplements. In order to prevent medications from causing harm, it is vital for nurses to possess the informed knowledge to educate their patients and their family members. The primary objective of this project is to conduct a nursing assessment aimed at evaluating knowledge regarding safe medication disposal practices for hospitalized patients after discharge to the home or community setting. The goal is to assess the proficiency of nurses regarding appropriate methods for disposing of unused or expired medication, knowledge-gaps, and improve nurse’s comfortability providing education to patients and their families. Oncology clinical nurses, under the guidance and direction of nursing leadership and clinical educators, have collaboratively developed an educational module and information handout. These materials serve as a comprehensive resource designed to outline the CDC and FDA latest best practices regarding medication disposal. A post-survey will be used to assess the impact of the education provided and identify any barriers. The findings from this survey will play a role in ensuring that nurses are equipped with the requisite knowledge and comfort to effectively educate patients and their families. The primary aim of our project is to empower nurses with the necessary education and resources to effectively educate their patients on the proper disposal of medication. Doing so will improve patient and environmental safety, and contribute to the responsible management of pharmaceutical waste.

P318
NURSES TEACHING HOW TO PROPERLY DISPOSE OF MEDICATIONS AT HOME
Sandy Portillo, RN, UCLA Health system, Santa Monica, CA; Ismelda Trejo, RN, UCLA Health system, Santa Monica, CA
Patient Education and Safety

This project is to conduct a nursing assessment aimed at evaluating knowledge regarding safe medication disposal practices for hospitalized patients after discharge to the home or community setting. The goal is to assess the proficiency of nurses regarding appropriate methods for disposing of unused or expired medication, knowledge-gaps, and improve nurse’s comfortability providing education to patients and their families. Oncology clinical nurses, under the guidance and direction of nursing leadership and clinical educators, have collaboratively developed an educational module and information handout. These materials serve as a comprehensive resource designed to outline the CDC and FDA latest best practices regarding medication disposal. A post-survey will be used to assess the impact of the education provided and identify any barriers. The findings from this survey will play a role in ensuring that nurses are equipped with the requisite knowledge and comfort to effectively educate patients and their families. The primary aim of our project is to empower nurses with the necessary education and resources to effectively educate their patients on the proper disposal of medication. Doing so will improve patient and environmental safety, and contribute to the responsible management of pharmaceutical waste.
Oncology Nursing Certification is a recognized pathway for validating a specialized knowledge base and advancing competency in cancer treatment. Certification makes a difference to patients, employers, and allows a way for individual nurses to demonstrate their growth and knowledge. The Oncology Nursing Certification Corporation (ONCC) recognizes that certification is a way to grow both personally and professionally. The purpose of this project was to identify key barriers influencing the attainment of oncology nursing certification. In addition, workplace climate and nursing characteristics were explored. This project utilized a descriptive survey, created using current literature citing the most common barriers. The survey consisted of 12 demographic questions to gain an understanding of the overall sample population and 12 Likert scale questions focusing on the potential barriers to certification and workplace climate. Participants (N=82) were recruited from three Blood and Marrow Transplant (BMT) units, both inpatient (77%) and outpatient (23%) settings. The response rate was 80%, with a current certification rate of 42%. Notably, 67% expressed interest in taking a certification exam and 86% acknowledge that certification demonstrates specialized knowledge and expertise. Additionally, 56% reported that their nursing leader discussed certification, 57% indicated they are informed of opportunities and recognition for certification, and impressively, 84% stated they feel encouraged to pursue certification within their work area. Major barriers included insufficient institutional/financial reward (60%), inadequate employer-provided time for exam preparation (52%), previous test-taking anxiety (63%), and fear of failure (59%). Identifying potential factors influencing nurses’ attainment of certification allows for the development of evidence-based interventions and support programs to address these barriers effectively. It further helps identify resource gaps and highlights areas for program improvement. Furthermore, to raise awareness on the importance of certification, results can be disseminated to promote dialogue and obtain nursing feedback. Addressing these barriers may in turn increase certification rates and therefore contribute to the professional advancements of nursing and increase overall quality cancer care.

P320
EXPANDING THE NETWORK: MENTORING NURSES GOING FROM A LARGE ACADEMIC CENTER, TO A RURAL SATELLITE CLINIC
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Professional Development
The global shortage of healthcare professionals threatens the access to care in rural communities. Challenges for recruitment of nurses in rural locations include limited resources, opportunities for professional development, and connections to the region. Mentorship and teambuilding can be used to recruit and retain a pool of nurses in a rural setting. Recently expanding services to a new state of the art satellite center offering patients cutting-edge cancer care in a community setting has not come without barriers. Oncology nurses are vital to the patient-centered care our center delivers. Building a team of professionals focused on quality, empathy, and a strong knowledge base was vital. Nursing leadership is vital in building a cohesive team through mentoring and enhancing opportunities encouraging staff’s growth and development. Cultivating a new team of nurses to provide care in the clinical setting and infusion space focused on experience and flexibility. Providing resources and education to the team was a priority for the unit. All nursing staff were interviewed and hired prior to opening the new space and began an orientation encompassing the workflows of a satellite campus to develop skills needed to ensure quality outcomes. All nurses needed to have a chemotherapy and biotherapy certification through the Oncology Nursing Society. Uncertified staff were provided access to study groups to help achieve success. Educators came to the new site to help with staff competencies and collaboration with pharma representatives to connect staff with external resources. Staff were all expected to be engaged in shared decision-making councils to maintain multidisciplinary communication and collaboration across the health system. Creative team-building methods were executed to encourage integration and relationships. Daily huddles and 1:1 check-in’s, have helped to guide the on-boarding process focusing on needs of the staff. Debriefing after education opened discussion for future programs. Measuring success will include qualitative data on nurse skill confidence, trust in leadership, and access to professional development in Nursing Engagement surveys. Rural community centers can present challenges for the transition of nurses. Mentorship has been a vital component for personal and professional success of new employees.

P321
PAVING THE EXTRAORDINARY: IGNITING SUCCESSFUL NEW GRADUATE NURSES IN A CANCER CENTER INFUSION FLOAT POOL
LEARNING THROUGH FUN & GAMES

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Oncology Nursing Practice

Newly licensed nurses (NLNs) often are described as not being ready for practice (Harrison et al., 2020). In many health care institutions, NLNs begin their nursing career on the night shift. It is the job of the night shift clinical nurse educator to educate, support, and socialize them into their new roles and profession. As with many large, urban medical centers, this oncology department is extensive and spans over one hundred beds, 16 different units, and over 50 nurses on the night shift. With frequent educational initiatives, it is not possible to perform one-on-one teaching sessions with each nurse. To reach as many nurses as possible in a shift and make learning efficacious, teaching was done through fun and games! The initiative includes a variety of games and social events to educate and support nurses. The most popular game is trivia. The clinical nurse educator uses the charge-nurse cell phones to text trivia questions to the staff. The unit who responds first and correctly to the text wins a prize. The trivia questions include topics such as nursing practice, policy, and documentation; oncology treatment, emergencies, and associated nursing care; and nursing history and professionalism. Nursing BINGO recently entered the game rotation. Each participating nurse receives a BINGO card with a variety of different nursing and patient topics. Some topics were simple, such as “Patient had a first temp spike,” but others required researching nursing policies or patients’ charts, such as “Patient has an Infectious Disease Consult.” The first nurse to claim BINGO correctly wins a prize. The games not only created an opportunity for education, but also socialization. As the trivia questions were sent to one central location, the charge-nurse cell phone, it required the nurses on the unit to work together. Many times, nurses could be seen huddled around the charge phone discussing the questions, contemplating answers, and laughing. The nurses expressed their enjoyment and looked forward to the games. It proved to be such a simple and fun initiation that increased learning and encouraged socializing!
The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey collects patient feedback from an inpatient hospital stay. Developed by the Centers for Medicare and Medicaid (CMS) and Agency for Healthcare Research and Quality (AHRQ), HCAHPS evaluates patient perception of MD communication, RN communication, staff responsiveness, environmental, discharge information, and the overall patient experience. Only patients discharged to home receive surveys, eliminating patients who are discharged to facilities such as nursing homes, rehabilitation centers, and other non-home care areas. 10 West is a 16-bed Hematopoietic Stem Cell Transplant (HSCT) unit, which infuses more than 200 transplants annually. Majority of these patients are discharged directly to the hospital-affiliated medical tower for post transplant follow-up care. In 2022, 10 West received 11 HCAHPS surveys, far below the hospital average, earning 3.63 total stars out of 5. With so few HCAHPS responses, the team sought additional means to seek patient experience feedback. The purpose was to develop a bedside survey tool to obtain real time patient experience feedback. The goal is to improve overall HCAHPS star rating by 10% in over 6 months 3.63 to 3.99. Following evaluation of 2022 HCAHPS scores, an 11 question bedside survey was developed with questions focusing on responsiveness, respect, medication and discharge education, and bedside shift report. Project leaders provided education to the nursing team on how to integrate this survey into their discharge teaching. Within 24 hours of potential discharge, the nursing team encourages the patient to complete the anonymous survey via QR code. Implementing the bedside discharge survey gives the team real-time feedback about the patient experience on the HSCT unit. Responses have been exceedingly positive, with patients always reporting 100% in 9 of 11 domains. The HSCT unit received 12 HCAHPS surveys in 2023 yielding a 5.0 HCAHPS score year to date. The increase in surveys can be attributed to an increase in patients being discharged directly home or readmissions. Historically, HSCT units receive lower HCAHPS survey responses due to prolonged length of stay. Evaluation of the bedside survey responses provided the unit with areas of opportunity in bedside shift report adherence and quietness at night. Capturing real-time feedback from patients utilizing the discharge survey has proven to be an invaluable tool, which can be easily replicated in other areas.

P324 DEVELOPING A HEALTH EQUITY-MINDED CURRICULUM: THE IMPACTS OF CANCER CARE
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Psychosocial Dimensions of Care
A team of nursing professional development specialists conducted an assessment of an accredited oncology nurse transition-in-practice (TIP) curriculum. Educator and learner feedback was examined and learning objectives were cross walked with nationally recognized oncology competencies and residency accreditation standards. The team identified a gap in the integration of social determinants of health (SDOH) in the curriculum, which may significantly impact an oncology patient’s experience of care. The purpose of this project was to enhance learners’ awareness of the impact of cancer on a patient’s psychological, social, spiritual, and financial health, and how each are influenced by SDOH. Upon completion, learners will be able to assess SDOH and integrate appropriate considerations into their patients’ plans of care. The curriculum was updated to include relevant pre-learning activities, in-class discussion, and a case study for application of knowledge in assessing SDOH and integrating findings into the patient’s plan of care. Further enhancement will include the use of visual thinking strategies (VTS) to support discussion around this topic. Learners will be shown a work of art and asked open ended questions to explore perceptions about the piece. These questions are followed by an explanation of the art piece and a discussion about how the exercise relates to uncovering the multiple factors that impact the patient experience. This technique has been used in nursing and pharmacy education and may increase learners’ ability to see things about patients that might otherwise be missed. Program feedback is collected through educator and learner experience surveys. The curriculum revision is recent and outcomes data is limited; preliminary feedback is positive and has informed refinement of content. Feedback about the use of VTS in exploring SDOH will be available at the time of the conference. Understanding social equity is at the core of this project.
of this project. Before equity can be achieved, disparities must be acknowledged, identified, and addressed. Our curriculum promotes awareness of SDOH and how they impact a patient’s experience with cancer treatment. Inclusion of VTS to explore this topic will enhance the curriculum further and promote oncology nurses’ ability to appropriately assess the full impact of cancer on a patient’s care and respond accordingly.

P325
PROMOTING SUSTAINABLE EDUCATION - CONFIRMATION OF THE INTRINSIC VALUE OF VIRTUAL EDUCATION ACCESS

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Professional Development

The onset of the COVID-19 pandemic mandated closures and cancellations of in-person oncology conferences and classes, leading to a significant absence of oncology continuing education (CE) opportunities offering CE contact hours. Lack of CE opportunities had grave implications for certifications, RN licensure requirements, and clinical knowledge and competence. An innovative virtual platform was quickly developed to provide CE-accredited virtual education to nurses and other staff across multiple campuses and affiliate network locations, meeting immediate needs as well as addressing long-standing barriers to in-person education. The purpose was to describe the evaluation of an NCI-designated cancer center’s Clinical CE Library assessing sustainability and benefits to staff in the three years beyond the acute education needs introduced by the COVID-19 pandemic. In June 2020, a virtual Clinical CE Library was quickly created and launched to provide CE-accredited oncology education. Content consisted of pre-existing recorded presentations and live webinars, which were also recorded and made available for on-demand viewing, on diverse oncology topics from interdisciplinary speakers across the organization. The Clinical CE Library was a valuable source for quality, current, CE-accredited content for staff at the organization’s 7 campuses, 10 affiliate locations, and academic partner institutions. Data on site usage and growth was collected and analyzed quarterly from June 2020 – June 2023 and evaluated for ongoing quality improvement opportunities for the Clinical CE Library in the evolving educational landscape. Amidst easing of pandemic restrictions and the return of in-person education opportunities, the Clinical CE Library saw regular use and persistent growth. Annual total content views increased 70%, from 1186 views in FY2021 to 2011 views in FY2023. Similarly, annual total CE certificates awarded increased 67%, from 480 certificates in FY2021 to 801 certificates in FY2023. A project that initially began in response to pandemic limitations has longitudinally proven to be successful in addressing ongoing learning needs, even with the return of in-person education opportunities. Since its inception, content on the Clinical CE Library has been incorporated into standard onboarding curricula for new and experienced oncology staff and provided a significant resource for continued learning. The sustained growth of the Clinical CE Library, supported by the data, demonstrates that nurses and clinical staff continue to benefit from an accessible and dependable online source for quality CE-accredited education, strengthening knowledge for best oncology care practices.

P326
CHAMPIONS IMPROVE CLINIC COMPETENCIES FOR ONCOLOGY NURSES

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Coordination of Care

Outpatient oncology nurses work in a variety of settings, including clinics and infusion centers. In clinics, the nurse performs a number of activities to coordinate care and respond to patient phone calls and messages. A large multi-site cancer center was onboarding an unusually high number of new nurses at one location and did not have enough experienced nurses to support orientees. After reviewing orientation plans, the Nursing Professional Development (NPD) practitioner noted inconsistencies across departments and a prior survey found new nurses reported their orientations were unorganized and disjointed. Improving the orientation model is a priority that impacts nurse satisfaction, retention, and patient outcomes. The purpose was to address gaps in clinic orientations and increase new nurses’ competency with specific clinic tasks by leveraging preceptors from other sites to provide training and resources. Utilize the Plan-Do-Study-Act (PDSA) cycle to rapidly improve the intervention. The NPD practitioner recruited six experienced preceptors from clinics at other sites to train nine nurses on competencies. Initial training was intermittent over two months, scheduled by preceptor availability, and structured using the traditional preceptor/orienteer dyad model. Preceptors focused on initial competencies for new clinic nurses with the most common being care coordination and patient message management in the electronic medical record. Following the PDSA cycle, training was restructured to use group sessions, focusing
on two specific competencies, along with 1:1 sessions on sequential days with three preceptors. Post-training surveys assessed for confidence level and intent to stay. 17 new nurses attended the training. Surveys after the 1:1 sessions showed 80% of respondents felt more prepared for their role, and 40% reported they are more likely to stay at the organization. After the group sessions, 72% percent of respondents reported feeling more prepared for their role and more likely to stay at the organization. Pre and post confidence levels were also measured after groups sessions. Respondents reported a 41% increase in confidence performing care coordination and a 47% increase in confidence managing patient messages. The data shows that the training increased the nurse’s confidence in performing clinic prep and answering in-basket messages. For this reason, changes are being made to have this course added to the orientation plan for any new clinic nurses. Organized and detailed training for a nurse’s role, increases nurse retention.

**P327**

**SIM-PLEMENTATION IN EDUCATION: UTILIZING HEALTHCARE SIMULATION TO DIRECT TRAINING FOR IMPLEMENTING ALCOHOL WITHDRAWAL PROTOCOLS**

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**Professional Development**

Implementation of evidence-based best practices at a multi-site cancer center is a powerful tool to influence patient outcomes but can be complex and require the collaboration of multiple departments. Providing education to the staff who will carry out practice changes requires an understanding of how the change will affect them, why it is relevant to their practice, and what the best framework and methodology for teaching would be. Simulation of planned interventions prior to education can be a valuable process for structural engineering of clinical tools, and to plan education. The implementation for a new alcohol withdrawal algorithm included simulation performed with clinical staff prior to education, to direct educational priorities. This allowed for the implementation team to make practical changes to the policy and target key objectives in education to successfully bring the tool to the clinical setting. Two simulated experiences were conducted where patient presentation required interventions from nursing and advanced practice providers. Nursing informaticists were present to run the documentation training environment and observe clinician’s interaction with the system. Nursing Professional Development Specialists educated the participants on the new clinical tools prior to the simulations, and then observed and debriefed the participants with attention to their thoughts on how the education prepared them and what could be improved. Participants were able to express key areas of educational deficits that should be highlighted, including assessment, medications, and clinical cues and safety features they felt would be helpful. Additions to the clinical documentation to reflect these safety features were able to be made prior to implementation. Areas of documentation that presented unexpected difficulty were able to be highlighted in the education to prevent errors in the live clinical environment. Nursing workflows such as the process of moving through physical space including patient care areas, medication rooms, and controlled substance cabinets were able to be fine-tuned through simulation and resulted in education reflecting the live clinical space and true workflows. The simulation process informed the education process for clinicians. Having time to walk through the challenges presented by the physical workspace and workflows allowed the tool to be tailored and the educational content to be honed. This resulted in a successful workflow and a quick implementation period, with house-wide education completed within three weeks and no need for re-education identified within the following 9-month period.

**P328**

**HYPERSENSITIVITY REACTION SIMULATION IN THE OUTPATIENT AMBULATORY INFUSION SETTING**

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**Patient Education and Safety**

In the 2022 needs assessment, nurses and advanced practice providers (APPs) at a private practice ambulatory oncology infusion office requested more education and hands-on practice surrounding hypersensitivity (HSR) reactions. Nurses and APPs manage all emergencies within each office and have varying levels of experience and confidence with the equipment and processes. The nurse educator created a hypersensitivity simulation to address gaps in knowledge and skills. There are three scenarios that the nurses and APPs work through together: an iron infusion reaction, a paclitaxel anaphylaxis reaction, and a cytokine release syndrome reaction. The reactions range from moderate to severe. A staff member acts as the patient role and a
kit is available with simulated rescue medications. The kit consists of vials of simulated rescue medications, act-o-vials, syringes, flushes, tubing, fluid bags and an epi-pen trainer. A small card is given to each participant with the concentration of rescue drugs to facilitate practicing administration. Certain checkpoints must occur, including pausing the infusion, obtaining vital signs, inviting the APP and administering proper rescue actions. Depending on chosen actions, the patient can decompensate or improve. After the simulations are completed, there is a team debrief. During this time, staff can ask questions, clarify processes and make suggestions. The educator reviews the policy and emergency equipment in further detail, including the oxygen tanks, AED and emergency medications available. A post-simulation survey was conducted. 100% of staff reported that the HSR simulation increased their confidence. 70% indicated they would make practice changes and included comments such as “careful thumb placement with epi administration,” “assessment of and early intervention for patients with acutely deteriorating conditions,” and clarity surrounding roles. The HSR simulation is added to orientation for each new nurse and APP and completed annually with competency review.

P329
EDUCATION STRATEGIES FOR OUTPATIENT ONCOLOGY
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Professional Development
Outpatient oncology centers have become the primary treatment setting for cancer patients (National Academies of Sciences, Engineering, and Medicine, 2016.). Therefore, a strategic education plan is necessary to equip nurses to safely deliver high quality care in the outpatient setting. Nurses hired to work in outpatient oncology are often required to administer chemotherapy/immunotherapy sooner than their inpatient peers. An outpatient oncology practice aimed to create an education strategy that prepares nurses to administer chemotherapy/immunotherapy within ninety days of hire and to support knowledge expansion through subsequent continuing education. Three pillars of the education strategy used by the outpatient oncology practice include a structured orientation plan delineated by role, weekly education, and a clinical ladder program in support of continuing education. Microsoft applications were utilized to organize, display, and disseminate education content. The structured orientation plan promotes training continuity, regardless of location or trainer, while continuing education after orientation increases nurses’ knowledge and confidence. Employee retention rates demonstrate a positive benefit since the implementation of the strategic education plan. Two-year data reveals 96% of 2021 RN hires successfully completed orientation, an 84% retention rate at year one, and an 80% retention rate at year two. A ninety-day orientation plan was created utilizing a variety of sources including the Oncology Nursing Society (ONS). A Microsoft SharePoint page was created for each nurse role (infusion nurse, nurse navigator) and serves as the homepage for organizing and accessing orientation content. Learning checkpoints are embedded within the plan to monitor progression and evaluate competency. The ONS Fundamentals of Chemotherapy Immunotherapy Administration course and Chemotherapy Immunotherapy Certificate course are key components of the orientation and continuing education plan. Weekly education is disseminated via two activities: a pop quiz and an education email. The weekly pop quiz, created in Microsoft Forms, is optional and anonymous. Results of the quiz allow the educator to evaluate staff knowledge and identify areas for review. The weekly email, coined Fact for Friday, provides a summary of a current hot topic. A clinical ladder program further encourages continuing education by awarding points for completing oncology courses and attending local/national oncology conferences. Nurses may apply annually for recognition and monetary incentive in acknowledgement of their efforts.

P330
THE IMPORTANCE OF SPECIALTY CERTIFICATION FOR REGISTERED NURSES
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Professional Development
Specialty certification is crucial in nursing practice for the delivery and management of high-quality patient care and the associated outcomes. There is a need for nurses to become more knowledgeable about the benefits of achieving national certification status within their specialty. These benefits affect self, employer, and, perhaps most importantly, our patients as they ultimately are cared for by a more knowledgeable nurse able to tackle any complications that may arise in their oncology journey. The purpose was to educate, encourage and motivate registered nurses to attain specialty certification, with a focus on oncology certification in the care of the adult population. An educational session focusing on certification for oncology nurses employed at an outpatient infusion center was developed.
and presented by an Oncology Certified Nurse (OCN). The session focused on providing those without a comprehensive understanding of specialty certification a clearer insight and understanding. A pre-survey was given to assess their level of knowledge and motivation before receiving education; this was compared to the same survey after education. The survey consisted of eight questions with a Likert scale of strongly agree to strongly disagree. The nurses were also asked to rank where they felt their knowledge of the certification process was on a scale of 1-10 (little knowledge to very knowledgeable). Results interpreted the average knowledge level at 3/10 which represented 77% of the nurses surveyed. The post-survey results displayed an increase in the nurses’ knowledge to 8/10 (40%). Once education was complete the staff voiced their interest in beginning the process for becoming certified. In addition, leadership is now involved in gaining approval for ONCC’s Free Take Program. Creating an educational in-service to explain the process of becoming certified allowed the presenter to explain the meaning and importance of certification in nursing practice. This education led to enhancing interest and motivation for obtaining certification. It was identified that the nurses were not hesitant to attain certification due to disinterest, rather they were not knowledgeable enough about the benefits in various aspects of nursing, including their professional development and growth. The results of the post-survey demonstrated an improvement in all areas of knowledge and has motivated them to pursue specialty certification in the field of oncology.

P331
WE’VE HAD THE TIME OF OUR LIVES: USING HUMOR AND POP CULTURE TO DECREASE LAB COLLECTION ERRORS.
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Oncology Nursing Practice
The Joint Commission has identified “Improve the accuracy of patient identification” as a National Patient Safety Goal since 2003. Included under this goal are the elements of utilizing two patient identifiers and labelling lab containers at the patient’s bedside. Incorrectly labeled lab tubes may lead to rejected samples, increased cost of care, and serious safety events. The purpose was to explore factors associated with lab collection errors and develop an effective approach to nursing education to prevent sample rejection due to an insufficient amount of blood or incorrectly completed requisitions. Collection errors lead to patient care issues such as repeated venipuncture or accessing central line, increased discomfort, risk of infection, and delaying care. Estimated (organizational) cost of lab redraws was $4,037.35 over three weeks, and $1,518.64 over five months for blood bank redraws (excluding time/labor costs). In the inpatient Comprehensive Cancer Center, 145 lab samples were rejected in 2022. Lab samples were rejected because of incorrect labeling/requisitions and insufficient fill volumes of collection tubes. Patient scenarios using humor and well-known pop culture themes were deployed over the inpatient Comprehensive Cancer Center during annual education, beginning in Fall 2022. Nurses were required to complete a patient scenario, which included demonstrating proper blood collection, container labeling, and requisition completion to acquire a code to “escape” the room and win a prize. Additionally, lab collection tip-sheets were dispersed, along with reminder signs at pneumatic tube stations used to transport labs. Descriptive data was collected via the hospital event reporting system. Data collection from January to August 2023 noted a 58% decrease in lab sample collection errors. Staff verbalized an increased understanding of safety standards and expectations when collecting and labelling lab samples. Additionally, staff gave positive feedback at the educational approach of humor and jokes used during the education. Nursing educators recognized the overwhelming number of competencies nurses must assimilate into their practice, thus using humor in education was trialed to provide vital education while strengthening relationships and opening communication among learners. Utilizing humor during educational sessions may provide a more comfortable learning environment, allowing staff to learn in a non-punitive environment and increase understanding of objectives. Further research is indicated in this novel approach to staff education and subsequent effect on patient safety indicators.

P332
REDEFINING ONCOLOGY ORIENTATION: STREAMLINING CLASSROOM CONTENT
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Professional Development
Streamlining classroom content and introducing components of relaxation to reframe learning in a non-punitive environment allows for more comfortable learning, promoting student success.
The ONS position paper on Oncology Nursing Specialty emphasizes the importance of providing quality cancer care from diagnosis through treatment and symptom management. Support of patient and family / caregivers requires an understanding of general principles of oncology nursing as well as the capability to work closely with a multidisciplinary team to improve outcomes and reduce any negative impact on the patient and family / caregiver. Information on oncology content in nursing programs is limited, incidental, and rarely in-depth. Facilities that employ new graduates or nurses new to oncology may provide programs to assist these employees as they transition to oncology.

Our experience with new graduates indicates there is a limited understanding of the depth and breadth of the disease process, treatment options, management of side effects, and care needs at end of life. The goal of the didactic portion of the original internship was to provide a foundation for practice. New graduates received 12 weeks of orientation during which time they may begin working on an off shift where there are less resources. The project goal was to provide basic information related to oncology thereby increasing the amount of clinical time spent with the assigned clinical coach on the unit in the clinical setting. The oncology director, clinical nurse specialist, and educator met to redesign the classroom didactic experience. The existing program is offered three times a year and originally consisted of 23 hours of clinical content with 4 hours of specialty training for staff on the bone marrow transplant unit. Content was condensed to 10.5 hours. The transplant session was expanded to 8 hours and updated to include a telemetry lecture. Additionally, several sessions were redesigned to increase class participation in the learning process. To date, one internship class has taken place with the revised curriculum. A second class is currently underway. The average class score for the revised internship was 4.4 (using a 1-5 scale with 5 being excellent). The first class had some technical issues as the class was offered both live and virtually. Additionally, there were some issues with maintaining the slimmed down session time frames. Participant reception was overwhelmingly positive. The second program is currently ongoing as a live offering, with strict adherence to presentation time frames.

P333
ONCOLOGY REVIEW SERIES: UTILIZING GAME-BASED LEARNING TO PREPARE FOR ONCOLOGY CERTIFICATION
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Professional Development
The Commission on Cancer requires that every nurse at a COC accredited institution hold an oncology specific certification or obtain 36 CEUs in oncology for each accreditation cycle. Nurses at a large cancer center in New York City self-reported a deficit in oncology knowledge, and a hesitation to sit for oncology certification examinations due to this deficit of knowledge. In 2023, the cancer center entered into contract with ONCC for the ONCC Free Take program in the hopes that nursing certification rates would increase. The educators for the ambulatory cancer center recognized a need for knowledge enhancement, examination preparation, and contact hour opportunities to prepare the nurses to take their exams. A six-part game-based review series was created and conducted focusing on subject areas present on the oncology certification examination including medications, breast cancer, symptom management, oncologic emergencies, and treatment modalities. Facilitators utilized Kahoot!® to review OCN-level questions, answers and rationales. Nurses earned 1 contact hour for each session attended, allowing them to obtain a total of 6 contact hours. At the submission of this abstract, three review sessions have been completed with the other three scheduled before the end of 2023. Fifty evaluations have been completed by attendees showing a general increase in knowledge and confidence after attending each session as well as positive feedback about the game-based platform. Many attendees requested resource material to be distributed after each session as a way for them to review the subject matter on their own. Facilitators of this review series have received positive feedback from attendees regarding the format and content of each session, and its ability to help them prepare to take their oncology certification exam. Future plans include facilitating the oncology review series again in 2024, while incorporating changes based on feedback from participants including the creation and distribution of resource materials after each session to reinforce subject matter. Other plans include the possibility of inviting nurses from across the health system to participate as the session is conducted virtually.

P334
INTEGRATING ONS BREAST BUNDLE AS AN ORIENTATION REQUIREMENT
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Professional Development

A dedicated breast cancer center in a large teaching hospital located in New York City noted a 100% turnover in outpatient office practice nurses over the past 16 months. The newly hired staff had limited if any oncology experience and no breast oncology experience. While on orientation, nurses verbalized a lack of knowledge and confidence in caring for this specific population. An assessment of breast cancer-specific education was conducted and oncology nurse educators recommended the Oncology Nursing Society’s Breast Cancer Bundle be implemented into orientation. A justification was requested to demonstrate the need for education. The oncology nurse educators completed the Breast Cancer Bundle and developed a pre-test based on the material which was taken by all of the newly hired nurses. The average score was 44%. On average, nurses rated their current knowledge as 2.85 out of 10 and their confidence in providing education to patients as 3.5 out of 10. Based on the pre-test scores, the ONS Breast Cancer Bundle was incorporated as an orientation requirement. Nurses who have recently come off orientation are being given dedicated time to complete the bundle to enhance their knowledge and professional development. Thus far, one nurse has successfully completed the bundle and felt it improved her knowledge and confidence. Once all the nursing staff have completed the bundle, they will be asked to complete a post-test and once again rank their knowledge and confidence. We anticipate that completion of the Breast Cancer Bundle will improve nurses’ actual knowledge, perception of knowledge, and confidence in caring for this specialty population.

P335
IMPACT OF FALL EDUCATION TO NURSING STAFF ON ONCOLOGY PATIENT FALL RATES
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Patient Education and Safety

Falls and fall-related injuries impact patients’ health outcomes and are the most commonly reported adverse event in hospitals. Patient falls also affect reimbursement rates and can increase length of stay by about 6.3 days and increase undue patient harm. An increase of patients falls on the medical and surgical oncology acute care units have caused undue physical harm, increased moral distress, mental fatigue, and burnout in nurses; as well as placing financial burdens on the healthcare system. Implementing fall education and interventions aligns with national patient safety goals, is a top-priority project, is in alignment with the organization’s strategic plan and is a cost-savings topic related to reimbursement rates. Several evidence-based fall bundles have been shown to help reduce patient falls. The hospital where the intervention was implemented has many fall-risk interventions; however, there is no standardization of interventions or education for the caregivers implementing fall prevention interventions, making it a non-standardized approach for patient fall prevention. The purpose of this project is to evaluate the effect of tailored fall education to oncology RNs and CNAs on fall reduction on the medical and surgical oncology acute care units. This project used a quasi-experimental design with a pre- and post-test evaluating the nursing staff’s knowledge pre- and post-fall education. Retrospective and prospective reviews of patient fall rates, were conducted two months before the fall educational sessions, and prospective reviews were conducted after implementing fall education. This scholarly project showed a statistical significance in knowledge gained about fall prevention and fall precautions when comparing the pre- and post-knowledge test given to the nurses and nursing assistants in the medical and surgical oncology units. However, this project did not show statistical significance in the fall rates pre- and post-education. The implications for practice are immense. It will be essential to ensure that the organization updates its education of new nursing staff regarding fall education to ensure that all new nursing staff are equipped with the same fall education, and the new practice does not fall by the wayside. Some limitations of the project were the number of participants, a 10-day labor stoppage during the post-intervention phase, and short staffing post-implementation. The researcher will suggest the organization continue to monitor the long-term results of patient falls via the NDNQI database.

P336
EMPOWERING ONCOLOGY NURSE RESIDENTS THROUGH REFLECTION
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Professional Development

The expected number of new cancer diagnoses and cancer-related deaths in the United States continues to rise, while the number of nurses joining the workforce is shrinking due to stress, burnout, retirement, and nursing shortages exacerbated by the COVID-19 epidemic. Transitioning into professional nursing requires critical thinking, clinical reasoning, clinical judgment,
and a well-structured nurse residency program (NRP). In March 2023, the nursing professional development (NPD) team at a multi-site National Cancer Institute (NCI)-Designated Comprehensive Cancer Center was designed to support nurse residents (NRs) during the first 12-months of employment. Through rounding and conversations during class, the NPD practitioner recognized that NRs were struggling with unique challenges and needed additional support. The purpose was to offer additional support to NRs by creating and facilitating a 1-hour reflection session, Nurse Residents: Ribbons in the Sky Reflections (NR-RISR). The NR-RISR session was held at approximately three months of hire. The NPD practitioner used five guiding questions to facilitate the session:

- What has been your lows thus far?
- What has been your high thus far?
- How can we help you get to a better place?
- What are you dealing with during your orientation process?
- What words describe your experience related to professional nursing practice thus far?

Ten NRs attended the NR-RISR session. NRs were asked to respond to a statement about the NR-RISR on a five-point Likert scale. In the case of the question, NRs indicated whether they were very dissatisfied, dissatisfied, neutral, satisfied, and very satisfied. The questions and comments included, “I felt the Ribbons in the Sky debriefing benefited me.” NR response ratings were between 4 - 5, with a mean of 4.80. Comments included, “Identifying how to relate and empathize with patients is a skill that’s gonna build with time, and I’m glad I was able to express my feelings.” “It was helpful to have a place to talk about our experiences and feel supported,” “I left feeling heard and with understanding about the experiences in the first year of nursing.”

Discussion: NRs perceived the benefit of participating in a reflection session during the Oncology Nurse Residency Program (ONRP). Participating in an evidence-based ONRP provides support and decreases the intent to leave during the first 3-months of employment.

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IMPROVING INFUSION STAFF NURSE ORIENTATION THROUGH FOCUSED ONBOARDING AND ORIENTATION BINDER

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Professional Development

The clinical landscape is changing in a post-pandemic world, leading to fewer experienced oncology nurses applying for infusion staff nurse positions. With higher vacancy rates and fewer applicants, the Infusion Suite management team at The University of Iowa Hospitals and Clinics removed many qualifications from job postings with a plan in place to educate new-to-oncology nurses. A literature review was conducted. The University of Iowa Holden Comprehensive Cancer Center Infusion Suite implemented a focused orientation process including an orientation binder to help new-to-oncology nurses learn the skills and knowledge needed to function in a fast-paced 59 bed infusion center in June 2023. This focused orientation process included highly experienced preceptors, specific instructions for each week of orientation, and a binder that housed policies, procedures, and other relevant resources. A baseline pre-orientation survey was performed that included both “I feel” statements, and oncology knowledge questions to gauge the orientee’s knowledge before orientation. The orientee then was provided with the binder and spent the first few days in 1:1 training with the unit’s Clinical Practice Leader. These trainings included central line access and cares, hazardous drug administration and safe handling, charting, and PIV practice. Each week the orientee had different goals and focuses. For example, week 3 is “Supportive Cares and Immunotherapy”; during this week, the orientee is perfecting blood product administration and charting, electrolyte replacement, pain medication administration and administering various kinds of immunotherapy. The triage nurses and preceptor were educated about these expectations and focuses each week. When orientation was completed, the same survey was distributed, and results were compared. The two orientees that completed the process improved knowledge scores from 50% to 80% and 35% to 85%. All “I feel” statements had improvements in confidence. Other nurses commented that they wish they had this process during their orientation. The structure of the new orientation process was found to be beneficial to the new RNs, with only positive comments on the survey. Additionally, all RNs were off orientation in 8 weeks or less, improved from an average of 10-12 previously. Challenges included minimal learning opportunities for the week (example: no peripheral vesicant patients scheduled for the peripheral vesicant week), so modifications were made based on patient volumes.

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NEW GRADUATES NURSES AND ONBOARDING SKILLS DAY
The sudden, widespread development of COVID-19 caused noteworthy disturbances in nursing education and in onboarding a recent new graduate nurses. Overwhelmingly, the pandemic caused clinical hours to be shortened or eliminated. Many student nurses participated in simulation, but it was seen that there was significant difficulty applying the knowledge learned to patient care. A formal skills day was formulated to provide kinesthetic learning that is similar at the bedside and where nurses can learn and perform the task at hand without being interrupted. The aim was to tailor skills day content to the specific needs of the patient population which has been everchanging since the pandemic first started. The purpose of these skills orientation days were to review specific nursing practices a month into nursing orientation in a classroom setting. This classroom environment provides an anxiety free environment to practice. Skills orientation days provide an environment in which nurses can review the policies, practice in a simulation experience, then practice on a patient with the supervision of a tenured nurse. After the skill is performed feedback is provided according to the policy to ensure patient safety. Tasks reviewed reflect our nursing and hospital indicators. They include central line dressing changes and maintenance, blood cultures from central lines, administration of blood products, Foley maintenance care, and patient-controlled analgesia. Not only are tasks reviewed and performed but it is also a space to talk and offer support amongst tenured nurses and their peers. Evaluation/Results: Ten nurses completed the skills orientation days thus far. Overall, the feedback and responses were positive. A new nurse who went through the session reported, “I thought skills day was very informative and well structured. I was able to practice the skills in the classroom with opportunities to correct my errors.” Not only are we seeing a positive impact amongst our new nurses but our seasoned nurses have also mentioned how beneficial it has been. Proposed outcomes will include survey results from staff participation, unit turnover, and CLASBI rates through March 2024. This skills day allows for nurses to develop knowledge and practice of hospital policies. Skills day also fosters a mentoring relationship between the novice nurse and the tenured nurse providing instruction.

P339
CREATIVE REFLECTIONS AS AN INTERVENTION IN DEALING WITH STRESSFUL EXPERIENCES

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Professional Development

Stress reduction for nurses in clinical practice is an ongoing need. Oncology nurses are continually exposed to the suffering of oncology patients. Often, traditional methods of stress reduction are either not possible due to time constraints or ineffective. An individual approach such as creative reflection may be more effective. Creative reflection is based on the work in art therapy that has been used with patients for many years. The purpose of this presentation is to provide an overview and some outcomes of creative reflection as an approach to understanding and potentially resolving stressful situations. Creative reflection incorporates an individual’s unique artistic talents to examine situations and reduce stress. Nurses can select a form of expression that best fits their needs and their comfort level. Nurses encounter stress in varying situations in the clinical setting. Creative reflection engages them in exploring a situation and developing sensitivity to their own feelings, those of patients, and staff. They are directed to describe the situation and their perceptions in writing, in art, poetry, or other artistic forms. Nurses may or may not feel comfortable in sharing their feelings. They can use this approach alone or by discussing their reflections with others. The directions are simple. Nurses are told to select a situation that was particularly stressful and use an art form to describe the situation and examine their feelings and perceptions. Art has been used to facilitate feelings of release in difficult situations. In the clinical setting, it can also help nurses to gain insight into their responses to stressful situations. Creative reflection allows nurses to debrief after a stressful situation. Introducing creative reflection to nurses may provide a method to enhance coping through better understanding of situations and their responses which could lead to prevention of compassion fatigue and burnout. Students who participated in creative reflection saw it as an effective outlet for feelings derived from difficult or unexpected clinical situations. Creative reflection is an economical approach to management of difficult situations that can be used alone or in groups. Research with students has resulted in the students finding meaning in suffering and death, and the ability to use this approach to destress. Students selected varying forms of expression and many
freely shared their work with others deriving additional feedback and support.

**P340**
**REDUCING CLABSI: A HEMATOLOGY SERVICE LINE INITIATIVE**
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**Oncology Nursing Practice**

Central Line Associated Blood Stream Infections (CLABSI) are associated with significant morbidity, mortality, and health care costs. Quarterly observation reflects continued high rates on in-patient hematology units at City of Hope Research Hospital (COH) despite previous efforts of implementing a CLABSI prevention bundle. The hematology leadership team added additional layers of education and surveillance to help decrease CLABSI rates. Core principles recommended by the Agency for Healthcare Research and Quality (ahrq.gov), were used to engage and educate staff in an effort to decrease incident rates. The purpose was to reduce CLABSI rates on all hematology units at City of Hope Research Hospital by 50% over a 6-month period starting from March 1st-September 28th. Data will be compared to the previous 6 months. Interventions- Ongoing: Hand hygiene oversite, monthly staff meeting metric review. Interventions-New: Standardized communication regarding CLABSI’s for unit team sharing, engaged colleagues with a multidisciplinary review of each CLABSI case, signage for visitors and staff created to increase hand hygiene compliance, centralized supplies for CVAD care, required RN education modules, CLABSI bundle updated to reflect best practice based on literature review, required RN skills day education including a CVAD station. A 45% decrease in CLABSI was observed in a 6-month period. The months beginning with new interventions were compared with those months prior. Barriers that were encountered by the leadership team include:
- Difficulty having consistent members of the multidisciplinary team available to review cases.
- Staffing shortages in nursing and ancillary departments which impacted availability of support and supplies.
- A PICC line shortage occurred, and a new product was used until regular supply could be obtained.
- Travelers/Float Staff support the nursing units but are not as rigorously trained and usually have a shorter orientation.
- Patient refusals for skin cleansing increase their chances for infection.
- Continued low hand hygiene scores increase patient changes for infection. The organizational goal for hand hygiene compliance is 95% or higher. Unit based council in each hematology unit were on-board with new interventions and assisted in promoting education plans, volunteering for skills days, and leading unit huddles and multidisciplinary discussion. They are also currently involved in sustaining these efforts and influencing organization-wide initiatives. We hope to see continued decreases in CLABSI rates, which will help to reduce patient costs and length of stay.

**P341**
**A STATEWIDE COMMUNITY ONCOLOGY NURSE RESIDENCY PROGRAM FOR NEW GRADUATES**
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**Professional Development**

For an ambulatory oncology practice to compete with the challenging Nurse (RN) staffing crisis, a new way of hiring, onboarding, and training novice RNs was developed through a Residency Program (RP) to produce competent Oncology RNs. Due to the impending nursing shortage, the RP was created in 2018 with the goal of hiring novice RNs. The Education Team (ET) manages the standardized RP which consists of 8 weeks of structured training; 2 weeks classroom lecture followed by 6 weeks in the infusion room. The program alleviates onboarding challenges and site staffing needs by placing each Resident RN (RRNs) into an infusion position. Recruiting: Talent Acquisition screens and reviews potential candidates for interviews with the ET every Fall and Spring. Each candidate is scored during their interview and job offers are made to highest rated. RRNs are paired with Preceptor RNs. Preceptors volunteer to mentor in the infusion room. Preceptors are OCN preferred, not required, and have at least 2 years oncology experience. Classroom: Completion of Fundamentals of Oncology Nursing e-learning program, Foundations of Oncology Nursing bundle through ONS, cancer-specific lectures, and various patient specific topics. State-wide Directors present areas of focus regarding their specialized field of expertise. Infusion: All RRNs complete onboarding checklists that include vital training for infusion safety practices ensuring competency. To assess milestones and overall feedback, the ET has...
communication weekly with RRNs and preceptors. Since the inception of the program, overall retention is 67%. A total of 51 RRNs have completed the program. Certificates of completion for the ONS and e-learning courses are shared with ET as part of the clinical checklists. To ensure program success and sustainability, preceptors and RRNs are supported by the ET weekly who work to address any concerns quickly. If RRNs are not progressing, training is extended. End of residency evaluations are completed by both RRNs and preceptors to ensure a successful program. Tracking RRNs occurs for two years after completion of the program for retention record. The role of the RP is to create a standardized clinical onboarding process to train RRNs to become successful oncology RNs. After completion of the RP and additional weeks of mentoring, education, and completion of oncology course exams, our RRNs begin their careers in the infusion room increasing the nursing workforce and profession.

P342
ALL ABOARD THE CHEMO TRAIN: A COLLABORATIVE APPROACH TO TRAINING NON-ONCOLOGY NURSES FOR CHEMOTHERAPY ADMINISTRATION

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Professional Development

Inpatient Oncology leadership at a large urban academic medical center performed for than 320 chemotherapy administrations on non-oncology units, spending over 12,155 minutes (203 hours) coordinating and administering the drugs, resulting in significant time away from their own unit operations in FY22. More than 1/3 (90) of these administrations were completed in the medical intensive care unit (MICU). The purpose of this project was to implement phased in chemotherapy administration training for MICU nurses and decrease the number of administrations and time spent coordinating and administering chemotherapy drugs in MICU by inpatient oncology leadership in FY23. Feedback was obtained related to current concerns and barriers to hazardous drug training in the MICU setting. Institutional oncology leadership support was obtained for financial resources and departmental collaboration. Based on this feedback, a small cohort of MICU nurses were identified and a training plan was implemented and resources were created regarding safe handling and administration of chemotherapy.

Multiple barriers were initially encountered during the rollout of this project related to medical record chemotherapy template access, financial funding, and changes to MICU and oncology leadership teams. To date, five MICU nurses have completed the chemotherapy course and practicum necessary to safely administer chemotherapy/immunotherapy drugs. They completed initial training of online didactic course, electronic medical record for chemotherapy templates and clinical practicum. Ongoing training is in process with evaluation of number of administrations and time saved by oncology leadership at this time. While tracking of data is ongoing, to date, three off unit administrations have been completed by the trained MICU nurses. This also has increased patient safety for oncology patients in the MICU with the additional skill set and knowledge base of chemotherapy trained MICU nurses with the intention to increase patient safety in oncology by having leadership remain on the unit. The current training plan is in process for training the next cohort of MICU nurses and adjustments will be made based on feedback from those who have completed their training. This new skill set also allows for professional development in the MICU nurses beyond their current scope and for an expanded knowledge base. This process can be applied on other units and standardized throughout the hospital system, as well as other institutions with a large off-unit chemotherapy volume.

P343
OCN CERTIFICATION PREP CLASS

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Professional Development

Thedacare Regional Cancer Center has 60 RNS working in our center, with 30 being OCN certified. The following goal was proposed by the completion of 2023. By the end of 2023, Thedacare Regional Cancer Center will increase its number of OCN-certified nurses by ten percent. Nurses were surveyed on interest in OCN certification and anything holding them back:

- Nurses are afraid of failing the exam
- Lack of books for studying
- Cost of exam
- Cost of review class.

Three nurses were interested in OCN certification this year. An application for the ONCC voucher program gained approval, and an OCN review class was developed. I’ve asked that we supply nurses with a free-of-
charge review course and contacted ONCC. I was provided with 3 NPs who worked with me to develop our own OCN review class.

- Several additional study books for nurses were purchased
- Application submitted for the voucher grant through national ONS

After this program, the participant should be able to:

- Identify at-risk populations and preventive health practices.
- Review carcinogenesis and disease course for specific cancer types.
- Discuss treatment modalities for cancer patients.
- Explain the role of research in the treatment of cancer.
- Recognize the most common oncologic emergencies and treatments.
- Review the potential psychosocial disturbances and alterations that can affect cancer patients.
- Recognize potential issues that can occur post-treatment.
- Identify resources available regarding Scope and Practice Standards of Oncology Nursing.

Goal: To enable the learner to apply evidence-based information to the care of cancer patients. This course will provide the registered nurses with classroom instruction and nursing expertise to prepare them to take the Oncology Certification Nurse (OCN) exam through the Oncology Nursing Certification Corporation (ONCC). To increase our percentage of OCN-certified nurses.

METHODS (Setting; Study Design; Participants):

- Applied for the ONCC Voucher program
- Applied for a Thedacare Foundation grant to cover the cost and supplies to run the OCN review class
- Developed an OCN Certification review class

RESULTS:

- Was accepted to the ONCC voucher program
- Applied for and was approved for a Thedacare Foundation grant to cover the cost and supplies to run the OCN review class with 21 nurses attending four review classes
- We now have 18 nurses interested in testing for their OCN this year

**P344 INTEGRATING ONCOLOGY CONTENT ACROSS NURSING EDUCATION: AN EXPLORATION OF METHODS IN UNDERGRADUATE PROGRAMS**

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Oncology Nursing Practice

The demand for competent, well-equipped oncology nurses is on the rise, as healthcare organizations prepare to meet the increasing needs of a growing patient population. Undergraduate nursing programs offer varying exposure to oncology content in their clinical and didactic environments. Most programs prepare students to be generalist nurses and offer little oncologic exposure, especially in the clinical setting. Upon graduation, nurses often feel unprepared to practice in specialized oncology areas and often likely require more intensive training programs upon hire. Even if they are practicing outside of oncology, students and new graduates will encounter these patients in other care settings considering the increasing numbers of those diagnosed with malignancy. The primary objective of this presentation is to explore methods of incorporating oncologic content across undergraduate nursing programs, so student might acquire competencies associated with the administration of comprehensive, evidence-based, oncologic care in a variety of settings.

A review of the literature was conducted using the following key words: oncology, undergraduate nursing, and clinical education. Themes are associated with the integration of oncology content were identified and organized by teaching method. The literature revealed common themes related to the integration of oncology content across undergraduate nursing education. Multiple teaching modalities were identified and include the use of case studies, simulation, projects, clinical opportunities, interprofessional experiences and expository teaching strategies to introduce the specialty of oncology to undergraduates. Quality oncology education is essential in developing competent nursing graduates that will manage the growing oncology patient population within the United States. Students and graduates will encounter these patients in a variety of care settings. Exploring the integration of oncology content across undergraduate nursing programs will demonstrate existing teaching methods that can be implemented to increase exposure to the specialty. This will improve the ability of new graduate nurses to care for this growing population and can encourage an earlier student interest in oncology. In addition, obtaining an understanding of graduates’ baseline oncologic knowledge will guide staff educators in developing training programs for new hires. This increased awareness is required to assess new graduate job readiness, and facilitate the development of adequate internships, workplace orientation, and continuing education.
opportunities setting newly hired nurses up for success and improving patient safety.

**P345**

**CLINICAL RESEARCH UNIT CLINICAL RESEARCH NURSE ELECTRONIC HEALTH RECORD DOCUMENTATION OPTIMIZATION PROJECT**

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Oncology Nursing Practice

The Clinical Research Unit (CRU) within this National Cancer Institute designated Comprehensive Cancer Center is comprised of 12 cancer research programs (Research Programs) with individualized research documentation workflows. For the years 2021 and 2022, attrition of clinical research professionals (CRPs) resulted in annual onboarding of 46 new CRPs. For these same years, 23 of the CRPs were clinical research nurses (CRNs) of varying research and oncology backgrounds. The CRU’s Education/QA and Clinical Research Operations leadership (Leadership) recognized that the Research Programs’ divergent documentation workflows and the CRNs’ experiential differences created CRN research documentation inefficiencies. Leadership’s collaboration with the Health System’s electronic health record (EHR) Education Team (EHR/Education Team) ameliorated these challenges. The EHR/Education Team developed and implemented the CRU Clinical Research Nurse Optimization Proposal (Proposal). The Proposal’s aim was to facilitate optimal CRN EHR research documentation by creating uniform, accessible, and efficient documentation best practices for CRN progress note (Note) efficiencies and routing, order entry (laboratory and radiology), EHR In-Basket Messaging, and participant allergy, medication, and medical history documentation. The Proposal had three phases, the EHR/Education Team (1) shadowed CRNs and determined opportunities for improvement and application of efficiencies (Shadow/Evaluation); (2) formulated and evaluated recommendations, determined interventions, and discussed education delivery logistics (Assessment/Plan); and (3) provided a CRN research documentation webinar and dedicated CRN 1:1 sessions, reviewed post-education surveys and provided feedback of education effort, and explored education sustainment opportunities (Education/Wrap-up). The EHR/Education Team shadowed 24% of the CRNs for eight days. After review and evaluation of this activity, the EHR/Education Team made these primary recommendations: (1) utilize the ‘Research Non-Chargeable Visit’ for research-related visits to reflect CRN authorship, (2) use the streamlined ‘co-sign required’ functionality to forward CRN Notes to providers for attestation, (3) teach general SmartTool functionality and create improved Note templates to include links for Concomitant Medication and Adverse Event tables, (4) create/edit order panels and laboratory preference lists, and (5) improve EHR In-Basket Messaging to study participants and staff. The collaboration between Leadership and the EHR/Education Team has resulted in CRN onboarding education updates (1:1 sessions with onboarding CRNs and the EHR/Education Team), CRN 1:1 sessions on-demand, piloting/adoption of standardized Note templates for CRN documentation, creation of a CRU research-specific handbook for all research clinicians, and institution of unit-wide research webinars.

**P346**

**MEETING THE STANDARD: CENTRALLY MANAGING THE COMMISSION ON CANCER STANDARD FOR ONCOLOGY NURSING CREDENTIALS 4.2**

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Professional Development

The Commission on Cancer (CoC) a national, multidisciplinary quality consortium supports the continuous improvement of cancer care through organizational accreditation. In 2021, the CoC implemented the new Standard for Oncology Nursing Credentials 4.2 that requires all non-oncology certified registered and advanced practice nurses to obtain a minimum of 36 oncology-focused contact hours per 3-year accreditation cycle. Each CoC accredited organization is responsible for providing evidence of meeting this standard. To comply with this new standard, an innovative method of monitoring and tracking nursing contact hours was crucial. The purpose was to incrementally develop...
a centralized method to efficiently collect and track contact hours for non-certified nurses that promotes standardization, efficiency, and accuracy. The process allows validation of quality contact hours, while demonstrating evidence of meeting the CoC standard 4.2. Registered and advanced practice nurses submitted their contact hour certificates into a centralized learning management system (LMS). Contact hour certificates must include nurse’s name, title and date of education, and number of contact hours. Two-three nurses regularly review each submission to validate accuracy and inclusion of oncology nursing specific content as described by the certificate title. Reports generated by the LMS counted the details and number of contact hours submitted per nurse. This report was merged with staff data reports from the current human resource management system. This final report summarized the number of contact hours submitted by each non-certified oncology nurse demonstrating proof of meeting the CoC requirement. From 2021-2022 a total of 4,887 contact hour certificates successfully through the LMS. During that time, 4,887 contact hour certificates were reviewed and accepted as accurate in meeting the standard. Collection continues in 2023. Final reports are now readily available for reference. The new CoC Standard for Oncology Nursing Credentials 4.2 poses a challenge for large organizations with hundreds of nurses, as adherence can be burdensome for management and frontline staff. Creative use of existing LMS and human resource records may be untapped resources. The resulting centralized submission, review, and reporting process, successfully managed by only 2-3 nurses at a large Midwest cancer center was more efficient and effective than previous collection methods.

P347
AN INNOVATIVE METHOD TO ASSESS COMPETENCE: USING OBSERVATION, REFLECTION, AND SELF-ASSESSMENT TO VALIDATE ONGOING COMPETENCE IN REMOTE ONCOLOGY NURSE NAVIGATORS

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Professional Development

Oncology nurses provide patient care in ever-expanding care locations including entirely non-direct, remote settings. These nurses practice a high level of autonomy; however, it can be difficult to assess competence in these roles. Literature surrounding competence assessment tends to focus on observable psychomotor skills in direct care. This poses a unique challenge and necessitates creativity when evaluating the cognitive and affective competence of remote non-direct care nurses like oncology nurse navigators. An innovative method to evaluate oncology nurse navigator’s practice competence was developed using self-reflection, a pre and post-assessment survey, and peer discussion as methods for demonstrating cognitive and affective skills needed in the role. Twenty-six nurse navigators (NN) completed a half-day clinical observation experience in an oncology clinic they support. Pre and post-experience data were collected using a six-item Likert-scale self-assessment survey developed from NN role standard workflow. Response options ranged from strongly agree (5) to strongly disagree (1). The survey addressed identifying valuable patient information and how it’s used by the care team; thoroughly assessing and addressing barriers to patient care; and understanding clinic flow, and the patient’s experience. Using guiding questions, participants also wrote self-reflections comparing their thoughts after the shadow experience with their current practice. Navigators were encouraged to discuss the experience with their peers. Responses were completed by n = 17 navigators pre-experience and n = 11 navigators post-experience. An independent samples t-test (alpha = 0.05) between pre and post scores demonstrated a statistically significant increase for two questions: “I understand the ‘flow’ of routine clinical activities for the providers I serve.” (p = .004) and “I have a thorough understanding of the patient experience.” (p < .001). Self-reflections indicated a better understanding of patient flow during a clinic visit. Survey results combined with self-reflections of an in-person clinical shadow competency activity resulted in improved self-perceived competence. This demonstrates benefits in being at the clinic even for a half-day for completely remote NN. Understanding changes in clinic routines and the patient experience may help the remote NN provide more support to patients and better address barriers to care. Incorporating periodic shadows for other remote workers may be beneficial to patient care for other roles as well.

P348
THE CHALLENGE OF ON BOARDING A NON-ONCOLOGY NURSE IN AN OUTPATIENT ONCOLOGY INFUSION CENTER

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Professional Development

Post COVID, we are seeing significant changes within
the profession of nursing. Coveted outpatient positions that took years of experience within a specialty to obtain are now being offered to applicants with minimal oncology experience. The outpatient oncology infusion area in our organization is fast paced, requires a level of autonomy and critical thinking skills developed over years in the specialty. Six open RN vacancies within the department were filled with nurses that have various levels of nursing experience but minimal oncology experience. Our current orientation process does not address the gap between nursing and oncology nursing.

Challenges identified included finding the "sweet spot" for engagement, multi-generational disciplines. Thus far, six months of rounding have been accomplished by enlisting both administrative and clinical managerial support. Additionally, collaboration with hospital-wide nursing councils, clinical educators and the professional development team offered support to "gain entrance" to the in-patient units was accomplished by enlisting both administrative and clinical managerial support.

A National Cancer Institute (NCI) designated Comprehensive Cancer Center conducts an annual professional nursing education survey. The past two years revealed a need for enhanced and accessible professional education specifically on acute care units during night shifts. Requests included the broadening of clinical skills, supporting the patient experience, opportunities for scholarship such as academic, certification and research pursuits and the expansion of interprofessional collaboration across institutional disciplines.

The purpose of this intentional process is to ensure equitable professional development and educational offerings around the clock to staff who have articulated that the time constraints of working during night shifts precludes access to "live" educational opportunities. An additional purpose is to create a culture that values professional oncology nurses as life-long career learners and to demystify the perception that education is only available during main-stream hours. The initial method to "gain entrance" to the in-patient units was accomplished by enlisting both administrative and clinical managerial support.

Additionally, collaboration with hospital-wide nursing councils, clinical educators and the professional development team offered support to establish a program of professional education rounds on all units. Rounds consisted of preparation of both formal and informal "live" content. Topics focused on relevance to the particular unit and were tailored to meet the needs of individual learners. Collaborative rounds included representation from administration, clinical educators, advanced practice nurses, staff nurses and multidisciplinary specialists. Bimonthly night rounds were convened during a mutually convenient time for staff to take part. (Typically, evening and night shift access must take place during the "wee hours")

Evaluation: This evolving initiative has demonstrated tremendous acceptance for staff to feel part of "one institution" and underscores the value of professionalization of nurses. Preliminary survey findings revealed an intense desire for acquisition of knowledge and opportunities for growth and collegueship across disciplines. Thus far six months of rounding have been offered with approximately twenty nurses engaging at each encounter. Challenges identified included finding the "sweet spot" for engagement, multi-generational

P349 PROFESSIONAL STAFF DEVELOPMENT AVAILABLE AROUND THE CLOCK

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Professional Development

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acceptance and ensuring that this effort is perceived as valuable by participants. The field notes from this ethnographic approach to promote collegiality across a multidisciplinary oncology setting will continue to formalize as annual needs surveys are conducted and professional education is solidified.

P350
PASSION, PERSEVERANCE, AND COMMITMENT – THE SEVEN-YEAR JOURNEY OF A DEDICATED CLINICAL ONCOLOGY NURSE TEAM
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Healthcare Delivery

The aim of this work was to revolutionize the case study paradigm and deconstruct the traditional case study approach, placing the patient, instead of the provider, at the center of the narrative. This new case study method intercalates the clinicians’ analysis of the case with the patient’s commentary on the lived experience. The unique approach to this case study method is the addition of the patient’s and caregiver’s voices. The lived experience is embedded within the case study format. Employing Interpretive Phenomenology, patients and caregivers shared their stories about the transplant and cellular therapy journey. Seeking a more holistic approach, the method places the patient, not the disease, at the center of care delivery closely aligning with the Relationship-Based Care (RBC) model and Jean Watson’s Theory of Human Caring. Including the patient’s story in the case study provides authenticity by outlining the clinical significance of the disease process and its treatment with the thoughts and feelings of the patient and caregiver included. The lived experience of the pair is illuminated in parallel with the evolving physical care and experiences of the transplant journey. The reader has the opportunity to have a window into those experiences which can help guide care based on those experiences. Further research needs to be completed to determine if this type of case study provides an effective tool to educate nurses. We offer these patient centered case studies both to provide an exemplar for clinical nurses in all areas of specialization. It is the research team’s hope that by outlining the methods used to create these case studies, other nurse researchers will adopt this method and use it to describe individual experiences and a collective phenomenon of interest in their patient populations and bring more patient stories to life.

P351
CANCER BASICS STAFF EDUCATION CLASS TO IMPROVE ONCOLOGY NURSING PRACTICE
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Oncology Nursing Practice

We have growing oncology and infusion clinics with a number of new hires. The new core staff are predominantly experienced RNs, LPNs, and CMAs but they lack oncology experience. We identified a gap in learning as there is no structured learning after orientation for clinic staff while infusion RNs rely on the Oncology Nursing Society’s Chemotherapy Immunotherapy Certificate class for structured educational content. We strove to minimize this gap by providing structured learning opportunities with a set of cancer basics classes. The goal was to increase the knowledge and comfort level of our novice oncology team members. We developed a cancer basics course, open to all nurses, comprised of eight 30-minute modules providing an overview of eight cancer types. Class content included pathophysiology, diagnosis, treatment, treatment side effects, and administration tips. It was reviewed by experienced infusion nurses using evidence-based resources. A short survey was developed to measure participants self-reported levels of comfort with the various cancer types. It was administered to participants pre and post class for comparison. The survey results were anonymous. Three open-ended questions were included on the post survey to collect additional feedback from participants. The survey used a Likert scale of one to five with one being VERY UNCOMFORTABLE and five being VERY COMFORTABLE. The average score was calculated for each survey and compared. Out of a total possible points of 25, the average comfort level pre-class was 12.05. Post course results revealed a comfort level of 18.05 out of 25. On average there was an increase of 24% improvement in the comfort level. The average number of participants was 8.25. The staff responded positively to this educational offering. All of
the participants indicated higher comfort levels after the classes. These findings have generated interest in the provision of additional educational opportunities to improve nursing practice. We plan to offer these classes again with an expanded duration to allow greater breadth and depth of the topics.

P352
DEDICATED DE-ESCALATION TRAINING FOR NURSE NAVIGATORS
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Professional Development
Oncology Nurse Navigators (ONNs) are the first point of contact for Dana-Farber Cancer Institute patients when they call or message their oncologist. During the COVID-19 pandemic, verbal and physical abuse experienced by nurses was exacerbated (Thompson et al). Providing education and support to staff to manage escalating patient distress was imperative. The purpose was to provide dedicated de-escalation training specific to ONN workflows and experiences to better prepare ONNs in their day-to-day interactions. Education was provided at the virtual ONN Practice Committee meeting. This meeting was followed up with two small group sessions on Zoom. Content was delivered through de-escalation tips, best practices and role playing. Role playing consisted of a case study portraying an ONN and difficult spouse that was based on real themes and scenarios that ONNs experienced. Content expert and Director of Psychology lead the discussion and provided tools and strategies. It was the first time that ONNs received dedicated training on difficult patients and scenarios using real scenarios reflecting their unique role. Additional smaller breakout sessions allowed the opportunity to dive into strategies in a more intimate setting. The engagement and attendance of ONNs in the committee and follow-up sessions was high. An electronic post-training survey showed 83% (n=48) of ONNs found the content of programming relevant to current practice. More trainings and programming on de-escalation topic was reported by 85% (n=39). When asked how they wanted to receive the additional content, 33% requested another committee training, 33% requested a separate workshop, and 25% recommended new hire training. When asked how the session impacted their practice, themes of the qualitative responses included “it helped to discuss situations that come up and how to deal with them, examples and role playing helped a lot, information was very useful and provided tools for patient interaction”. The feedback from the ONNs confirmed the value of the additional dedicated training and provided validation and assertion in their practice. Creating content that is directly applicable to ONN challenges proved to be effective. How to best educate and support nurses managing aggression and abuse via telehealth visits may be a gap in practice and research.

P353
VIRTUAL ONCOLOGY NURSE TRAINING: ELEVATING ONCOLOGY CARE NATIONWIDE
Professional Development
Oncology Nursing requires specialty knowledge and skills to provide safe and effective care. Growth in outpatient oncology, coupled with the impact of the Great Resignation, has created a mounting need to onboard new to oncology nurses in outpatient settings. Our organization has over 500 outpatient sites of service ranging from large urban centers to small community clinics with various models and resources for nursing education. The influx of new nurses to these settings highlighted weaknesses in existing models for orientation. Interviews and organizational surveys revealed approximately 40% of nurse new hires and leaders rated orientation resources as inadequate. Analysis pinpointed gaps in training content and inconsistencies in delivery and support. The purpose was to create a comprehensive organization wide foundational oncology orientation program providing consistent education to prepare nurses for clinical oncology practice. Leveraging collaborative insights from stakeholders, the plan centered on an interactive, evidence-based curriculum focused on foundational oncology nursing practice. Our live virtual program model engages nurses and subject matter experts in case studies, real-time Q&A, and gamification covering carefully selected topics to ensure nurses are adept at handling diverse oncology scenarios. A successful pilot was conducted, and feedback loops were established to continuously refine program offerings. To date we have had over 100 participants. Pre- and post-training evaluations evidenced a 20% improvement in nurses’ self-assessment of knowledge and ability to address 13 key oncology topics and 98% rated their onboarding experience as good or above with 43% rating it as excellent after participation in our program. It is important to note that
many participants had already completed standard orientation and were working independently before taking this program. Leaders and preceptors reported great satisfaction with the enhanced orientation support and the ability to integrate new staff fully into care models. Preliminary data also suggests a positive impact on nurse retention. Moreover, by offering virtually, the program reaches over 500 sites of service nationwide with one clinical education specialist. The program has demonstrated that virtual orientation can be effective in increasing nurse knowledge and self-efficacy in oncology nursing and allows educators to deliver consistent education to nurses at diverse geographic locations synchronously without requiring travel to a centralized location. Challenges still exist accounting for multiple time zones, unique practice workflows and considerations for staffing.

P354
PATIENT-CENTRIC: BEYOND AN INFUSION CLINIC

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Professional Development

Patients with hematologic malignancies endure challenging journeys from diagnosis to surveillance and can benefit from a specialty clinic. Creating an outpatient infusion clinic designed for vulnerable patients required strategic step-by-step design and implementation of a learning curriculum to precept nursing staff. Intervention: When a new infusion clinic dedicated to patients with hematologic malignancies was announced, a team of leaders, providers, and nursing experts brainstormed how to create an environment that would provide optimal care for patients including transplant and chimeric antigen receptor (CAR) T-cell candidates. Five key competencies were identified for staff including peripheral stem cell collection and leukapheresis for CAR T-cell, chemo/immunotherapy, bone marrow aspiration and biopsy, lab work/injections, and transplants including donor lymphocyte infusion. Historically, these patients received treatment in general infusion areas, and this specialty infusion center would provide critical care. Precepting new staff while simultaneously treating existing patients required comprehensive planning to ensure a smooth trajectory from planning to execution. Resources from Oncology Nursing Society and National Cancer Institute were utilized to create a teaching model that consists of a BMT workshop, one-on-one mentorship, a competency checklist and other learning and evaluation elements. Seven nurses were recruited to staff this clinic and learn through this curriculum while supervised by a mentor with the support of three expert nurses. One nurse mastered all five competencies including administration of donor lymphocyte infusion as well as boost infusion for an autologous patient, and six nurses mastered four competencies. Both patients and nursing staff quickly recognized a higher standard of care provided through this environment. The success of the infusion clinic is reflected by patient testimonials including being in a “calm and quiet environment”, “I know every face”, and “check-in staff calls you (nurse) when I don’t look well”. Through a continuum of care, nurses are able to quickly recognize deviations in patient conditions allowing for earlier intervention. Creating a patient-centric infusion clinic has many successes particularly when leveraging educated and experienced nursing staff in hematologic malignancies. Patients recognize the effective collaboration between healthcare professionals which results in higher trust in the staff. By building a truly patient-centric environment that is led by expert nurses who were precepted through a combination of unique learning methods and expert mentorship, patient-care is enhanced making this project worthwhile.

P355
LEVERAGING TECHNOLOGY FOR SELF-PACED ONCOLOGY SPECIALTY CERTIFICATION REVIEW

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Professional Development

Specialty certification in Oncology and blood and marrow transplant has been shown to have value for both nurses and patients (“Benefits of certification”, 2023). Additionally, maintaining specialty certification rates is a component of Magnet® designation and Commission on Cancer accreditation standards. Increasing demands on RN time and group gathering constraints due to COVID-19 made traditional classroom certification review courses impractical. Alternatively, online learning platforms provide advantages which resolve some of these limitations including time and location flexibility, the ability to reach a wider audience, and immediate availability to the course content. The purpose was to create enduring, online learner-paced certification review material for RNs to obtain sup-
PORT PREPARING FOR OR RENEWING OCN® OR BMTCN®

Microsoft Sway was utilized as a platform to collate content and resources corresponding to the OCN® and BMTCN® test blueprints; including embedded video presentations from subject matter experts, links to podcasts, written materials, and Microsoft Forms quizzes to engage all learning styles. Nurses who are already certified have the option to interact with specific sections of their choosing to fulfill NCPD corresponding to the renewal point categories. Certification rates have started to increase since the roll-out of these asynchronous review materials. RNs have expressed appreciation for the flexibility associated with supporting learner pace and opportunities to return to the content as many times as desired. Additionally, the Sways contain opportunities to obtain over 100 free NCPD. This is incredibly beneficial for nurses given the decreased funds available to reimburse for nursing continuing education. This has been an innovative way to support RNs in preparing for or renewing certification. In-person review courses were previously hosted once or twice a year. The creation of enduring content has allowed more RNs to gain access at their own convenience. Moving forward the hope is to facilitate virtual study sessions to create opportunities for collaboration among RNs planning to certify. As data becomes available, there will be opportunity to quantify the impact of these resources on new certifications and renewals.

P356 USING LEAN MANAGEMENT PRINCIPLES TO GUIDE NURSE SELECTION OF IMPLANTED PORT NEEDLES ON TWO FAST-PACED INPATIENT ONCOLOGY UNITS TO PREVENT UNSAFE CONTRAST ADMINISTRATION AND UNNECESSARY DELAYS IN THE CT SUITE

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Oncology Nursing Practice

Implantable venous access devices (“ports”) are safe, convenient, and efficient in patients receiving cancer treatments. Power-rated ports can be safely used for contrast-enhanced computed tomography (CT) scans if they are accessed with power-rated port needles. Extravasation, catheter rupture, fragmentation and embolization are adverse events that can happen if contrast is power injected through a standard port. While the use of power-injectable ports is becoming standard practice, many patients still have non-power-injectable ports. Verifying whether a port is power-injectable requires a standard assessment by a trained nurse. Accurate identification of a port before accessing it is a critical nurse-driven step that can prevent unsafe contrast administration and unnecessary delays in the CT suite. In November 2022, all inpatient nurses working in a large urban NCI-designated cancer center were trained to identify and access power-injectable ports. After training completion, five reported safety events involving patients with implanted ports requiring contrast-enhanced scans were reported between two inpatient units. Power ports were being accessed with non-power-rated needles, requiring replacement of port needle or peripheral IV insertion. This quality improvement project’s purpose was to use Lean management principles to decrease the number of safety events related to improperly accessed ports. Secondary goals included improving nurse proficiency in power port identification and decreasing delays for radiology staff and patients. Applying principles of Lean management like visual control, jidoka (automation with a human touch), and muda (waste), brightly colored note cards were posted on the containers holding non-power-rated needles on two inpatient units’ supply machines. The process of gathering supplies for port accessing was symbolically interrupted with an exclamation (“wait”) and a list of indicators for a power-injectable port. This example of visual control prompted reassessment or reassurance of the type of implanted port and allowed for the process to continue or be corrected, demonstrating jidoka. Reduction of waiting (time) and incorrect processing, two major types of muda, were the objectives of this intervention. After placing the reminder notes, zero safety events related to inappropriately accessed power-injectable ports were reported. Lean management concepts facilitated this quality improvement project and may have reduced waste as intended. This simple intervention may have prevented serious events, though more information is needed.

P357 MULTIDISCIPLINARY PARTNERSHIPS FOR STAFF ONBOARDING PROMOTING VISIBILITY AND COLLABORATION

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Professional Development

At a large ambulatory NCCN-designated Cancer Center, the Hematology team underwent major expansion of services necessitating onboarding of many additional staff. Oncology practice warrants multiple components for successful onboarding - comprehensive
clinical orientation and team mentoring to effectively meet the challenges of delivering complex cancer care. Staff onboarding was a siloed process for each team, which created gaps in essential oncology patient care knowledge and expertise across nursing, advance practice providers (APP), and patient care coordinators (PCC) roles. With the increased hiring and need for assembling a new hematology service group, an intentional analysis revealed where the quality of orientation needed enhancement to produce the best possible orientation for oncology care provision and staff retention. The purpose was to develop a comprehensive multidisciplinary inclusive oncology orientation process establishing a shared standard of oncology clinical knowledge and curriculum refinement. A team including APP leadership, frontline nursing, and schedulers (PCCs) convened and identified specific gaps in the process of orientation training and designed program recommendations. The recommendations included: first, creating scheduled days of clinical observation with nursing personnel; second, content enhancement by adding new job aids to orientation training material; third, guidelines for orientation utilization of shared resources. The meeting of the interdisciplinary hematology team brought heightened awareness to orientation inadequacies. The committee members also established a dedication to initiate shared teaching content for implementation of clear, consistent expectations for all staff orientation. The meetings demonstrated the integral value of listening and working as a cohesive collaborative team. Post the initiation of this orientation program, newly onboarded staff members voiced a better understanding of team members and increased confidence with resources available to them with their new positions in hematology care delivery. Currently, ongoing survey evaluation is being conducted to inform a continuous process improvement for the orientation program. A sense of equity and inclusivity at orientation fostered an environment of belonging, which has empowered staff to cultivate the highest quality of proficiencies in hematology clinical expertise. Strategies for team engagement also have promoted a spirit of community to achieve the best possible outcomes for hematology patients.

**P358**
**SUPPORTING PATIENTS WITH ADVANCE CARE PLANNING**
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End of Life
In the United States, over 600,000 people died from cancer in 2021. Approximately one third of adults complete advance directives specifying their wishes for treatment and/or health care proxies at the end of their life, and that number is much lower for people of color. That means that approximately 400,000 people die each year without giving their family and friends the gift of knowing what their wishes would be in a medical crisis, leaving the patient to receive or be denied treatments that they may not be in line with their wishes, and also leaving caretakers with questions about whether or not they did right by the patient. This is especially true in communities of color. Having conversations about end of life are often emotional and anxiety-producing. These conversations are often never had because of this emotional toll and our own fears and taboos about death. Empowering medical professionals to begin these conversations can be very meaningful to the patient and family, reducing distress and conflict amongst family members. Educating medical professionals about how to begin conversations about advance care planning, and practicing with them in a less emotionally-charged setting, will build confidence and empower professionals to speak with their patients. End of Life Choices New York uses several tools to open this conversation, including The Death Deck and The Hello Game, which can increase communication and reduce stress. Opening these conversations has proven to increase the likelihood that patients will complete advance directives. Access to education and discussions about advance care planning have proven to be effective in increasing the chances of completing advance care planning. Completing advance care planning has been shown to reduce stress, and sometimes even increase life expectancy. Although more research is needed, these finding are encouraging. Advance care planning is not only a gift that a patient can give to family and friends, but it can also reduce stress, both physical and psychological. It is important for every adult to complete one. White people are more likely to complete one, due to several factors, so it’s even more important that that clinicians feel comfortable talking to people in communities of color, as they often are the patients that end up receiving medical care that is not aligned with their values.

**P359**
**IMPLEMENTATION OF AN ONCOLOGY NURSE NAVIGATOR JOURNAL CLUB**
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Professional Development

The role of the Oncology Nurse Navigator (ONN) has subtle differences from the role of staff nurses; they eliminate potential and real barriers in caring for oncology patients to ensure they receive quality care without any delays. Understanding the nuances of the ONN role and the associated core competencies is necessary to assist in orienting the novice ONN and providing ongoing support for each ONN to grow in their practice. The purpose was to assist in orientation to the role of ONN for newly hired novice ONNs and improve confidence in their practice. In February 2022, a biweekly ONN journal club was implemented. Between February 2022 and February 2023, the journal club met seventeen times and included eight participants. Four of the participants were newly hired novice ONNs. During this time each ONN took turns presenting a peer reviewed journal article of their choice. Topics ranged from the ONN scope of practice to current topics in oncology. After the presentation of the article, the group would discuss the article, and determine how to implement the article’s findings into everyday practice. The 4 novice ONN participants completed a 6-question survey at the conclusion of the first year of participation. Utilizing a scale of 0-5, 0: having no knowledge of the ONN role and 5: having expert knowledge of the ONN role. Participants scored their knowledge as 4 prior to the implementation of the journal club, and after one year their knowledge score increased to 4.75. All participants reported that the journal club increased confidence in their practice, and positively influenced their job satisfaction. Three-quarters (75%) of participants reported the journal club caused a change in their practice, and that it was not intrusive to their work schedule. Implementation of an ONN journal club has proven successful in improving the perceived knowledge of the novice ONNs. The journal club also increased novice ONNs job satisfaction and confidence in their practice. Most novice ONNs report the journal club caused changes in their practice and these meetings were not intrusive to their work schedule. An ONN journal club can be used to aide in the orientation of newly hired novice ONNs.

QUALITY IMPROVEMENT

P360
CAPACITATING LESOTHO WITH ONCOLOGY

HEALTHCARE PROFESSIONALS AND EDUCATORS

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Oncology Nursing Practice

Lesotho faces the burden of cancer, with cases increasing yearly. Due to the new cancer registry in Lesotho, between June 2020 and August 2022, twelve cancers were registered at Senkatana Oncology Clinic. Cervical cancer is the most reported cancer (560), followed by breast cancer (170), prostate cancer (136), endometrial (24), and lung cancer (19). Cervical cancer is the leading cause of death among persons diagnosed with cancer in Lesotho, even though it is preventable and curable. The Lesotho Ministry of Health prioritizes cancer control through disease control, primary health, health promotion, and prevention/screening/early detection. Currently, cancer prevention and control are developing, and there are inconsistencies in activities in the areas of prevention and early detection in all districts in Lesotho. The Lesotho cancer registry is at the infancy level, and the only captured data reflects hospital data captured in the CanReg5. The Quality Improvement project aims to evaluate/assess the current status of professional health workers, such as nurses’ training and competencies in providing cancer care. Hence, the question we are addressing in this QI project is, Does cancer basics education and chemotherapy, biotherapy, and immunotherapy training through didactic online, in-person, simulation, observation/shadowing, and competency demonstration of chemotherapy administration, pre, and post-assessment of knowledge and skills, impact the capacity increase of nursing from two component oncology nurses to twenty within 3 to 6 months timeline? Intervention: Approach to Impact nursing care, education, and build capacity. Nursing initiatives and priorities were as follows:

- Objective 1: Audit process in clinic and inpatient: Examine workflow and Policies/procedures & SOP.
- Objective 2: Train the Trainers to be experts in cancer care.
- Objective 3: Inpatient should be able to give Cisplatin and FOLFOX by the end of the visit.
- Objective 4 (Cohort 1 minimum 8 nurses maximum: above 20): Train nurses from novices to experts in cancer/oncology
- Objective 5: Collaboration with Nursing Institutions to incorporate oncology education in their content.
- Objective 5: Institute a mentoring and coaching program for oncology nurses
Objective 6: Pilot a certificate program for oncology nursing and primary physicians’ education PDSA used. Participate in a pre and post-knowledge survey. 98% of the participants passed the basic oncology. Our next step is to design a toolkit for such QI projects globally.

P361 EMBRACING DIVERSITY, BUILDING BRIDGES: TRANSFORMING BREAST CANCER NURSING CARE THROUGH CULTURAL SENSITIVITY TRAINING
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Professional Development
Promoting cultural sensitivity and understanding in healthcare settings is crucial for achieving positive health outcomes and reducing disparities. The USC Breast Center recognized the need to improve cultural competency among its staff to provide equitable breast cancer care. A previous project highlighted a lack of cultural sensitivity among the center’s staff, particularly towards African American female patients. Existing institutional cultural sensitivity training programs have been underutilized by Breast Center staff, potentially resulting in inequitable care. This study aimed to enhance cultural competency through a training program and assess its impact on nursing staff perceptions in the USC Breast Center. In addition to addressing the identified gaps in cultural competency among them. The level of cultural competence was measured using the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals (IAPCC-HCP) tool. Baseline data showed that staff fell within the categories of culturally aware and culturally competent, but none reached the level of cultural proficiency. An interactive in-person cultural competency training program consisting of two one-hour sessions was developed and implemented. Pre- and post-training assessments were conducted to evaluate staff understanding and perceptions. The training covered topics such as cultural humility, disparities in breast cancer care, unconscious bias, and strategies to enhance cultural competency. The cultural competency training intervention had a positive impact on nursing staff perceptions and self-perceived cultural competency in the USC Breast Center. The findings highlight the effectiveness of an interactive training approach in enhancing cultural sensitivity and understanding among healthcare professionals. Ongoing efforts will focus on the practical application of acquired knowledge during patient interactions, to ensure sustained improvements in cultural competency and the delivery of equitable breast cancer care. A total of 87% of nursing staff attended the cultural competency training sessions. Post-training assessments demonstrated a significant 71% improvement in self-perceived cultural competency, with a notable increase in the number of staff classified as culturally competent from 7 to 12 nurses with a denominator of 13. Evaluation feedback was positive regarding the clarity of training objectives, relevance of the content, interactivity of the sessions, and increased awareness among participants. Each nurse identified at least one action to implement to provide culturally sensitive care.

P362 DEVELOPMENT AND EVALUATION OF A NURSE PRACTITIONER DIRECTED BONE HEALTH SCREENING FOR PROSTATE CANCER PATIENT IN ONCOLOGY PRACTICE
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Treatment Modalities
Bone health impairment is a recurring detrimental outcome of prostate cancer cells’ high bone tropism. The impairment is further exacerbated by administering androgen deprivation therapy (ADT), one of the current gold standards of care in treating advanced prostate cancer. Androgen deprivation therapy causes bone mineral density (BMD) loss, risk of osteopenia, and osteoporosis, leading to poor quality of life. Cancer treatment-induced bone loss is well known, but greater awareness of the risks and preventive measures is required. The aim is to improve providers’ adherence to bone health screening in prostate cancer patients receiving ADT utilizing an electronic medical record (EMR) standardized order set for screening. This evaluated providers’ adherence to ordering bone health screening tests and patient knowledge about bone health as measured by the Osteoporosis Knowledge Assessment Questionnaire (OKAT). The pre-treatment bone health screening helped to identify at-risk patients for bone loss, osteopenia, and osteoporosis. Thirty high-risk prostate cancer men aged 50 to 90 participated in the project. A new bone health policy and patient education were developed. A standardized bone health screening order set was built and used to screen all high-risk prostate cancer patients for bone health prior to initiation of androgen deprivation therapy (ADT). All providers and nurses were provided with an
educational session on navigating the EMR order set. Lastly, the pre-and post-osteoporosis knowledge questionnaire was provided to eligible patients to test their osteoporosis knowledge. System-generated data revealed that 30 out of 30 patients (100%) were screened for bone health utilizing the standardized bone health order set post-implementation compared to one out of 30 patients pre-implementation (3%). 30 out of 30 charts reviewed post-implementation have documentation of bone health screening ordered. Patient knowledge of osteoporosis with the use of questionnaires increased from 8.4 to 13.6 questions answered correctly post-implementation, an overall increase of an average of 5.2. Using a standardized order set to screen high-risk prostate cancer patients for bone health before initiating ADT proved effective. All ACPs and other providers are required to perform bone health screenings before ADT treatment. This increased compliance with the National Comprehensive Cancer Network standard of care and best clinical practice for high-risk prostate cancer patients. Bone health screening prevents bone disease and increases the quality of life for the already vulnerable patient population.

**P363 DECREASING FALLS THROUGH RAPID-CYCLE QUALITY IMPROVEMENT**

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**Patient Education and Safety**

Falls continue to be a problem on oncology units. Oncology patients fall at higher rates and have more falls with injury compared to other hospitalized patients. Most fall risk assessment scales have not been validated on oncology patients or have been shown to not be predictive of falls in this group. Research suggests that oncology patients have risk factors that differ from the general patient population. Standardized interventions such as toileting rounds have not been shown to significantly impact fall rates in oncology patients, possibly because they do not address their unique characteristics. This project describes how we used rapid-cycle quality improvement to reduce fall rates on a busy inpatient oncology unit. A rapid-cycle quality improvement model allowed us to perform multiple iterations of implementation and evaluation of fall-prevention interventions based on best evidence. A literature review found that most recommended interventions had already been implemented at the site without measurable improvement in fall rates. Bi-weekly chart audits were instituted to evaluate and encourage compliance with assessments and interventions. We reviewed all falls-related information presented at 2023 ONS Congress and implemented all relevant new information. A door sign specifying mobility-related information was added to each patient room specifying the staff and equipment needed for patient mobility. After a 2-week trial period, the sign was updated to include bed/chair alarm recommendations. Data was collected and reviewed bi-weekly. Chart audits with follow-up produced an increase in documentation of fall assessments but did not impact fall rates. Documentation of bed alarms has improved from 65% to 82% over the past 9 months. Falls with injury has dropped 50%. In the six weeks since implementation of the mobility communication tool, there has been a 50% decrease in the number of falls. The mobility communication sign appears to have produced a measurable difference in fall rates. Staff members have stated they feel they are more responsive to call bells, including those for non-assigned patients. This may help patients be more willing to wait for staff assistance. Ongoing assessment will be needed to determine if the trend is sustainable.

**P364 BUILDING AN ONCOLOGY-NURSE LED AMBULATORY SAFETY NET IN THE GREATER MERRIMACK VALLEY: PRINCIPLES OF EQUITY, HUMILITY AND SOCIAL JUSTICE IN COLORECTAL CANCER SCREENING**

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**Screening, Early Detection, and Genetic Risk**

We received a grant from CRICO to implement an Ambulatory Safety Net (ASN) to reduce gaps in timely diagnosis of cancer due to missed screening opportunities. We’re implementing an Oncology Nurse-led community intervention in partnership with local hospitals to serve a population of historically marginalized patients at highest risk for falling through cracks of a complicated and fragmented healthcare system.
We first established an internal workgroup to select partner hospitals and learn about perceived barriers to cancer screening. We started with stakeholders to establish trust and pared down groups to staff connected to daily work. In weekly meetings we mapped workflows from referral to procedure to results and specialty care. We encountered multiple electronic medical records that don’t interface leading to gaps in communication. Our community partners are candid about the vulnerabilities in their systems and open to suggestions for improvement. Our nurse made visits to multiple endoscopy suites. Endoscopy nurses provided insight regarding barriers, emphasizing need for generalized education about screening and need for procedures. Many colonoscopies are cancelled due to incomplete prep or other patient issues such as lack of ride and accompaniment. We evaluated cancellation data and found cancellations occur in all racial and ethnic groups; lack of health literacy and communication leads to missed appointments or poor prep. Our intervention includes phone calls with patients to educate them on procedure and assess for barriers. The intervention begins when patient is scheduled; initial chart review done by Nurse Navigator. Patient navigator makes initial telephone call confirming time/date and beginning discussion on prep and ride status. Subsequent calls are used to collect detailed demographic data and continue education. Our culturally inclusive intervention provides targeted information to decrease disparities in morbidity and mortality for colon cancer. The ASN will allow us to gather data in RedCap about the population to tailor our work. We will explore barriers for why patients don’t engage in screening and identify resources. CRICO has several measures we will report on monthly and have several internal metrics we follow. In 2023 patients are still not completing cancer screenings. We need to learn from the individuals themselves to know why gaps exist. We need to create a sustainable and automated ASD to monitor these patients across the care continuum. Becoming integrated in the community will create trust and pared down groups to staff connected to daily work. In weekly meetings we mapped workflows from referral to procedure to results and specialty care. We encountered multiple electronic medical records that don’t interface leading to gaps in communication. Our community partners are candid about the vulnerabilities in their systems and open to suggestions for improvement. Our nurse made visits to multiple endoscopy suites. Endoscopy nurses provided insight regarding barriers, emphasizing need for generalized education about screening and need for procedures. Many colonoscopies are cancelled due to incomplete prep or other patient issues such as lack of ride and accompaniment. We evaluated cancellation data and found cancellations occur in all racial and ethnic groups; lack of health literacy and communication leads to missed appointments or poor prep. Our intervention includes phone calls with patients to educate them on procedure and assess for barriers. The intervention begins when patient is scheduled; initial chart review done by Nurse Navigator. Patient navigator makes initial telephone call confirming time/date and beginning discussion on prep and ride status. Subsequent calls are used to collect detailed demographic data and continue education. Our culturally inclusive intervention provides targeted information to decrease disparities in morbidity and mortality for colon cancer. The ASN will allow us to gather data in RedCap about the population to tailor our work. We will explore barriers for why patients don’t engage in screening and identify resources. CRICO has several measures we will report on monthly and have several internal metrics we follow. In 2023 patients are still not completing cancer screenings. We need to learn from the individuals themselves to know why gaps exist. We need to create a sustainable and automated ASD to monitor these patients across the care continuum. Becoming integrated in the community will create trust and foster spread education.

P365
COMBATING MORAL DISTRESS USING “POSITIVE ATTITUDES STRIVING TO REJUVENATE YOU: PASTRY”
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Psychosocial Dimensions of Care
Moral distress can be physical or emotional, however, acknowledging and addressing moral distress is integral for nursing to preserve their integrity. “Positive Attitudes Striving to Rejuvenate You: PASTRY” is a program developed at a tertiary cancer center to combat the burden of moral distress among oncology nurses. Inpatient oncology nurses often feel powerless against providers and a false sense of hope for their patients. Providing a safe place to share their moral distress can result in increased job satisfaction and retention. On a hematology oncology unit at an NCI-designated Comprehensive Cancer Center, a nursing developed quality improvement pilot to combat moral distress was implemented 2017-2019. Initial results, from Hamric’s Moral Distress Scale-Revised (MDS-R) did not show a statistically significant improvement in moral distress, however staff requested to continue PASTRY sessions. Next steps included long term implementation. Monthly, two one-hour sessions, with lunch provided, were led and organized by the unit social worker and two trained staff nurses and attended uninterrupted by registered nurses (RNs). Staff learned of strategies to discuss moral distress and mind-body practices. Various themes such as burn out, incivility, self-care, and physical rejuvenation exercising were presented. Meetings were concluded by sharing updates on patients and their success stories, with their permission. Nurses were provided a protected environment to share their struggles with moral distress and receive feedback from colleagues facing similar experiences. Staff reported feeling supported and closer to their coworkers after sharing a meal and discussing their feelings of moral distress. In post-session surveys, novice nurses reported feeling a new sense of validation, camaraderie, and confidence in interacting with senior nurses knowing they experience the same feelings. Nurses additionally felt more aware of and empowered to utilize available resources to combat their moral distress. PASTRY has been so successful, it has been requested and expanded to 3 other inpatient units, as well as the home unit’s night shift. The establishment and long-term implementation of these collaborative learning and discussion sessions represents a proactive approach to addressing moral distress amongst inpatient oncology nurses. By bringing nurses together in an uninterrupted setting, nurses can foster comradery and learn skills to cope with their moral distress. This
collaborative and inclusive model serves as a valuable example for other healthcare institutions seeking to reduce moral distress.

**P366**
**I NEED CLARIFICATION: A QUALITY IMPROVEMENT PROJECT TO INCREASE COMMUNICATION IN AN AMBULATORY OUTPATIENT ONCOLOGY CLINIC**

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Coordinated by Care

Communication failure is costly, causing 1,744 patient deaths and 7,149 malpractice cases over a 5-year period and incurring 1.7 billion in total losses. National and international organizations have attempted to address communication failures over the past 2 decades by offering tools to improve communication. Despite this, an ambulatory outpatient oncology unit survey recently identified overall communication failure as an ongoing theme and priority problem to address. The purpose of this quality improvement project was to improve communication between the provider clinic and infusion department in an ambulatory outpatient oncology unit at an academic health system. The I-PASS communication tool was adopted into the electronic health record (EHR) as a dot phrase when communicating with infusion staff about patient infusion treatment plans over a 10-week period. The I-PASS tool is an evidence-based research tool with the components of (I)llness severity, (P)atient summary, (A)ction list, (S)ituation awareness/contingency plan, and (S)ynthesis by receiver for utilization in handoff communication in complex patients. Prior to the use of the tool, data was collected for two weeks, noting occurrences of provider communication failures. Additionally, adverse communication-related events reported within the infusion department in the three months prior were documented. During the intervention period, an infusion communication tracking form and I-PASS audit tool was utilized to collect data. A qualitative 5-point Likert Scale survey was administered to providers and infusion staff in the last two weeks. A run chart and paired t-tests were used to compare two-week pre-intervention data with that data collected over the intervention period, including: total number of communication problems/clarification incidents, time spent on clarification of communication, total number of adverse events reported, and total time a patient had to wait (chair wait time). Expected outcomes were evaluated including a decrease in total time (mins) spent clarifying order, total number of required order clarifications, total time (mins) a patient waits in the chair, total number of communication-related adverse event reports, and 85% provider use of I-PASS communication tool. These outcomes have relevance and significance in evaluating the impact of the I-PASS tool implementation. Provider and staff feedback are also valuable in providing continuous quality improvement and likelihood of sustained adoption of the EHR dot phrase.

**P367**
**EVALUATING THE SAFETY OF CHEMOTHERAPY INFUSIONS AT HOME USING A CLOSED-SYSTEM TRANSFER DEVICE**

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Oncology Nursing Practice

Preventing inadvertent exposure to hazardous drugs (HD) is an important safety consideration when administering chemotherapy infusions at home. United States Pharmacopeia (USP) 800 guidelines require using a closed-system transfer device (CSTD) when the dosage form allows. Limited data exists regarding the complications associated with use of CSTDs for intravenous chemotherapy administered at home on portable home infusion devices. The goal of this quality-improvement project was to promote standard use of a CSTD on chemotherapy home infusion pumps for spill prevention and to minimize exposure to HDs in the home setting. In September 2022, a large oncology infusion center affiliated with an academic cancer center standardized the use of a battery-operated home infusion pump with a two-piece CSTD and separate overlying locking device. Staff were educated regarding appropriate application of the CSTD and placement of the locking device over the CSTD to prevent tubing disconnection. Three return demonstrations of pump connections were required for initial staff training. Patient and caregiver education included managing infusions at home, use of personal protective equipment, HD spill management, and troubleshooting issues. Initially there were reports of the CSTD pieces coming apart with subsequent pump alarms and increased patient calls to troubleshoot. No exposure occurred with these since the CSTD prevented free flow. The review of events concluded that either the locking device was applied backwards or not at all. Additional education and the use of an adhesive securement was shown to
reduce these events. In addition, accidental disconnection of the CSTD on the tubing was identified in a few cases which resulted in HD spills. A new locking, swivel CSTD was implemented to mitigate this problem. Finally, there were events related to the CSTD disconnecting from the needleless connector on patients’ central lines. A new needleless connector was initiated that allowed for a more secure connection. Evaluation of outcomes when using CSTD products for home infusions is vital to identifying safety issues and exploring solutions. Staff, patients, and caregivers need clear, stepwise instructions about managing disconnections and HD spills. Needleless connector and CSTD features to prevent disconnections, such as compatibility and swivel/locking-luer attachments, should be explored when considering products for home infusion.

P368
THE DEVELOPMENT OF AN ASSISTIVE PERSONNEL ROLE TO SUPPORT QUALITY INITIATIVE COMPLIANCE AND IMPROVE PATIENT OUTCOMES ON A INPATIENT HEMATOLOGY/ONCOLOGY UNIT
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Professional Development
UNC Health Care’s Inpatient Oncology Unit faces the challenge of task overload and increased acuity due to a variety of diagnoses, including AML, ALL, DLBCL, Solid Tumor Carcinomas, and Non-Oncology patients. With heightened demands for documentation and the initiation and maintenance of multiple quality initiatives, there is a pressing need to improve compliance and subsequently enhance patient outcomes. This role addresses these challenges and seeks cost-effective methods to achieve better compliance. The primary purpose of this initiative is to introduce a dedicated Quality Liaison Role within the unit. By doing so, the aim is to significantly reduce healthcare-associated infections (HAI) such as Central Line-Associated Bloodstream Infections (CLABSI), Catheter-Associated Urinary Tract Infections (CAUTI), Clostridium difficile Infections (CDI), Urinary Antiseptic Preparation Initiatives (UAPI), Hospital-Acquired Pneumonias (HAP), and falls. This role will focus on reinforcing educational practices and performing key interventions to improve compliance and, in turn, patient outcomes. Interventions: The Quality Liaison Role will undertake several crucial responsibilities to enhance compliance and mitigate HAI. These include:
- Reinforcing education on Chlorhexidine Gluconate (CHG) baths.
- Actively performing CHG baths.
- Updating signage to prompt Q2-hour patient turns.
- Actively performing Q2-hour patient turns.
- Reinforcing falls prevention education, involving the use of falls bracelets, non-slip socks, and bed alarms. Conducting perineal care for all patients with indwelling urinary catheters.
- Reminding RNs to assess the daily necessity of indwelling urinary catheters.
- Reinforcing education on proper oral care practices.
- Actively performing oral care.
- Conducting daily patient weight assessments.

The effectiveness of these interventions will be evaluated through a series of audits covering various aspects of compliance. These audits will focus on assessing the following key areas:
- Central Line Dressings
- IV Tubing
- Q2 Hour Turns
- Oral Care
- Urinary Catheter Care
- Intake & Output (I & O)
- Daily Weights

The introduction of the Quality Liaison Role and the associated interventions aim to address the challenge of task overload, increased acuity, and the demand for rigorous documentation on the Inpatient Oncology Unit. By enhancing compliance in critical areas related to HAI and patient safety, we anticipate improved patient outcomes, reduced complications, and a cost-effective approach to delivering high-quality care. This initiative represents a proactive step toward elevating the standard of care within the unit, ultimately benefiting both patients and healthcare providers.

P369
EFFECTIVENESS OF A TIP SHEET FOR MEDICATIONS WITH OBSERVATION TIMES
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Oncology Nursing Practice
Our NCI-designated Comprehensive Cancer Center outpatient infusion unit regularly administers treatments with required observation periods post-administration. The lack of readily available instructions in the medication administration record (MAR) required
infusion nurses to browse through various resources for information. Additionally, nurses floating from different units were unfamiliar with these regimens and thus further highlighted the need for a consolidated resource. This identified need led to inquiries regarding best ways to address this gap in knowledge. A tip sheet listing drugs with their associated observation times was proposed to enhance efficiency and education for infusion nurses. The purpose was to enhance the accessibility of essential information about observation times that is required for monitoring patients. Pre- and post-surveys were administered to the nursing staff on one infusion unit in July and August of 2023. The surveys assessed nurses’ confidence in knowing medications and their observation times both in general and in regard to specific medications along with the availability of identifying this information. In addition to the multiple choice pre-survey, the post-survey was formatted with both multiple choice and open-ended questions. The open-ended questions provided an opportunity for nurses to give feedback regarding what they liked about the tip sheet and to provide suggestions for improvement. The scores from before and after the tip sheet’s introduction were used to measure its overall effectiveness. The survey results demonstrated significant improvements following the implementation of the tip sheet. Confidence in medication administration with observation times increased by 33.4%, while accessibility of information showed a 41.6% improvement based on nurses’ responses. Knowledge-based questions in the survey saw an average accuracy increase of 36.1% once nurses had access to the tip sheet. The open-ended questions showed that while the nurses overall felt that the tip sheet was a very effective instrument, they had suggestions to increase the efficacy and usefulness. Overall, the results demonstrated that the tip sheet successfully addressed the identified issues. Confidence, accessibility, and knowledge among nursing staff improved substantially. The tip sheet allowed nursing staff to have access to a resource that consolidated information about medication observation times in one place, thus leading to improved patient safety in administering specific medications.

**P370**  
**KNOWLEDGE IS POWER: PATIENT EDUCATION ON CHLORHEXIDINE GLUCONATE (CHG) TREATMENT TO IMPROVE CENTRAL LINE ASSOCIATED BLOODSTREAM INFECTION (CLABSI) IN HEMATOPOIETIC STEM CELL TRANSPLANT (HSCT) UNIT**  
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**Patient Education and Safety**

Hematologic cancer patients are high-risk patients and account for 45.5% of the central line associated bloodstream infection (CLABSI) cases (Kato et al., 2018). Patients undergoing hematopoietic stem cell transplant (HSCT) are at high risk for CLABSI due to high dose chemotherapy and prolonged neutropenia. According to the CDC (2021), CLABSI s are one of the most deadly types of HAIs, with a mortality rate of 12%–25%.

Evidence-based practice of Chlorhexidine Gluconate (CHG) treatment improves CLABSI (Reynolds et al., 2021). There has been an increased CLABSI incidence rate of 4.6 in December 2022 compared to the monthly average of 1.87 cases in 2022. After each CLABSI case, a thorough root-cause analysis was complete, finding no attributing factors to each case. Focus shifted to inconsistency of CHG treatment practice of the patients as probable cause for the increase in CLABSI s. The purpose was to reduce CLABSI incidence by 20% within 6 months of implementation of patient education on CHG treatment on the 16 bed, inpatient adult HSCT unit. HSCT nurses collaborated with HAI champion nurses to utilize a standardized educational tool, based on current hospital policies and a teach-back methods on the CHG treatment usage instruction. The intervention focuses on the self-care patients because all bed-bound and assisted patients are CHG wiped by nursing staff. Patient learning needs were evaluated. Several learning methods including explaining, demonstrating, reading, picture approved educational materials and preferred language interpreter via telephone were utilized to individualize patient learning style of preference. A total of 67 HSCT patients have been educated on CHG treatment since February 2023 when this educational intervention started. From February to August 2023, the monthly CLABSI rate was 1.48 per 1000 central line days, compared to the monthly rate of 2.6 from July 2022 to January 2023. This is a 43% decrease of CLABSI within 6 months of the intervention. Oncology nurses play a pivotal role in preventing CLABSI in the vulnerable HSCT population. CHG treatments are an essential way to ensure proper central line practices and reduce CLABSI. Effective patient education involves learner assessment, utilizing patient preferred tools and a teach-back method. The interactive teaching and learning process engaging the patients
promotes adherence to the proper daily CHG treatment and empowers them in preventing CLABSI.

P371
IMPROVING TELEMEDICINE: PERSPECTIVES OF PATIENTS WITH CANCER RECEIVING OUTPATIENT PALLIATIVE CARE TELEHEALTH VIDEO VISITS
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Coordination of Care
The COVID-19 pandemic caused a shift in healthcare policies and a significant rise in use of telehealth services, both video visits and phone calls. Patients and providers alike have adapted to a new way of providing healthcare. In an embedded palliative care outpatient practice at a single-site urban cancer center in New York City, 70% of scheduled follow up visits in 2022 were telehealth video visits. Studies confirm telehealth video visits can be an effective way to deliver healthcare in some patient populations, data is lacking regarding patient satisfaction with telehealth video visits in an oncologic palliative care patient population. The goal is to understand patients’ perspective and satisfaction relating to telehealth video visits with their supportive oncology palliative care team and to explore if their healthcare needs were met via telehealth video visits. While telehealth services include phone calls and video visit, we focused on video visits alone. A 13-item survey was created and distributed via EPIC, text, and/or email to patients who were seen by video visit over a four-month period, from March 2023 through June 2023, to obtain qualitative and quantitative data regarding experience and satisfaction related to video visits. Questions will be answered using a rating scale (1-5) for quantitative data, or free-word answers for qualitative data. No validated patient satisfaction survey was found on literature review for this patient population. 234 individual patients were seen over a four-month period. 41 patients died at time of data collection. The following patient-reported outcomes will be measured: ease of technology, quality of video and sound, patients’ preparation, difficulty troubleshooting issues with connecting, needing someone to help them, quality of time spent with provider, productiveness of addressing patients’ symptoms, patients’ views on the collaboration between the oncology and palliative care team, patients’ overall satisfaction of the video visit, and patients’ preference of telehealth video visit or in person visits and why. The overall results will be broken down based on varying demographics (age, race, gender, and ethnicity). Based on results, our hope is to gain objective and subjective information to improve telehealth video visits, highlighting what aspects are currently a success and what may need to be improved. Hoping can then be transferable to other practices with similar patient population.

P372
DEVELOPING A QI PROJECT TO ADDRESS DELAYED SYMPTOMS OF CHEMOTHERAPY EXTRAVASATION
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Oncology Nursing Practice
An estimated 0.1% to 6% of oncology patients receiving chemotherapy experience intravenous (IV) extravasation. Nurses routinely assess for extravasation during infusion visits. Delayed extravasation symptoms (occurring after the patient has left the facility) can also occur days or even weeks after treatment. Symptoms may develop over time as was the case study of a patient receiving peripheral Docetaxel in 2021 at our facility. The purpose of this project was to develop a nurse-driven tracking tool to monitor patients’ extravasation symptoms remotely and ensure provider follow-up, thus reducing the risk for tissue damage. A process for ongoing monitoring of post-infusion patients to detect delayed extravasation promptly was implemented, as was a protocol for the nurse to connect the patient with needed care and resources. Our goal was to decrease delayed chemotherapy extravasations to zero. A root-cause analysis was conducted with stakeholders including nursing staff, providers, and administration. A fishbone diagram was completed, identifying a knowledge gap among staff regarding delayed extravasation symptoms. A thorough literature review of best practices was completed. Delayed extravasation education was provided to all stakeholders including patients. A tracking tool was developed to assist the nursing staff to ensure timely identification and coordination of intervention to treat suspected extravasations. The tracking tool was developed, approved, and implemented in April 2022 and delayed extravasation rates were tracked until March 2023. The rate of complications from delayed symptoms of extravasation prior to the intervention was 0.13%. After implementation of the intervention, five patients out of 9760 were identified to be tracked for suspected extravasation symptoms. Each of the patients were monitored closely with expedient nursing assessments followed
by either telemedicine video visits or via photo submission on the secure electronic record platform. During the study, no new delayed symptoms of extravasations occurred. The monitoring tool decreased the incidence of long-term extravasation symptoms and provides a way to track patients who have had suspected or known extravasation. This protocol utilizes technology such as telemedicine video visits and patient-submitted photos and can decrease the rate of complications from delayed-onset symptoms of chemotherapy extravasation.

**P373**

**ENSURING PATIENT SAFETY IN THE MIDST OF EVOLVING CANCER CARE**

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Oncology Nursing Practice

In 2022, UPMC Shadyside had a nursing related car t infusion error that led to a patient unable to receive their car t cell product. A car t cell product is often a patient’s last hope of achieving remission. Since cancer care is always evolving and expanding, an investigation to view our safety measures surrounding Car T infusions was necessary. To prevent this from occurring again, the nurses were surveyed to look at their educational and comfort level for caring for the car t patient, risk masters were reviewed, and a infusion checklist was implemented to improve patient safety. The purpose of this project was to improve infusion nurses educational and comfort level surrounding car t infusions by implementing an infusion checklist to enhance patient safety and decrease infusion related errors. A Likert Scale survey was sent to all infusion nurses gauging their educational/comfort level surrounding car t infusions. This survey was sent prior to initiation of checklist, six months after initiation, and at one year after implementation. “Risk Masters” were reviewed surrounding car t infusion errors prior to initiation of checklist and then again after initiation (6months, 1 year). Checklist were collected and reviewed for compliance purposes. The Implementation of a checklist surrounding car t cell therapy increased the overall knowledge of the bedside RN and increased patient safety. Average score prior to check list:

- General Education- 3 neither agree nor disagree
- Administration of Product- 3 neither agree nor disagree
- Pre/Post safety impact (Riskmasters)- 3 neither agree nor disagree

Average score post check list:

- General Education- 5 strongly agree
- Administration of Product- 4 Agree

- Pre/Post safety impact (Riskmasters)- 4 Agree
- Risk masters place surrounding infusion
- Prior to checklist: 14
- Post checklist: 3

As car t products continue to expand, the need for education surrounding the infusion remain high. The checklist will need to be edited to fit the educational needs of the bedside RN and car t product.

**P374**

**UTILIZATION OF A CLEAN CHECKLIST TO DECREASE CENTRAL-LINE ASSOCIATED BLOODSTREAM INFECTIONS (CLABSIS) IN A MIXED MEDICAL-SURGICAL ONCOLOGY UNIT**

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Oncology Nursing Practice

Patients with cancer face a heightened susceptibility to Central Line-Associated Bloodstream Infections (CLABSIs) due to their compromised immune systems and frequent need for central venous access. CLABSIs are associated with significant morbidity and mortality, prolonged hospitalization, and increased costs. Implementation of a CLABSI bundle has been associated with a decrease in CLABSI rates. In 2022, a mixed medical-surgical oncology unit faced a troubling challenge with four documented CLABSIs. These CLABSIs occurred between March and July 2022. The purpose was to evaluate the effectiveness of a multifaceted intervention to decrease CLABSIs by raising awareness of elements of the CLABSI bundle. Our multifaceted intervention included several strategies, such as regular huddle announcements on CLABSI prevention, an escalation plan for Chlorhexidine Gluconate (CHG) refusal, staff education during meetings, and the implementation of the “CLEAN” Checklist. This checklist, placed outside patient rooms with central lines, provided an easy reference for nurses to systematically review critical aspects of the CLABSI bundle. These included the completion of CHG baths, proper labeling of lines, the presence of dual caps, patient education, comprehensive assessment of the dressing, and thorough documentation of necessity. The intervention started on March 1, 2023, and ended on May 31, 2023. Audits were attempted weekly to assess for compliance with the “CLEAN” Checklist. 127 audits were completed and there was a 65% compliance with the “CLEAN” checklist as evidenced by the correct date on the checklist. The nurse’s feedback on the use of the checklist...
was generally positive, as it served as a visual reminder of the CLABSI Bundle. However, some expressed discomfort with the need to physically check off items. Subsequently, the checklist was adapted to eliminate the checkboxes. Despite the absence of CLABSIs since July 2022, following the project’s initiation in March 2023, the unit witnessed a substantial rise in central line days, increasing from 215 in 2022 to 334 in 2023—a remarkable 55% surge. To date, the unit continues to experience no CLABSIs. This project illustrates how providing daily signage related to the CLABSI Bundle through the “CLEAN” Checklist, can significantly impact CLABSI rates. The checklist served as an effective visual tool to reinforce adherence to the CLABSI Bundle. The success highlights the importance of ongoing vigilance and adaptability in preventing healthcare-associated infections.

P375
UTILIZATION OF AN ANTISIPHON VALVE TO DECREASE AIR-IN-LINE ALARMS FOR ADMINISTRATION OF CHEMOTHERAPY AND OTHER INTRAVENOUS FLUIDS
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Oncology Nursing Practice
The transition to B.Braun large volume pumps has resulted in consistent complaints from nurses and families about alarms due to air-in-line (AIL). Many factors contribute to the production of air within the intravenous tubing including medication-specific factors, plastics used in manufacturing, and cold differentials between the medication and tubing, among others. Mixed chemotherapies, intravenous immunoglobulin G (IVIG), etoposide, and rituximab are especially gaseous and lead to clinically insignificant alarms. The Association for the Advancement of Medical Instrumentation (AAMI) recommends utilizing an anti-siphon valve (ASV) on the end of the tubing to decrease AIL alarms. The purpose was to evaluate the effectiveness of an ASV on primary intravenous tubing to decrease air-in-line alarms. The primary measurement is air-in-line alarms. Secondary measurements are downstream occlusion alarms and nurse feedback regarding ease of use and interference with workflow. Nurses utilized an ASV on all intravenous primary tubing with few exceptions. Tubing attached to a chemotherapy infusion did not have an ASV but was Y-sited into a primary line with an ASV attached. Blood products and medications with filters (total parenteral nutrition or peripheral parenteral nutrition) were excluded. Nurses were told to keep pumps on the unit to track serial numbers to gather unit-specific information. The intervention was started on September 5, 2023, with a thirty-day intervention period. Data will be ready in October to assess the results of an anti-siphon valve on AIL alarms and downstream occlusion alarms for multiple infusions but focusing on those known to be especially gaseous (sodium bicarbonate, mixed chemotherapies, and rituximab). Data will be gathered from individual B.Braun pumps used in this study. Data will be compared to previous months when an ASV was not utilized. Previous studies have shown an ASV to help at decreasing AIL alarms with sodium bicarbonate and mixed chemotherapies. The use of an ASV can, hopefully, decrease AIL alarms for more infusions, thus decrease alarm fatigue for clinicians and allow patients to get restful sleep needed for healing.

P376
AN INPATIENT ONCOLOGY UNIT NURSE RESILIENCE ROOM
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Oncology Nursing Practice
Oncology nurses are particularly at risk for high stress and burnout levels due to the complexity and acuity of oncology patients. Stress and burnout negatively impact nurse health and wellness, staff turnover, and patient safety; however, taking breaks and incorporating mindfulness and self-care activities have been shown to mitigate stress and burnout, and increase resilience. Providing an on-unit nurse resilience room can encourage inpatient oncology nurses to take breaks and practice activities that contribute to the reduction of stress and burnout. This purpose of this quality improvement project was to provide a convenient space for inpatient oncology nurses to take breaks and practice evidence-based mindfulness activities so that they may reduce their stress and burnout levels. A room on the inpatient oncology unit was selected for use as a nurse resilience room. The room contains a window to provide daylight access with views; the walls were re-painted with a calming paint scheme. To promote mindfulness, a yoga mat and meditation cushion were installed in the room, and a recliner and table were set up with a reusable water painting board for art for self-care; hand exercisers were provided for stress relief. Cohen’s Perceived Stress Scale (PSS-10) was administered electronically using an anonymous form emailed to nurses employed on the oncology unit to measure stress and burnout levels due to the complexity and acuity of oncology patients. Stress and burnout negatively impact nurse health and wellness, staff turnover, and patient safety; however, taking breaks and incorporating mindfulness and self-care activities have been shown to mitigate stress and burnout, and increase resilience. Providing an on-unit nurse resilience room can encourage inpatient oncology nurses to take breaks and practice activities that contribute to the reduction of stress and burnout. This purpose of this quality improvement project was to provide a convenient space for inpatient oncology nurses to take breaks and practice evidence-based mindfulness activities so that they may reduce their stress and burnout levels. A room on the inpatient oncology unit was selected for use as a nurse resilience room. The room contains a window to provide daylight access with views; the walls were re-painted with a calming paint scheme. To promote mindfulness, a yoga mat and meditation cushion were installed in the room, and a recliner and table were set up with a reusable water painting board for art for self-care; hand exercisers were provided for stress relief. 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Cohen’s Perceived Stress Scale (PSS-10) was administered electronically using an anonymous form emailed to nurses employed on the oncology unit to measure
their stress levels prior to project implementation. It was found that the average stress level was 19.31, which is considered moderately stressed. The effectiveness of the resilience room and the provided mindfulness aids were assessed by asking nurses to rate their stress level on a scale of 1 to 10 (1 being least stressed and 10 most stressed) before and after use of the room. Self-reported stress levels were found to average 7.4/10 before use of the room, and 3.8/10 after use of the room, for a reduction in stress of 3.6 points out of 10. A unit-based resilience room with access to daylight, views, and mindfulness activities successfully assists oncology nurses in reducing burnout and stress while promoting resilience and well-being. Proximity to the unit is an important factor in promoting use of the room, and the investment in the space and mindfulness activities is repaid in potential gains in nurse health, patient safety, and nurse retention.

P377
BRIDGING THE GAP: EDUCATIONAL INITIATIVE FOR IMPROVING TRIAGE COMMUNICATION BETWEEN CLINICAL SECRETARIES AND MEDICAL TEAM CARING FOR THE CELLULAR THERAPY PATIENTS
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Professional Development
Outpatient hematology-oncology management is growing rapidly as many patients prefer frequent clinic visits over inpatient hospitalization. However, this comes with risks as it places the burden on patients and caregivers to report symptoms to their providers in a timely fashion. Cellular therapy is a subspecialty within hematology with a high call volume. These patients are frequently monitored in the day hospital for post-transplant complications as they are on multiple medications, have compromised immune systems and are at risk for severe and life-threatening complications. Swift access to their healthcare team when experiencing symptoms is vital. There is wide variability in the design of telephone triage models across institutions, affecting response time of medical providers (Wheeler et al., 2015). At our center, clinical secretaries with varying levels of medical knowledge handle the intake and routing of patient calls, leading to challenges in triaging patient symptoms effectively. Patients’ medical concerns are sent to the medical team using in-basket electronic messaging rather than verbal communication, which may result in delayed responses, negative patient outcomes and decreased patient satisfaction. This project’s objective was to increase the clinical secretaries’ ability to triage patients and appropriately route calls to decrease delays in patient care. A presentation was developed to educate clinical secretaries on how to prioritize cellular therapy patient symptoms. Triage algorithms dictate an in-basket message for calls with routine issues such as medication refills or changing appointments, versus direct verbal handoff for critical or life-threatening symptoms such as fevers or confusion. A hierarchical phone directory was distributed to the clinical secretaries in order to expedite communication with the providers. The impact of this education was evaluated by pre and post questionnaire scenarios to determine if an in-basket message or telephone call was appropriate. Sixteen clinical secretaries participated; thirteen completed the pre with 60.4% accuracy. Twelve completed the post with a 72.7% accuracy. This demonstrates that the thirty-minute presentation had a positive impact on the clinical secretaries’ comprehension of appropriately triaging the cellular therapy patient. Regular in-services and tracking of inappropriately triaged calls are being conducted, focusing on non-punitive counseling and reinforcement. This presentation will be added to the orientation material for all new clinical secretaries and will be reviewed quarterly to determine sustainability of this educational process.

P378
INTAKE EXCELLENCE: THE NURSE NAVIGATOR’S CRUCIAL ROLE IN HEMATOLOGY CLINICAL INTAKE
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Coordination of Care
In response to a critical hematologist shortage within the hematology/oncology team, the roles of nurse navigator and clinic coordinator were adapted to form a new intake coordinator role to ensure timely and appropriate intake of new hematology patients. Building off an existing, metric-based new patient workflow, the process of scheduling this group of patients was augmented into a robust clinically-based triaging system. Effective intake nursing establishes the initial connection of patients to the healthcare system while also setting the tone for their journey through the complex
cancer care landscape. The purpose of this role is to triage and prioritize new hematology referrals, ensuring they are scheduled with the correct provider in the appropriate timeframe amid a critical provider shortage. Two nurses with 20 years of combined hematology experience were selected to share the new role. Using knowledge from experience, clinical resources, and guidance from leadership, records for every patient referred to hematology are reviewed, including laboratory results, pathology reports, imaging reports, and progress notes. Phone triage to obtain additional information from patients or referring providers are completed as needed. After thorough review and, if necessary, collaboration with physicians, determination of appointment timeframe and most appropriate provider is established. Patients are contacted by a scheduler or nurse to offer the best available appointment and answer questions. The effectiveness of nurse-led intake within the hematology/oncology clinic can be evaluated through various metrics, including operational efficiency. In 10 weeks, 424 patients have been contacted, records reviewed, and scheduled with an appropriate provider in a safe and effective timeframe based on data tracked within a secured, confidential spreadsheet. The hematology/oncology nursing team has utilized a strong foundation of autonomy as demonstrated by identifying needs and concerns related to a critical provider shortage, in addition to being agents of change in the interest of patient safety. The established process of scheduling new patient appointments was examined and transformed to meet current needs in a time of crisis. By funneling scheduling concerns and needs to two RNs instead of the entire nursing and provider team, all clinical personnel have remained focused on patient care. Additionally, the process has reduced rescheduling appointments due to clinical needs or availability changes. Overall, the new intake coordinator role has been received well and viewed as beneficial to patients and providers.

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**VENOUS ASSESSMENT PRIOR TO TREATMENT FOR EARLY PHASE ONCOLOGY CLINICAL TRIAL PATIENTS**

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**Oncology Nursing Practice**

On average, patients enrolled in our institution’s outpatient early drug development oncology clinical trials have undergone three lines of cancer therapy with a standard deviation of 2. Each line of treatment can impact the patient’s venous access. The clinical trials in our unit require robust lab collection throughout each cycle of therapy. Patients with difficult venous access may experience several failed attempts, which causes delays in care and impacts the ability to obtain quality data. We aimed to identify patients who would benefit from having central venous access placed prior to initiating treatment. We designed an assessment form that included van Loon et al.’s (2019) validated Modified A-DIVA (Adult Difficult Intra Venous Access) Scale. The Modified A-DIVA Scale predicts the likeliness of a successful first intravenous cannulation attempt. Furthermore, our form also collects additional patient information pertaining to current central venous access and blood return. Like Miller et al.’s (2023) study, if a patient scores four on our assessment, the nursing staff discusses central line placement with the provider and patient. Principal factors in user compliance included standardizing the process, keeping the form brief, and functional usability with nursing tasks. During 34 business days, we assessed 15 patients using the Modified A-DIVA scale. The average score of all 15 patients was 2.3, with a ± standard deviation of 1.95 on the 0-5 scale. Out of the 15 patients evaluated, 4 scored 0, 2 scored 1, 2 scored 2, 2 scored 3, 1 scored 4, and 3 scored 5. Additionally, 8 (53.33%) patients already had ports placed. Nursing identified 4 (26.67%) patients who scored a 4 or above on the Modified A-DIVA scale. With the identified needs mentioned above, 75.00% were able to get ports placed or revised prior to the initiation of treatment. Unfortunately, port placement was contraindicated for one patient (25.00%). We will continue to collect data around this intervention and work with a statistician to look at sample power and confidence intervals. This intervention has already positively impacted patients, nursing, and the quality of the clinical trial data. Future studies will investigate the effect of adding ultrasound guidance for patients who may not be suitable candidates for central line access, refuse, or were not assessed prior to treatment.

**P380**

**ASCO CERTIFIED: NEW CERTIFICATION PROGRAM USING EVIDENCE-BASED ONCOLOGY MEDICAL HOME STANDARDS**
ASCO Certified is a comprehensive oncology care delivery certification built on evidence-based oncology medical home (OMH) standards developed by ASCO and COA. ASCO Certified consists of 7 domains supported by 39 specific standards, including the chemotherapy safety domain, which incorporates the existing ASCO QOPI® Certification Program. ASCO Certified has demonstrated value and benefit to practices, patients, and insurers. The purpose was to test the standards and assess the feasibility of a vigorous certification process, ASCO embarked on a two-year pilot with twelve oncology practices. All twelve practices achieved certification, although each practice had to address gaps. We present the results of the gap assessment as determined by both onsite survey and practice self-assessment. The ASCO Certified process involves an onsite survey, followed by cycles of monitored improvement. Certification is awarded after a practice has satisfactorily met all standards. We report on the 17 care delivery standards. Onsite survey teams consisting of qualified oncology professionals evaluated practice performance against the standards. The final scoring was reviewed and agreed upon by a governance committee. In the final phase of the pilot, practices were surveyed to determine which standards required practices to adopt new procedures or to improve existing care processes to meet certification requirements. At the initial site survey none of the twelve practices met 100% of the 17 care delivery standards. Combining the experience of all 12 practices – 68% of the care delivery standards were met (range 47-82%). Following quality improvement initiatives through implementing new or modified processes of care all 17 standards were met resulting in certification. For example, 85-95% of the practices had to implement new or improve existing processes to meet advanced care planning & goals of care standards; and 90% needing to address the health equity standard. ASCO Certified was deemed to be feasible and is now being expanded to a national program. The presented pilot data suggest that even among oncology practices experienced in the implementation of therapy administration safety (10/12 were already QOPI® certified) and practice transformation (11/12 participated in OCM) there is significant room for improvement to meet the standards of certification. The pilot also demonstrated that practices could identify and rectify gaps through a continued quality improvement focus leading to ASCO Certified award demonstrating high quality, patient-centered, value-based cancer care delivery.

**P381 USING A MULTIDISCIPLINARY APPROACH TO ENSURE ORAL CHEMOTHERAPY ADHERENCE IN THE ADULT CANCER POPULATION**

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**Patient Education and Safety**

Oral chemotherapy allows some patients to be more autonomous and control their treatment by reducing hospital and infusion center visits; however, aging oncology patients have comorbidities and social barriers that can affect adherence. They need education, repetitive review of medication dosing, compliance and side effects to report. Using a multidisciplinary approach is key to help the patient and caregiver(s) to reinforce education and adherence. Our cancer institute has created a six week adherence program that is helping our patients by using a multidisciplinary team to ensure oral chemotherapy adherence and monitoring for barriers before and during therapy. Our multidisciplinary team consists of oncologists, nurse practitioners, pharmacists, oncology nurse navigators (ONN) and social workers. Starting in February 2023, this Cancer Institute created a multidisciplinary approach to monitor and track oral chemotherapy adherence. This approach consisted of a series of appointments and education sessions pre-treatment and six weeks of monitoring once starting treatment. A template of appointments or phone calls with an oncologist, nurse practitioner, pharmacist and ONNs are mapped out in a spreadsheet for tracking during the six weeks. This six week adherence tracking supports the patient during the overlap of the end of first cycle into the second cycle. During the past six months we have tracked 89 patients, we identified two patients who were taking their oral chemotherapy incorrectly however due to the adherence tracking we are able to re-educate early in their treatment for accuracy. A cancer diagnosis is very stressful and overwhelming for patients and their caregiver(s). Their medical care can be complex due to aging, comorbidities, physical and psychosocial issues. Using systems and technology to help them with their...
adherence can only improve the accuracy of taking their scheduled oral chemotherapy. Utilization of smart pill bottles that link to your phone, reminder text messages, phone calls and phone apps are some examples of ways to improve adherence.

P382
NURSE-LED IMPLEMENTATION OF ORTHOSTATIC VITAL SIGNS TO REDUCE FALLS
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Patient Education and Safety
In the last year, 30 patient falls occurred on the inpatient oncology unit. Many of the falls were among patients not identified as high fall risk using the Morse Fall Scale (MFS). Literature showed that often the MFS is not effective in the oncology patient population and implementing a nurse-led orthostatic blood pressure intervention may significantly decrease falls. The goal of this project was to increase patient safety by reducing the number of falls related to orthostatic hypotension. We developed a user-friendly intervention to increase compliance with blood pressure monitoring and provided automatic vital signs machines in every patient room that connected directly to the electronic charting system. A chart review was conducted for each patient who fell on our unit to identify contributing factors. We identified that an orthostatic blood pressure drop was present in 12 of the 30 patients. Literature supported that having the orthostatic vitals taken every 12 hours may allow early identification and timely intervention to help prevent orthostatic signs and symptoms. In collaboration with physicians, an intervention was developed that required blood pressures to be obtained and if the patient met the criteria of orthostatic the physician would be notified, a fluid bolus ordered, and fall precautions implemented. Inpatient staff (RNs and PCAs) were educated on the change and how to accurately perform orthostatic vitals. We had automatic vital sign machines installed in every patient room which automatically charted the vitals in the electronic medical record. This helped increased the staff compliance in this practice change as it did not add time due to the aid of technology. Since implementation, 20 patient orthostatic hypotension episodes were identified and treated for orthostatic blood pressures, potentially preventing falls in these patients. We have not had a fall due to orthostatic since this practice change was implemented 14 months ago. We have increased our patient safety by reducing falls thus omitting potential injuries. It has become a standard part of nursing practice when providing care to these patients. Perhaps expanding this intervention to other patient populations will result in similar outcomes.

P383
PATIENT SAFETY AND QUALITY IMPROVEMENT CONSULTATION PROGRAM FOR NURSE MANAGERS: CLINICAL SAFETY AND QUALITY REIMAGINED
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Professional Development
Many nurse managers, while highly skilled in clinical care and managing cancer patient operations, often lack formal education in patient safety and quality improvement (QI) science. Nurse managers within a comprehensive cancer center at an academic medical center reported lack of knowledge related to QI methodology and data analytics. By implementing a Nurse Manager Consultation Program, quality and safety professionals bridged these knowledge gaps, fostering a culture of continuous improvement in patient care. The purpose of the consultation program was to develop an innovative method for promoting a safety culture and improvement science among frontline leaders. Quality experts engaged directly with frontline staff on the units, gaining deeper insights into their workflows and the obstacles they encountered. Personalized coaching, spearheaded by a dedicated leader in quality improvement and patient safety was tailored to enhance nurse managers’ comprehension of unit-specific quality metrics. To achieve the creation of a quality & safety consultation program, the team: (1) performed a SWOT analysis and interviews to better understand unit culture and nuances; (2) developed a nurse manager dashboard to enhance visualization of unit performance; (3) met weekly with nurse managers to review and prioritize under-performing unit-specific metrics; and (4) implemented targeted performance improvement initiatives at the bedside with support from quality professionals. This program empowered nurse managers to proactively address quality and safety concerns, aligning their efforts with the broader organizational goals. Nurse managers have taken a proactive role in reviewing safety and quality metrics, forging collaborations to disseminate best practices. Monthly Nurse Manager dashboards are now being consistently completed. The initial accomplishments of the consultation program prompted its expansion, moving beyond inpatient units to encompass ambulatory managers.
in radiation oncology, infusion spaces, and provider clinics. Focusing on quality and safety issues at the unit-level can positively impact patient outcomes. Due to the success of this program, there is interest from other departments to adopt this program across the hospital. Future direction of the program could include oncology-specific nurse-driven metrics, interdisciplinary collaboration, and research translation.

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**SCORES FOR SMORES: A DIFFERENT APPROACH TO QUALITY IMPROVEMENT**

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**ONCOLOGY NURSING PRACTICE**

In year 2023, Cincinnati Cancer & Cellular Therapy Center as with many other centers noted a large influx of newly graduated RNs. In reviewing nursing documentation through random audits, it was noted the unit had a gap in their pain assessment and reassessment documentation. The gap noted also proved another question into what the actual nursing practice for pain care delivery was on the unit. The baseline compliance for documentation of pain evaluations for patients was at 47%. The clinical coordinator (charge RN) team met to discuss how the unit could evaluate improving this compliance for appropriate patient care delivery and documentation needs. The team decided to start performing weekly audits of all patients for pain documentation. In order to support staff growth and buy-in, the weekly progress scores were then posted on the unit for staff to see their weekly compliance rates. Daily reminders for pain evaluation was provided in daily shift huddles. Clinical coordinators after performing the audits would follow-up with the RN staff in real time sharing best practice for improved compliance to improve their practice. The project started end of May with goal of increasing compliance by 20% to 65%. Time period was set for four weeks along with a staff recognition at the end if goal was it which was titled Scores for Smores. At end of June the team had increased compliance to goal of 65% and received scores made by leadership. The next goal was set for increasing compliance to 85%. This goal timeframe started early July over a 4 week time period and completed early August. The team hit the goal of 85% and received recognition of Working for Waffles where leadership made chicken and waffles for the staff. Currently we are working on increasing our goal to 95% which started early September with the goal recognition being Skilled Nurses for Grilled Cheese. Feedback from staff has been very positive on how the constructive feedback was delivered from the clinical coordinator team in real time that allowed for process improvement. Staff also have provided feedback on how they truly felt recognized with the different awards set with the goals that were achieved. This process has been shared with other units for setting up future quality/performance improvement initiatives to help increase staff participation and buy-in.

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**NO MEDICATIONS LEFT BEHIND**

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**ONCOLOGY NURSING PRACTICE**

There is a large number of patient medications left behind upon discharge. From January – July 2022 (7 months), 4 South had 32 medications left behind. 4 South was the second-highest unit hospital-wide to leave patients’ medications after discharge. This unit is an Oncology/Hematology and Bone Marrow Transplant unit. Our goal was to decrease the number of patients own medications left behind upon discharge, from an average of 5 medications per month to an average of 3 medications per month by June 30, 2023, as measured by the hospital the “Patient Medications Left Behind Report” and “Courier Report.” By adhering to medication, patients’ health outcomes can be better because the treatment prescribed helps manage their disease. Patients’ non-adherence to medications contributes to a decrease in the effectiveness of treatment. Interventions: 1) Place Holographic armbands on patients who have their medications dispensed by the pharmacy, stored in security, or brought in from home (the pharmacy does not carry the medication). 2) Re-educating staff to adhere to the discharge checklist in the electronic charting system, which states if the “patient’s own medications have been returned.” 3) RN to include security/patient’s own medications in discharge instructions upon admission or acknowledging when patient medications need to be returned. We successfully met our goal of averaging three medications left behind per month by June 30, 2023. From
January 2022 to September 2022 (9 months), we had 34 medications left behind. Once we initiated our interventions from October 2022 to June 2023 (9 months), we had 22 medications left behind. We noticed a decrease of 35 percent. Cedars Sinai Medical Center: Shared Leadership Council (SLC), a shared governance of nurses and other ancillary departments, notes that this was also a hospital-wide issue. South gave insight into this issue and worked with the council to inform them of our unit-specific project and our interventions. The Patient Experience and Quality Outcomes Council collaborated with nurse informatics on this issue and created a “Best Practice Alert (BPA).” In May 2023, this went live hospital-wide. This BPA prompts nurses on the day of discharge, reminding nurses that the patient has medications to be returned. Along with innovation and interdisciplinary collaboration, this project demonstrates how nurses drive practice and are vital to improving quality outcomes.

P386
IT DOESN’T HAVE TO BE THIS WAY: HOW TO ASSESS AND TREAT CANCER RELATED FINANCIAL TOXICITY
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Coordination of Care
From the perspective of oncology patients throughout the United States, the financial burden of paying for cancer care is as concerning as their own potential mortality, if not more (ASCO, 2018). This is not just a matter of perception for cancer patients, we know approximately 40% of cancer patient will deplete their savings within 2 years of treatment, and that cancer patients declare personal bankruptcy at a rate 2.5 times higher than the general population – those who declare bankruptcy have a 2-fold higher mortality rate, regardless of disease stage (Ramsay et al, 2016). As healthcare professionals we agree that change is needed to improve health outcomes for our patients and yet time and again great ideas, great research, and great possibilities become trapped in the quagmire of our own systems. We knew within our patient population that only 25% of patients with signs of financial distress had attempted to access available resources for which they were qualified (Aviki, 2022). We sought to change the financial trajectory for cancer patients by leveraging the skills of a multi-professional group to proactively screen for financial toxicity and connect patients to available resources prior to financial decompensation. The first step was to steer a multi-professional team to a nursing-focused solution that optimized the role of the oncology outpatient nurse to systematically assess and refer patients for financial assistance. Through a collective effort, a screening tool and reflexive referral order-set was designed, implemented, and promoted to all disciplines. 675 nursing referral orders were placed for patient screening positive, with 86% of patients completing the application process receiving qualified aid totaling more than $1.2 million dollars. The translation of research into clinical practice took less than two years. Eliminating silos in program development presents extraordinary opportunities to ignite advancements in patient care.

P387
DEVELOPMENT OF AN ALGORITHM TO PREVENT HOSPITAL-ACQUIRED PRESSURE INJURIES
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Patient Education and Safety
Analysis of baseline data at the project hospital located in Los Angeles County revealed that from January 2021 to December 2022, there were 485 HAPIs hospital-wide. Of the 485 HAPIs, 52% occurred in intensive care units (ICUs). Patients in the ICUs are at greater risk for the development of HAPIs due to hemodynamic instability, vasoactive drug use, and increased medical device use. The design is a quality improvement approach, supported by evidence. The adaptation of the PARIHS framework guided all aspects of the HAPI algorithm. The anonymous surveys, adapted from AHRQ, were used to collect data from staff nurses working in the pilot unit and identify the nurses’ views on HAPI prevention. Inclusion criteria were all full-time, part-time, and per diem staff nurses working in the MICU were invited to participate. Exclusion criteria were contract nurses, registry nurses, and float pool nurses. The evidence-based algorithm elements were derived from the hospital’s policies on skin care, tissue injury management, and nursing mobility protocol. Using evidence, flow chart was created to list all the HAPI prevention interventions. The PARIHS model guided the creation of the algorithm. The surveys were given to the participants using Qualtrics links via work emails. The surveys
used a 5-point Likert-like scale and were given before the staff education on the HAPI prevention algorithm tool. Participants were educated about the HAPI prevention tool during their unit practice council (UPC) and staff meetings. The overall HAPIs in the pilot unit had a 50% decrease from the baseline data after the education on HAPI prevention algorithm was provided to the participants. The engagement from the UPC members increased staff empowerment in clinical practice change in a collaborative way. The shared governance secured mutual understanding in adherence to change. Out of 11 survey questions, three resulted in statistical significance (p = .040, p = .048, p = .006). This QI project highlighted that positive attitudes and views were insufficient to ensure a practice change occurred. Strategies to introduce change must acknowledge the complex nature of change management, where staff can be empowered. Improving the nurses’ knowledge of HAPI prevention not only contributed to the quality of care, but also shortened the LOS, prevented readmission, decreased hospitalization costs, and improved the patient’s quality of life.

P388
NEXT GENERATION CANCER CARE COORDINATION: NURSE NAVIGATOR & DIETICIAN LEVERAGING REMOTE HOME BASED MONITORING TO OPTIMIZE CLINICAL OUTCOMES
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Cooperation of Care
The QI/IS project was conducted within an NCI designated cancer center in the southwestern region of the United States serving a primarily (≥60%) Hispanic population. The project encompassed a collaboration with Agilix Health, a home-based dietary monitoring company, and the oncology nurse navigation (ONN) program. Lack of oncology dietary reimbursement from Medicare, and many other payors, has caused significant barriers and delays. Delay in nutritional services caused downstream delays initiating oncology treatment, readmissions, and frailty resulting in poor outcomes. The project has allowed for a value-based care environment with increased safety, quality, and decreased cost regarding nutritional support and care collaboration. Many of our underserved, most vulnerable populations, were able to participate because of funding from ACS. Main goals were as follows:

- Develop a scalable sustainable home monitoring dietary model and reimbursement pathways to successfully integrate Patient Generated Health Data (PGHD) into our EHR workflows to optimize patient clinical outcomes.
- Combine data science methods of PGHD with EHR data to predict and mitigate treatment disruptions and barriers to care.
- Leverage gained knowledge to support and educate patients regarding clinical trials.

Interventions were as follows:

- Built workflows within the EHR for outside agency to have read / write access and downstream reimbursement.
- Patients were contacted by an ONN: SDoH assessments completed in discrete fields within the EHR.
- Patients were sent a scale and data was transmitted from the scale to the Registered Dietician (RD).
- Weekly RD telehealth visits: nutritional guidance.
- The dietitian reached out to the ONN via the EHR for a higher acuity of patient support by the RN/MD.

The primary and secondary outcome metrics were represented on control charts throughout each PDSA cycle. Primary outcome metric: 90% of patients receiving a consult for home dietary monitoring were placed on the program. Secondary outcome metric: 95% of all patients who received an order for home dietary monitoring program had a ONN SDoH assessment documented which defined the needs of our vulnerable patient population. We will have completed 3 PDSA cycles and will analyze data in February 2024 to present at the April 2024 ONS Conference. The ability to provide home dietary monitoring in collaboration with our ONN’s has provided the patient with support to maintain them on complex treatment plans and obtain the best possible clinical outcomes.

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WORKING WITH ACADEMIC FACULTY TO IMPROVE PATIENT EXPERIENCE DRIVER METRIC: “WORKING TOGETHER TO CARE FOR YOU”
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Coordination of Care

Patient experience is pivotal in healthcare delivery, impacting care quality, communication, and safety. A lower score can jeopardize organizational reputation and decrease Merit-based Incentive Payment System (MIPS) reimbursements from Centers for Medicare & Medicaid Services. The Quality Improvement (QI) project targets a National Cancer Institute (NCI) designated cancer center in the southwestern United States, serving primarily to a Hispanic population (60%). The project’s main goal is to elevate the patient experience score on the multidisciplinary Gastrointestinal oncology service line, related to the driver metric “working together as a team to care for you” from 94.3% to >= 98%. To tackle these challenges, the project adopts two major approaches / interventions: establishing a multidisciplinary QI team and implementing an online educational training program for healthcare providers. An analysis of the anecdotal text within the patient experience “overall assessment” domain, an Epic message to patients via MyChart portal from the oncology nurse navigator ONN, and a script for providers designated to inform patients of the care coordination occurring outside of clinic visits. Implementation will last 6 months: start date is October 2023 to conclude and enter sustainment & adoption phase by March 2024. Success is defined by reaching a outcome metric score of >=98%. The project consists of multiple process measures which will be measured via retrospective chart reviews and displayed via control charts. A balance measure will be done through a qualitative analysis of the patient comments within the domain of “overall assessment” on the patient experience survey. This project holds promise in enhancing patient-centered care, aligning with Medicare initiatives, and ultimately maximizing the experiences of cancer patients in a largely Hispanic population. Previous studies, such as the one conducted by Fustino et al. (2018), have identified “working together as a team to care for you” as a key driver contributing to positive patient experiences and the key metric likelihood of recommending the practice.

P390 WHICH WAY DO I GO? IGNITING THE PATHWAY TO EXCELLENCE THROUGH STANDARDIZED CHART REVIEW TRAINING
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Coordination of Care

Inconsistencies and delays in infusion care must be addressed by educating staff nurses on performing comprehensive chart reviews, thereby reducing preventable errors. These delays in care result in increased wait times due to issues such as orders not being entered or signed, orders and/or doses differing from provider notes, consent absent or incomplete, or central line placement confirmation missing. A successful chart review is integral to a seamless patient experience, improved staff and patient satisfaction, reduced interruptions in care, and increased optimization of the infusion process. This project’s purpose was to evaluate the inconsistencies and delays in infusion care, thereby improving staff satisfaction and preventing errors. We collected data to track preventable errors. A total of thirty percent of our scheduled patients had chart inconsistencies, inaccuracies in orders, and other errors, which took nurses’ focus away from patient care and shifted focus towards systemic problems. Interventions were developed using standardized education and tools which included: a written document, a step-by-step PowerPoint presentation, and process flow charts. The nurses at the infusion regional locations were also included in the training. Since implementing the standardized education and tools, the inconsistencies in training, errors, and delays decreased to two and a half percent. Feedback from nurses has been positive since implementing the process. Nurse leaders are observing improved teamwork and patient care delivery and an increase in patient volumes due to increased efficiency in infusion. Streamlining the education processes and tools to standardize nursing care has allowed us to decrease the number of preventable errors & delays that affect the patients we see on a daily basis. Standardizing the delivery of care in infusion allows the staff to provide patient-centered care rather than spending time on inconsistencies in care delivery. When quality chart checks are standardized and done in advance, it can prevent inconsistencies and delays in care.

P391 ONCOLOGY CARE TEAM REDESIGN AT AN ACADEMIC MEDICAL CENTER
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Coordinated Care

The healthcare system and workforce continue to undergo rapid change, and innovative solutions are needed to improve the care delivery system to reduce burnout and improve the patient experience. At an academic medical center, care team composition, and delivery models were inconsistent across cancer disease-based groups, creating challenges for complex care coordination. The face-to-face and non-face-to-face care combined with administrative and regulatory workflows have increased provider workload and contributed to burnout. MyChart (in-basket) is the electronic patient-provider communication portal in the electronic health record and the standard by which the healthcare team communicates digitally with patients and staff. Messages sent through the patient portal go directly to the provider, are not filtered, and have no standard mechanism (human or digital resource perspective) to support providers in managing messages. This project concentrated on the resiliency of providers and the efficacy of the healthcare system by cultivating a workplace culture that promotes clinical excellence through cancer care team redesign interventions at an academic medical center. The interventions focused on creating and implementing a new care team model that supports providers with complex care coordination and patient portal messages. A steering committee with diverse representation from the disease-based groups performed a baseline assessment, and then collectively worked to identify solutions for care delivery process improvement. The interventions were prioritized based on effort and impact using a Qualtrics survey. The highest priorities included creating a new care team, implementing standard work for care coordination, and developing In Basket management best practices. An ambulatory acuity tool was utilized to assess clinical teams’ current workload to optimize the use of human resources. Part of the process improvement included task alignment exercises with each clinical team. Patient satisfaction scores were evaluated along with daily in-basket patient messages per clinician, and provider/staff turnover. After implementing the interventions, all but one metric improved. Open positions and staffing variability were barriers to the complete implementation of roles identified by the steering committee. Instead, new interprofessional teams were created utilizing existing team members with role clarity and standard work for each member. Role clarity allowed each member to work at the top of their scope and organization of patient complex care coordination and patient portal message management.

Utilizing Paging Alerts to Optimize Order to Administration Time of IV Antibiotics in Cancer Patients

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Oncology Nursing Practice

Neutropenic fever in cancer patients is an oncologic emergency requiring immediate intervention. Guidelines recommend that patients with neutropenic fever receive intravenous (IV) antibiotics within one hour of fever onset to decrease risk of sepsis, organ dysfunction, and death. Because of the time sensitivity, it is important that nurses are immediately notified when IV antibiotics are ordered for neutropenic fever, bactereemia, and sepsis. The goal of this project was to optimize order to administration time utilizing a secure messaging system and the electronic medical record (EMR) to immediately communicate entry of new IV antibiotic orders to nurses. Utilizing a PDSA framework, nursing leadership worked with an EMR analyst to create alert logic. The hospital’s Sepsis Steering Committee helped identify the five antibiotics to include; cefepime, ceftriaxone, Zosyn, Unasyn, and meropenem. Nursing education was developed and provided to nurses on the Medical Oncology and Transplant and Cellular Therapies inpatient units. Nurses were reminded to enter their name to the patient’s treatment team in the EMR and to sign in to the Charge Nurse Role in the secure messaging system to ensure alert receipt. Upon implementation, when new IV antibiotics were ordered, an alert was sent to the nurse caring for the patient, the unit’s Charge Nurse, and the Director of Nursing via the secure messaging system. Various data were collected and performance was monitored. Three months after implementation adjustments were made to the
EMR logic to reduce unnecessary alarms and combat alarm fatigue. Antibiotic type, indication, order time, administration time, and other data were collected. 191 alerts with indications of neutropenic fever, bacteremia or sepsis were sent in the first four months. Zosyn was most frequently ordered. Antibiotics were initiated within one hour in 83% of cases. 90% were initiated within 75 minutes and 96% within 90 minutes. There were four instances of initiation beyond 120 minutes. Automatic paging is a helpful tool for alerting nurses of new IV antibiotic orders in real time; critical for rapid treating febrile neutropenia, bacteremia and sepsis. EMR logic was changed to exclude alerts for antibiotic modifications, reducing alarm fatigue. Future enhancements include provision of hospital-issued phones to nurses and development of automated reports, as well as implementation in departments beyond the Cancer Center.

P393
OUTPATIENT MULTIPLE MYELOMA STEM CELL TRANSPLANTS
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Treatment Modalities
The Blood and Marrow Transplant program has historically admitted patients for high dose chemotherapy followed by stem cell rescue. The typical workflow was to admit patients on Day -2 for high dose melphalan, receive stem cell infusion/rescue on Day 0, and remain hospitalized through Day +12. The purpose of post-transplant hospitalization is to provide supportive care while awaiting cell count recovery. As of August 2022, the cancer center is now open 7 days a week, this had been a barrier in the past. A required admission decreases inpatient bed capacity, puts patient at risk for hospital-acquired infections, and increases health care services/cost of care per patient. The objective of our project was to develop a plan to administer high dose Melphalan and infuse stem cells in the outpatient setting therefore decreasing the patient length of stay and increasing capacity of inpatient transplant unit. Extensive education was provided to patients, caregivers, nursing, and all supportive staff. Specific patient education material was developed including daily temperature logs, fluid intake logs, “when to call” handouts, treatment roadmaps and medication action plans. Patients are instructed to monitor their temperature and fluid intake daily. Patients are seen for daily lab and symptom check as well as daily provider appointments. We anticipated that approximately 50% of patients will be admitted due to neutropenic fever around day +6-8. To date twelve patients have had outpatient transplant. As we expected seven of those patients’ required admission for neutropenic fever. A total of 132 days of inpatient stays have been prevented. Continued research is underway to determine the exact cost savings achieved. Our program is working on plans to offer outpatient transplant to Hodgkin Lymphoma patients receiving high dose BEAM chemotherapy. This project would not have been possible without the amazing work of our incredible project team; BMT nurse coordinator, BMT nurse manager, infusion RN, apheresis team, BMT MD’s and APP’s, social work, pharmacy, and reimbursement specialists.

P394
CREATION OF AN ANTI-CANCER AGENT QUALITY IMPROVEMENT COMMITTEE (ACAQI)
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Patient Education and Safety
Chemotherapy and immunotherapy are essential treatment modalities for the hematology/oncology population. Treatments with these therapies include high risk medications which elicit potential concerns during the prescribing, administration, and monitoring phases. These can include proper dosing based on factors such as body surface area, assessing laboratory parameters, and even administering in the proper sequence. Published literature has indicated that chemotherapy errors occur at a rate of 1-4 per 1,000 orders and can occur at all stages of the medication process (Weingart, 2018). Voluntary reporting systems are a process that can be utilized to recognize near misses and actual incidents during this process. Review of these incidents can lead to process improvement initiatives, prevention of future errors and promote a culture of safety. A Cancer Care team at a large, urban, academic medical center identified a need to create a committee that was dedicated to reviewing and responding to safety occurrences involving the administration of anti-cancer agents. The Anti-Cancer Agent Quality Improvement Committee (ACAQI) was formed in June, 2022 and meets
monthly. Membership includes multidisciplinary representation made up of Physicians, Advanced Practice Providers (APPs), Nurses, Pharmacists, Clinical Quality/Patient Safety, administrative personnel, and others. The purpose of the committee is to improve safety surrounding all aspects of anti-cancer agent treatment, including ordering, patient consenting, documenting, dispensing, administering, and monitoring, as well as the systems that support these steps. The function of the committee is to review, analyze, and implement initiatives to enhance the safety, quality, and effectiveness of oncology medication use processes. Since implementation the Committee has reviewed ~50 cases, developed 15 action items, and completed 3 action items. The Committee reviews occurrence trends as well as individual cases and routinely monitors areas of high opportunity or high risk. Committee meetings are consistently well attended, physicians and providers are engaged, and discussions are robust. Feedback from participants is that the meetings are value added and action-oriented. These results indicate this Committee is a useful tool for monitoring and management of anti-cancer agent safety occurrences and contributes to the maturation of a Just Culture environment. Continued work will be needed to determine whether this model can be an effective strategy for significant and sustained reduction of errors and events.

P395
STANDARDIZING TRIAGE ASSESSMENTS IN A MULTI-SERVICE LINE ONCOLOGY CLINIC
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Oncology Nursing Practice
In a multi-service line ambulatory oncology clinic, nurses from varying specialties are assigned as daily triage nurses who assess and manage urgent patient calls and walk-ins for a variety of specialty oncology teams. Triage encounters can often be unpredictable, and no standardized process was in place to guide the nurses in their assessment of a patient who may require specialized service line focused care. The Schmitt-Thompson Triage Tool was built into the electronic medical record and prompts questions for the triage nurses to ask patients. Developing a standardized process and quality nursing triage assessment that is more patient and service line centered can improve patient outcomes and ensure patient safety while increasing nurse utilization of the Schmitt-Thompson Triage Tool. The purpose of this project is for the triage nurses to increase utilization of the tool after being educated on its use. The institutional after-hours hospital team was utilizing the tool and allowed the ambulatory oncology clinic to pilot the use of this tool to determine benefits and tracking for triage calls. Although the tool was approved for use, utilization was minimal due to lack of knowledge and comfort with the tool. All triage nurses in the clinical setting were provided access and were educated on usage of the tool and provided a tip sheet for reference. A resource nurse was assigned daily as needed and weekly reminders were sent out on the value of tool utilization. The usage of the triage tool during baseline data collection over 12 weeks was 21%. After staff was educated on the triage tool, utilization of the Schmitt-Thompson Tool increased to 82% over the following 12 weeks. The project showed positive results in the utilization of a standardized tool through education, creation of clear documentation for clinical team review, consistency in triage practices, and robust data. This tool can improve nurse triage confidence by decreasing opportunity for error, streamlining patient care, and facilitating communication with primary teams. The tool can also provide data to leadership teams on triage volumes, patient disposition, and service line trends for future improvement areas and expansion of clinic needs.

P396
FOSTERING A POSITIVE WORK ENVIRONMENT USING INNOVATIVE STRATEGIES TO PROMOTE GRATITUDE AMONG PATIENTS AND STAFF ON A BLOOD AND MARROW TRANSPLANT UNIT
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Professional Development
During a time of increasing nurse burnout, innovative strategies should be considered by nursing leadership to positively impact the nurses’ work environment. Positive, respectful relationships among healthcare professionals and patients can be protective across the harsh demands of workload, leading to lower levels of reported burnout and increased compassion satisfaction. Current methods to show appreciation and positive recognition among patients and staff can take several weeks to months to get to staff members, potentially limiting the positive impact it may have on the staff. The purpose of this quality improvement initiative was to implement a unique approach to facilitating
submissions of gratitude on a blood and marrow transplant unit, focused on the delivery of positive patient and staff feedback in a timely manner on a public-facing electronic screen. Over a three-month period, an electronic screen near the nurses’ station was utilized to display positive patient and staff feedback. Flyers in patient- and staff-facing areas featured QR code access to provide anonymous gratitude submissions to be publicly displayed on the screen. Submissions were screened and posted within 72 hours of receipt by the unit nurse manager and nursing faculty member. A total of 21 gratitude submissions were received during the study period, of which 90% were generated by nursing staff. Of those received, responses were directed towards nurses (81%), support staff (5%), and PCAs (15%). No negative feedback or rude comments were received during this study period. This project was positively received by staff and patients on the blood and marrow transplant unit, garnering increasing engagement among nurses over the duration of the project. It was a viable and creative way to show appreciation towards nurses and foster a positive work environment during a challenging time in the profession.

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**CULTIVATING A CULTURE OF GRATITUDE AND RECOGNITION AMONG NURSES AND STAFF ON THE BLOOD AND MARROW TRANSPLANT UNIT**

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**Professional Development**

Improving nursing resiliency can be an effective strategy for decreasing burnout and increasing nurse retention. Cultivating a positive work environment, focused on empowerment and positive recognition, may be helpful in addressing these concerns. The purpose of this quality improvement project is to implement and evaluate an innovative way to present positive feedback and expressions of gratitude for nurses and staff. The following aims will be evaluated:

- **Aim 1:** To measure baseline workplace gratitude among nurses and staff on a blood and marrow transplantation unit
- **Aim 2:** To evaluate the impact of a positive workplace recognition intervention on overall workplace gratitude, job satisfaction, and sense of community and belonging
- **Aim 3:** To explore the relationships between workplace gratitude, sense of community and belonging, and job satisfaction among nurses and staff and nurse sensitive indicators (NSI) outcomes

In this three-month pilot study, a pre/post survey included a demographic questionnaire and the Work Gratitude Scale. A publicly displayed electronic screen was installed and utilized to project positive recognition, including expressions of gratitude from patients and staff. Those with higher job satisfaction and a stronger sense of belonging and community reported higher work gratitude scores (p=0.001; p=0.034 respectively). There were no significant changes in the scores of job satisfaction, belonging and community, and work gratitude following the intervention, though their averages increased. Creating a positive work environment utilizing gratitude and positive recognition is a method for nursing leaders to consider to positively impact job satisfaction and a sense of belonging and community among nurses and staff.

**P398**

**STANDARDIZING A CHEMOTHERAPY EDUCATION SESSION AND DOCUMENTATION TOOLS IN A COMMUNITY HOSPITAL SYSTEM**

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**Patient Education and Safety**

Adequately preparing patients prior to receiving chemotherapy and immunotherapy is essential to reducing anxiety, empowering patients to be partners in their care, and influencing positive clinical outcomes such as managing side effects. The Oncology Nursing Society (ONS) and American Society of Clinical Oncology (ASCO) Guidelines indicate best practice as providing patients with comprehensive verbal and written or electronic information as part of an education process before starting each treatment plan. Creation of a standardized chemotherapy education session and materials positively affects nurse and patient satisfaction, as well as the quality of care (Gallegos et al., 2019). As part of a complex cancer care delivery system across 7 acute care hospitals and 13 infusion centers, there was significant variability in materials used for a chemotherapy teach session and documentation. The purpose was to create a standardized chemotherapy education session and documentation tools across all inpatient...
and outpatient cancer departments in a community hospital system. Documentation tools were created incorporating ASCO QOPI standards and core teaching materials were standardized. These tools and materials were utilized by oncology nurses, advanced practice providers and oncology pharmacists when providing a chemotherapy teach session. A chemotherapy audit tool was created and administered at each site by a registered nurse designee (5 per clinical care area where chemotherapy teaches occur) in March 2021 prior to standardization of materials and documentation tools and 6 months after the interventions were initiated in May 2022. The results indicated an increase in documentation of the following topics: 67% handling hazardous medications, 59% handling hazardous waste, 44% fall prevention brochure, 43% febrile neutropenia handout, 40% drug interactions, 39% learning assessment, 36% plan for missed doses and infertiltiy risk, 35% advance directives brochure, 31% appointment expectations, 25% pregnancy prevention, 19% supportive medications, 17% duration of treatment and adverse effects requiring immediate care, 13% follow up plans, 11% contact information, 10% fatigue management, 9% goals of treatment, 3% diagnosis, 2% drug names. Findings from this project demonstrated the feasibility of implementing a standardized chemotherapy teach and documentation tools in a community hospital system by leveraging the electronic health record. In doing so, the tool acts as a pathway to standardize the content of a chemotherapy teach session and demonstrate incorporation of ASCO QOPI standards across ambulatory infusion centers and oncology inpatient units in a care delivery system.

P399
A NATIONAL ONCOLOGY SPIRITUAL CARE DIRECTORY: CREATION OF A REFERRAL RESOURCE FOR USE AT THE POINT OF CARE
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Psychosocial Dimensions of Care
The Commission on Cancer, the National Comprehensive Cancer Network (NCCN) and the American Psychosocial Oncology Society each include in their guidelines the importance of spiritual assessment for cancer patients. Additionally, coping with COVID-19 provided evidence that meeting spiritual needs of individuals leads to less stress, anxiety, depression, and other negative emotional symptoms resulting in an increase in psychological well-being. Other research indicates spiritual well-being positively contributes to quality of life of cancer survivors. The NCCN’s recent focus on this issue is demonstrated by the edits to their Distress Thermometer’s Problem List increasing Spiritual/Religious questions from one (spiritual religious concerns) in the 2020 version to 6 in the 2023 version including:
- Sense of meaning or purpose
- Changes in faith or beliefs,
- Death, dying, or afterlife,
- Conflict between beliefs and cancer treatments,
- Relationship with the sacred,
- Ritual or dietary needs

Focusing on the need for spiritual assessments in the whirlwind atmosphere of providing cancer care creates need for easily identified spiritual care resources for cancer patients. The purpose was to identify if, across 3 major religions (Jewish, Muslin and Christian-accounting for 72% in USA), there are specific spiritual cancer care resources for cancer patients and determine what services they provide to create a referral source for oncology professionals. Interventions were as follows:
- Establish assessment questions for spiritual care organizations
- Internet search for keywords and terms from each faith background and medical terms to discover oncology, general healthcare and support organizations which serve cancer patients.
- Contact potential organizations for clarification on their listing information including service descriptions and contact information.
- The virtual 2023 Oncology Spiritual Directory was created to include all the confirmed national faith-based spiritual care organizations for cancer patients.

Search revealed 31 potential organizations. After vetting the organizations through their websites and contact, we arrived at 22. No organization we contacted suggested additional national faith-based oncology specific spiritual care organizations. Annual evaluation of the directory must be done to ensure accuracy. We welcome healthcare professionals to provide feedback on the 2023 version of the directory for the 2024 version. Also, we will highlight existing ONS spiritual care resources. In order for cancer patients to fully benefit from a spiritual assessment and/or the results of the NCCN Distress Thermometer, nurses need easy, efficient access to quality spiritual care programs for their cancer patients.

P400
ENTERPRISE ONCOLOGY NURSING: DEFINING EBP THROUGHOUT THE SYSTEM
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Oncology Nursing Practice

As health care systems continue to develop, the depth and breadth of oncology nursing expands from a single site of care to enterprise nursing. Aligning practices throughout the enterprise to support evidence-based practices brings both successful outcomes and challenges. In addition to aligning practices, there is an enterprise commitment to bring more complex therapies and clinical trials into the community settings to better serve the patient with cancer. The oncology nurses from a large academic medical center with enterprise sites in 2 states and multiple hospitals and infusion centers, came together to address these issues. The nursing group met to assure membership included all sites including inpatient and outpatient areas. The group was convened by the Director of Oncology Nursing Education. The initial goal was to provide education on diseases and treatments. Twice a month zoom sessions have been sustained to this date and were initiated during the pandemic. Education is ongoing. The next step was to address best practices. The first initiative was to align best practices in relation to assure oral adherence. This group meets every other week and continues to work together to address best practices. Other initiatives for this have included care of the implanted port, chemotherapy competency, chemotherapy administration practices, standardization of chemotherapy administration documentation and sign off for patients receiving oral antineoplastics. Next steps include aligning and updating chemotherapy checklists and sepsis outpatient protocols. The goal of bringing complex therapies and clinical trials has been successful with the support of the academic center. An example is consolidation with arsenic for APL. To date, 3 patients have successfully received this care in the community setting in addition to clinical trials. Many other therapies are in the pipeline. Presently, there are over 50 nurses included in this process. Other successes have been the ability for nurses at all sites to bring clinical issues to the group and urgent issues that need to be addressed through the director. The group is very cohesive and positive in terms of driving outcomes. Challenges have included two different EMR at sites within the enterprise and structured communication to the other members of the care team.

P401
PROVIDER EDUCATION ON CULTURALLY COMPETENT COMMUNICATION FOR CLINICAL TRIAL ENROLLMENT OF AFRICAN AMERICAN ONCOLOGY PATIENTS THROUGH LITERACY-BASED APPROACHES

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Oncology Nursing Practice

Enrollment disparity of African Americans (AAs) in oncology randomized clinical trials (RCTs) persists despite measures to engage this underrepresented population. The National Institutes of Health (NIH) and the Food and Drug Administration (FDA) issued guidance for institutions performing clinical trials and created thresholds for minority enrollment. Given patients who are enrolled in RCTs live longer, have positive outcomes, and receive integrated comprehensive care, further research is warranted to improve pathways for increasing racial and ethnic minority enrollment. The purpose was to enhance culturally competent communication methods when discussing clinical trial enrollment with African American (AA) oncology patients and increase AA enrollment in oncology clinical trials. An interactive provider focused presentation was created to illustrate the disparities AAs encounter in participation of oncology clinical trials. The teach-back intervention demonstrated how a focus on health care literacy as a method to use when discussing RCT enrollment with AA patients may increase engagement. Of the 21 attendees, 76% completed evaluations and all reported the objectives as being achieved. The average age of providers was 40yrs (26-56) and 87.5% were female (Table 1). One hundred percent of the attendees were white. Three-fourths of the attendees reported the information useful, with 44% involved in the clinical trial enrollment process. The intent to implement changes in communication methods with patient education, outside of the informed consent process, was recognized as a priority by a majority of providers. To date there is a two-fold need for minority providers to engage, first to engage other providers in approaches to connect racially and ethnically diverse patients in clinical trials, and second to relate with diverse patients to leverage their cultural influence in health care to minorities globally. Culturally competent communication methods for increasing racial and ethnic minority enrollment into oncology randomized clinical trials continues to be a priority for those engaged in clinical research.
CELEBRATING THE DIVERSITY OF OUR PATIENTS BY IMPROVING COMMUNICATION IN THEIR NATIVE LANGUAGE

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Psychosocial Dimensions of Care

“Effective communication is an essential duty of a provider and paramount for shared decision-making and patient-centered care” (Department of Health & Human Services, 2021). Communicating in the patient’s preferred language is an ethical duty that impacts patient experience and outcome. Clear communication can improve patient safety, patient experience, and patient adherence to medications and treatment regimens. Also, providing communication in the patient’s preferred language improves health disparities. The purpose was to incorporate patients’ cultural backgrounds into their care plans, with the aim of enhancing patient care and patient outcomes. Additionally, to elevate the overall communication between staff, the medical team, and patients. In November 2021, leadership took steps to enhance communication with patients who primarily spoke languages other than English. They initiated contact with staff through email, seeking volunteers interested in serving as unit interpreters. Following this, they worked closely with interpreter services to facilitate an examination that assessed mastery in oral, verbal, and written communication methods. Once staff members successfully passed this examination, they participated in a comprehensive two-hour orientation. Subsequently, they were awarded a certificate, granting them authorization to provide interpretation services. In the past three years, 23 registered nurses volunteered for interpreter training, with 10 successfully completing the interpreter exam. Currently, we have 8 active interpreters as a result of this initiative. The effectiveness of this initiative becomes evident through the positive feedback we’ve received from patients. Notably, patient responses underscore the significance of conversing in their native or preferred language, reflecting an elevated level of comfort and trust in their healthcare team. As noted by Curt et al. (2021), achieving health equity necessitates a comprehensive understanding of the needs of all individuals. Gleason et al. (2020) have also identified language as a contributing factor to diagnostic errors in emergency department settings. However, it is essential to recognize that language represents a healthcare barrier that can be effectively surmounted. In alignment with the Nursing Strategic Plan for FY21-25, which underscores the importance of “patient experience” in terms of care coordination, courtesy, and respect, patient education, safety, attentive listening, patient-centered care, and responsiveness, this initiative comprehensively addresses all facets of the patient experience. Consequently, it holds the potential to enhance the overall patient experience, aligning with the broader goal of ensuring equitable healthcare for all.

UTILIZING THE PATIENT PORTAL TO COMPLETE A QUALITY OF LIFE SURVEY

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Psychosocial Dimensions of Care

The Commission on Cancer (CoC) requires a Quality of Life survey be implemented that evaluates and addresses the psychological, social, financial, and behavioral issues that can interfere with their treatment plan and adversely affect outcome. The Quality of Life survey was developed in response to the American College of Surgeons Standard 5.2. It aims to ensure that comprehensive and holistic quality care is delivered to the oncology patient population. Clinical staff collects the survey for the patient receiving treatment to gather information about patient’s feelings related to emotional, psychosocial, spiritual and physical distress. Quality of Life screening furthers our commitment to excellence in care by finding out more about our patients and improving their knowledge of and access to support services. Patients receive it at pivotal points of care: at the second visit and every three months subsequently (or during the next visit after 3 months). Beginning June 2022 our site launched a revised Quality of Life tool using the “Patient Portal” in “My Chart” to assist staff in completing the screener tool and improving patient outcomes. Patients who are due for the screener are sent the tool via the Patient Portal two days prior to their appointment. Initially our completion rate decreased. In response to this, we added a column in the patient’s electronic medical record that designates if the screener is due, if they had the patient portal and if it was completed in the portal. Those patients without the portal are able to complete the screener on the computer at the provider’s office with the assistance of the Medical Office Assistants help as necessary. By
instituting the above practice, we were able to increase our completion rate from 15% to 90% over year. A daily report shows the previous day’s completion rate. Barriers noted include adequate staffing, time for completion. However, this best practice has allowed for improvement in responses and confirmation that usage of the Patient Portal significantly increases response rates. This allows for early detection and intervention for patients with identified issues.

**P404**
**FALL RISK: ASSESSMENT AND INTERVENTION IN THE OUTPATIENT ONCOLOGY POPULATION**
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Patient Education and Safety
Cancer patients are at increased risk of falls due to disease symptoms and treatment side effects (Holley, 2002; Overcash, 2007). Historically, this oncology clinic has not utilized a validated fall risk assessment during infusion visits. Additionally, fall prevention education and interventions for high fall risk patients are limited. A preliminary survey of infusion patients, developed by a staff RN, indicated that approximately 18% of oncology infusion patients have fallen in the past year, and 28% screened as high fall risk. The purpose of the project was to reduce fall risk in outpatient oncology infusion clinic patients by incorporating the Stopping Elderly Accidents, Deaths, & Injuries (STEADI) fall risk screening tool with referral orders for high fall risk patients to physical therapy (PT) and/or physical medicine and rehabilitation (PM & R). An information technology analyst assisted with building the STEADI screening tool into Epic, and automated orders within a Best Practice Advisory (BPA). Moderate to high fall risk scores also triggered fall risk prevention education to populate into the patient’s After Visit Summary. Staff RNs were educated on fall risk prevention and interventions, and the screening was implemented into the clinic triage workflow. Epic reports were used to measure data and outcomes. During the 5-month implementation period of this project, 524 STEADI fall risk screenings were completed. Of those, 21% scored at a moderate risk of falling, while 49% scored at a high risk of falling. Of the high fall risk patients eligible for referral, 69% were referred to PT, and 40% were referred to PM & R. The preliminary data highlights the need for ongoing structured fall risk screening and intervention to address physical conditioning needs in the outpatient oncology population. The American Society of Clinical Oncology recommends screening patients for fall risk factors during clinic visits (Cheville et al., 2008). Oncology nurses in the ambulatory setting are well positioned to identify patients at an increased risk of falling, and in turn, refer to PT and PM & R services.

**P405**
**SUPPORTIVE ONCOLOGY CHAMPIONS**
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Symptom Management and Palliative Care
Keeping patients and care partners connected to supportive resources can be challenging with competing aspects of care. Early access to supportive care may improve quality of life and survival (Berman, R. 2020). Organizational quality goals included improving utilization of Supportive Care resources toward ultimate reduction additional care, ED visits and hospitalizations for symptom control – OP35 (CMS). Nurses remain the most trusted profession in the United States (Gallup, 2022) and serve as advocates for patients and care partners at all points along the care continuum, yet they may not feel equipped to advocate for patients around Supportive Oncology. The purpose of this quality project was to support nurses in their roles as advocates and educators in making connections for patients with Supportive Oncology resources. The project was IRB approved, exempt from oversight. Built upon previous research within our center, a survey was developed to discern nurses’ perceived value of Supportive Oncology services, their participation in referral patterns, and barriers. Using baseline survey results, educational resources were developed, and nurse champions were identified for pilot clinics with the aim of better connecting our patients and care partners to evidence-based supportive care. The implementation of a “champion” model is documented in nursing literature to keep nursing teams connected to updates and information. RN Supportive Oncology champions serve as clinic specialists to support colleagues and patients through awareness building, education and self-care techniques based in Supportive Oncology practices. The baseline assessment reveals nurses (n=190) highly value Supportive Oncology resources for patients (3.94 mean, 1=least valuable and 5=most valuable); however, they reported gaps in knowledge and barriers in connecting patients to services. Monthly champion meetings provide opportunities for sharing challenges and wins. Nurses report improved confidence in referring to Supportive Oncology with the Champion model.
support. Evaluation will also include referral patterns to Supportive Oncology before and after ongoing project implementation. Nurses are uniquely suited as trusted patient advocates and coordinators of care. While nurse champions are not new, their application in better connecting individual oncology clinics to Supportive Care services and equipping them to facilitate appropriate referrals, may be innovative. For us, it is helping patients connect to needed resources.

P406
ANSWERING THE CALL TO ACTION: HOW NURSES HAVE BECOME PROGRESSIVELY MORE INVOLVED IN IMMUNOTHERAPY IME 2018 TO PRESENT
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Professional Development
In 2018, the Oncology Nursing Society held an immunotherapy summit to identify and prioritize the needs of oncology nurses as they relate to patients receiving immunotherapy for cancer. Proceedings from the summit concluded that all oncology nurses must continue in the development of their skillset, knowledge, and competence related to immunotherapy. However, whether that call to action would be heeded remained to be seen, given that most immunotherapy focused independent medical education (IME) in the oncology space is not geared toward oncology nurses. RMEI produces accredited IME in a variety of therapeutic areas including oncology. Analysis of learner data in our oncology programs revealed changes in the representation of nurses in programs focused on immunotherapy. In this study, we present the observed changes in the participation of nurses as well as how proficiency and educational needs have evolved over time for this population. All RMEI educational activities from 2018-2022 which address oncology immunotherapy-focused topics were identified. These activities include both live and online programs in a variety of sub-therapeutic areas. Professional participation was reviewed for each activity to determine the proportion of nurses present. Profession was designated via self-report either during registration or in the pre-test of the program. Twenty-four immunotherapy-focused educational activities were identified from 2018 to 2022 in our database which cumulatively reached 3,946 nurses (RN & NPs). Though sample sizes varied, a progressive increase in the number of nurses participating in immunotherapy focused oncology programs increased year over year (Figure 1). Evaluating engagement by sub-therapeutic area revealed that the most consistent progressive increase occurred in skin cancer programs. Analysis of changes in proficiency remains underway for this population, in the context of year over year change. We observed a steady rise in the number of nurses participating in immunotherapy focused education since 2018. This suggests nurses are trying to keep up with the continuous developments in immunotherapy. Specifically, that nurses are participating in and drawing practical knowledge from programs whether they target a nursing audience or not. These efforts have yielded progressive improvements in demonstrated proficiency, though, opportunity for future studies to investigate the day-to-day challenges of oncology nurses as they relate to immunotherapy remain. This study is limited by its observational nature and the variability in the participant reach of the platforms hosting the educational activities.

P407
A MODEL FOR INCREASING FRONTLINE ONCOLOGY NURSE ENGAGEMENT IN CLINICAL RESEARCH DURING TIMES OF STAFFING SHORTAGES AND BURNOUT
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Oncology Nursing Practice
During the COVID-19 pandemic, oncology care integrated alternatives, such as telehealth. Though evaluating these delivery systems is important, high nurse turnover and burnout make research involvement challenging. This presentation evaluates innovative techniques to increase frontline oncology nurses’ involvement in research conducted in 2022 on telehealth videoconferencing between nurses and patients. The strategies employed were: (1) partnering with an oncology quality and safety nurse (OQSN) to design study procedures and identify eligible nurses; (2) evaluating and revising recruitment strategies in real time; (3) streamlining both the consent process and study procedures; (4) minimizing disruptions in care delivery; and (5) implementing personalized study reminders. The success of these strategies was assessed through
recruitment and retention rates, survey responses concerning the acceptability of study procedures, and narrative data from the researcher’s procedural memos. Of 40 nurses approached for the study, 18 met the eligibility criteria, and 13 (72%) participated. Using staff meetings as a recruitment strategy was ineffective due to low attendance. In contrast, one-on-one conversations was a highly effective strategy: only two of the eligible nurses declined to participate when approaching in-person. The study’s relevance to their specific practice made nurses more receptive than when it was framed around telehealth in general. The study procedures received positive feedback: no participants withdrew, 95% completed an optional study questionnaire, and all expressed willingness to participate in a similar study in the future. The OQSN connected with key organization members and ensured that the study processes were both acceptable and feasible for participants. The narrative notes highlighted the importance of a good relationship between the researcher and nurse participants in ensuring successful recruitment and retention. The OQSN’s role in acquainting the researcher with the institution’s unique circumstances and jointly designing procedures enhanced both the recruitment and retention of nurse participants, contributing to the study’s success. This teamwork not only improved engagement but ensured that nurses recognized the significance of their contribution. The relationship between the researcher and nurse participants facilitated retention and might encourage these nurses to participate in future research. These strategies countered the common belief that nurses lack the time for research involvement, simultaneously reinforcing its importance to evidence-based practice.

P408
AMBULATORY RESPONSE TEAM: QUIETING THE CHAOS
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Coordination of Care
As more complex care is managed in the ambulatory setting, emergency response and support is often lacking compared to the inpatient setting. While an algorithm is in place for managing these situations, they are often chaotic and without role clarity, causing undue stress on staff and patients. Our clinic treats approximately 250 patients weekly, with treatments ranging from chemotherapies, immunotherapies, supportive therapies and blood transfusions. Last year, 77 chairside emergencies were reported. With the goal to minimize unnecessary chaos and confusion of excessive staff members responding to emergencies, we formed an ambulatory version of the current Rapid Response Team, like the one in our hospitals. Key objectives were to optimize emergency communication and streamline the roles and number of core responders responsible for managing the situation. We conducted a survey of the infusion nurses, comprised of questions with a numerical rating and open-ended questions. Topics included: comfort/confidence in managing reactions, support received from colleagues, post emergency follow-up, areas of strength, and areas for improvement. Based on survey responses, team member roles were identified as essential and supportive, and the Ambulatory Response Team (ART) was created. The team met with management to set guidelines and scope of practice. All staff was trained on the team and activation process. Criteria for activating the ART were identified, exempting minor reactions deemed safe to manage per existing algorithm (such as flushing or fever). ART activation is considered an escalation in emergency care. If the emergency bell is rung the closest staff member will use the intercom and call for ART activation. ART members will arrive chairside and are the only members to be involved and other staff can step aside. This will include 5 staff— an Advanced Practice Provider to make decisions, three nurses to execute care and an ambulatory care associate to run supplies, maintain privacy and notify other nurses of the situation. Post emergency debriefing with the attending and future planning will be managed by the APP and charge nurse. After six months of implementation, a post survey will evaluate effectiveness in responsiveness, creating a calmer environment and increased staff satisfaction/comfort in emergency chairside management. All staff was pleased with this new addition and optimistic for its improvement in patient care.

P409
BE AWARE OF ORAL CARE
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Symptom Management and Palliative Care
Oral mucositis (OM) is a side effect of oncologic treatments, such as chemotherapy, radiotherapy, and hematopoietic stem cell transplant (HSCT) occurring in 52-81% of patients. Prevalence of OM is increased in pediatric patients due to high cell-turnover. OM is associated with oral pain, malnutrition, weight loss, and poor outcomes secondary to delayed healing. Compliance
with treatment is much lower in pediatrics than in adults. Planned oral care education is statistically sig-
nificant in reducing the mean oral mucositis severity. The Multinational Association of Supportive Care in 
Cancer (MASCC) added patient education as a new intervention category that could contribute to prevent-
ing oral mucositis lesions. The purpose of this project 
was to implement an oral care bundle using chlorhexi-
dine and to provide education to impact the incidence 
and severity of oral mucositis in the pediatric oncology 
population during hospitalization. The oral care bundle 
was implemented and clinical practice changed through 
multimodal education from June 2023 to August 2023. 
The interventions included nursing education on the 
oral care bundle during staff meeting and in huddle 
messages. An educational flyer, available in English 
and Spanish on oral care and mucositis was also post-
ed throughout the unit, posted in each patient room, 
and given to patients and their families upon admis-
sion. Pre- and post-intervention chart audits yielded 
the outcomes examined to measure the efficacy of the 
applied intervention, including incidence and severity 
of mucositis, number of times oral education was per-
formed and charted, frequency of non-pharmacologi-
cal oral care and frequency of analgesic swish/swallow 
treatments. Data was obtained from electronic medi-
cal record documentation, including 20 patient chart 
audits during the pre-intervention stage and 21 patient 
chart audits during the post-intervention stage. From 
pre to post intervention the incidence of oral mucositis 
decreased by 5.7% and the severity of oral mucositis de-
creased from grade 3 to 2. Additionally, during the post 
intervention audits it was noted that documentation 
of the completion of oral care increased by 42.8% and 
compliance with swish/spit interventions increased by 
55.7%. Educational flyers equipped families and nurses 
with knowledge surrounding oral mucositis in order 
to empower them to better advocate for and become 
more involved in oral care. One limitation was small 
sample size and an ever changing inpatient population.

P410 IMPLEMENTING A JOURNAL CLUB FOR ONCOLOGY NURSE NAVIGATORS IN THE ERA OF ZOOM
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Professional Development
Journal club provides nurses a venue to evaluate evi-
dence-based practice (EBP) in oncology nursing liter-
ature. Oncology nurses collaborate and discuss how 
EBP translates into clinical practice and improves 
patient outcomes. The ambulatory oncology nurse 
avigators (ONNs) at a magnet-designated academic 
institution implemented journal club in 2018, but was 
paused in 2020 due to the COVID-19 pandemic. The 
ONN journal club re-initiated in 2023 via Zoom. This 
aim is to provide an opportunity for ONNs to discuss 
role-specific EBP and practice applications. Journal 
club is open to all nurses. Participants have opportu-
nities to meet ONNs from other disease groups and 
network sites, and receive continuing education (CE) 
hours. This helps nurses to meet Commission on 
Cancer standards or maintain certification, and the 
hospital to maintain Magnet status. The ONN journal 
club occurs once every other month for one hour over 
Zoom. Nurses are encouraged to read the article prior 
to discussion or to co-host a session. The chosen topic 
to be discussed is applicable to all ambulatory oncology 
nurses. Nurses receive one CE for participating after 
completing an evaluation survey. ONN journal club 
reinitiated in January 2023 with three sessions to date 
at the time of submission. A minimum of three and 
maximum of eight nurses participated. Participants 
included ONNs, nurse educators, infusion therapy 
nurses, and informatics nurses. Interactive discussion 
sustained the entire hour. Participants were surveyed 
via REDCap if participating in the activity increased 
their knowledge on the topic from a scale of one 
“strongly disagree” to five “strongly agree”. One hun-
dred percent of participants reported that they “agree” 
or “strongly agree” that the activity increased their 
knowledge base. Challenges observed included inter-
est, availability, and ambulatory-specific topics. ONNs 
completed an initial REDCap survey indicating interest 
in participating, but scheduling conflicts made partici-
pation low. Journal club is advertised to all nurses via 
e-mail, huddles, and staff meetings. New strategies in-
cluding guest presenters are used. Structured discus-
sion with questions yielded hour-long discussion and 
participant engagement, resulting in collaboration with 
colleagues for creative solutions. Utilizing a virtual for-
mat and REDCap survey helps expand access across 
roles and network sites, but incomplete evaluation of 
survey remains a challenge. Rotating dates and times 
to accommodate different schedules has been consid-
ered. ONNs want an opportunity for role-specific pro-
fessional development.

P411 IS IT MY TURN? LEVERAGING PROACTIVE COMMUNICATION TO INFORM PATIENTS ABOUT DELAYS
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Coordination of Care

Ambulatory clinics with high patient volume can lead to long wait times to see a provider. A busy urologic oncology clinic listened to patient complaints and took action to keep patients informed about delays thereby reducing frustration and improving their satisfaction. Oncology patients are unique because of the physical and psychosocial burden they have. Long wait times add to this burden. Adopting a patient-centered communication approach aims to relieve the frustration of long wait times and establishes a trusting relationship. Leveraging text messaging and a three-tiered communication approach to inform patients about delays is a practical and efficient way to manage expectations regarding wait times. Our approach is two-fold: The first is to communicate with patients who are still in the waiting room using a text messaging platform making them aware of the delay and providing an expected timeframe when they will be seen. The second is to provide routine updates to the patients who have transitioned into an exam room using a three-tiered communication process in order to reassure patients that their care team has not forgotten about them. The nurses and medical assistant first sincerely apologize to the patient for the delay and offer transparency as to why the provider is delayed. Consumers do not want to receive repeated apologies, so if the delay is prolonged, the second touchpoint is to offer comfort to the patient whether it is a drink, snack, or warm blanket. Finally, the third contact is to provide reassurance and sit with the patient to talk and actively listen to them. Although the focus was to improve the patient satisfaction scores related to being informed about delays, we did not see much improvement. However, all other areas of the survey showed sustained growth. Establishing trust at the start of the visit can lead to overall improved patient satisfaction. Receiving a cancer diagnosis changes one’s life forever. Patients choose healthcare teams based on reputation and outcomes. Patients who have a negative experience question whether their choice of facility was the right one. When healthcare teams know better, they do better. Understanding the patients’ point of view about their experience is crucial to maintain a high-quality reputation and alleviate the unwarranted burden of long wait times to the oncology patient population.

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Nursing comfort with advance care planning inquiry and documentation

Underuse and lack of documentation of advance care planning (ACP) is a clinical gap area in community oncology. The Centers for Medicare and Medicaid has identified ACP as a high priority process measure. The purpose of this evidence-based quality improvement project was to educate nurses on the importance of ACP. The objectives were to increase nurse and nurse practitioner ACP documentation in the electronic medical record (EMR) by 30% and to increase the clinical perception of nursing comfort with this process as evidenced by the scores of the pre-post implementation Kolcaba Advance Directives Comfort Questionnaire for nurses per and post education. An educational program on ACP was presented to the registered nurses in a private oncology practice. The survey was distributed 2 weeks prior to the education and repeated 6 weeks after the implementation. EMT chart audits for ACP documented were performed during the same period as the staff survey. Wilcoxon rank-sum tests were used to determine differences in survey scores pre and post education. Nursing comfort (N=8) with ACP pre-education means scores on the Kolcaba survey were 226.6 (max score 288) and 240.8 post education (p=0.14), effect size d=1.12. ACP documentation increased from 0% pre-education to 63% post-education. Nursing education increases documentation and comfort level of nurses’ assessment of ACP.

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Professional development

Retention of nurses when higher paying RN positions are available and recruiting to fill 18 RN positions from Sept 2022 to Sept 2023; the purpose was retaining and hiring nurses by creating a work atmosphere that is positive, has good work life balance, and a supportive
engaged management team. During the hiring process, the inbox for applicants is checked twice a day. Upon application, the candidate is called by us to set up a shadow and interview time. When they are here, the candidate gets a detailed tour of our incredible building, they are introduced to the team, and then shadow with a nurse for at least an hour. The candidate is made known of flexible scheduling, which can be 8- or 10-hour shifts and parking is compensated for. After spending a small amount of time with our staff you get the sense that our team is a family. The work we do every day is stressful, but so rewarding, the team relies on each other, and this really shows. We have an active Shared Governance that has grown over the past year. Besides troubleshooting problems in our work environment, they have planned quarterly group outings. We are readily available to our staff and have monthly meetings. After 2 years, we encourage obtaining their OCN, which increases the knowledge and skills of our nurses, and they are compensated for it. Since September 2022, we have hired 18 nurses, only two previous nurses have since left. One nurse didn’t return from leave due to personal reasons and one recently transferred to another department within our Institute. We currently are fully staffed as of September 28th 2023 and have a total of 55 RN’s. Out of the 55, 22 of them are OCN. All the time, effort, and stress that gets put into recruiting and retention is well worth it and one of the most valuable tasks you can do as a manager. Seeing our team work so well together is a success not only to management, but the patients we serve and get the pleasure to take care of every day. As the saying goes in nursing, “staffing makes the world go round.”

P414
USAGE OF VISUAL AIDS TO ASSIST IN CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION PREVENTION
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Oncology Nursing Practice

Oncology patients are at an increased risk for central line-associated bloodstream infection (CLABSIs) due to disease processes and side effects of chemotherapy. Central lines can be accessed multiple times a day, increasing the risk of developing an infection. CLABSIs can be detrimental for severely immunocompromised patients. Through the usage of visual reminders, staff education, and increasing CLABSI bundle compliance, there can be a positive impact on patient outcomes. Central venous access puts oncology patients at risk for CLABSIs. Our goal is to increase compliance with evidence-based CLABSI prevention bundle components in oncology units by providing visual reminders in patient rooms. Implementation of the project included creating visual aid reminder cards that hang on the IV pole in the patient rooms. Project leads hosted in-services for nurses on the purpose and use of the visual reminder cards along with re-education on the CLABSI prevention bundle. When creating the visual aids, the team ensured they were easy to understand and eye-catching for nurses. To evaluate the effectiveness of the cards, random audits were performed on the floor to ensure the CLABSI bundle was being adhered to. The visual aid card included information such as alcohol caps on lumens and Y sites, red caps on lines not in use, IV bag and tubing labeled, and dressing dated while also being clean, dry, and intact. Evidence suggests that with the implementation of the visual aid cards, there was an increase in compliance with the CLABSI prevention bundle. Data gathered from random audits from October through December showed the Leukemia unit (8TS) had increased compliance with labeling and dating IV tubing by 38%. However, not all bundle components were positively impacted, as demonstrated by a 4% decrease in orange alcohol cap compliance during this time. The Medical Oncology unit (8TN) data showed a 20% increase in labeled IV tubing and a 15% increase in alcohol cap usage. Overall, the visual aid intervention showed a positive increase in compliance with the CLABSI prevention bundle. Overall, there was an increase in CLABSI bundle compliance throughout this intervention. Staff were receptive and preferred the use of visual aids in the rooms. CLABSI rates during this time decreased as CLABSI bundle compliance increased. Overall, this implementation was successful and sustainable.

P415
IMPLEMENTING TARGETED RADIOLIGAND THERAPY TO IMPROVE OVERALL SURVIVAL IN METASTATIC PROSTATE CANCER PATIENTS
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Oncology Nursing Practice
Pluvicto is a new treatment for mCRPC (metastatic castration-resistant prostate cancer). Pluvicto, also known as Lutetium-177 vivivotide tetraxetan, was approved in early 2022 and improves survival for patients who are PSMA Scan Positive. Maimonides Cancer Center will be the first site in Brooklyn, New York to offer this innovative treatment. This will ensure that thousands of residents, who previously had to travel to other boroughs, will now have easier access to this therapeutic option.

We created and implemented a workflow for the administration of Pluvicto. Our policy and workflow are informed by our prior experience administering similar radiopharmaceuticals: Xofigo and Quadramet. Additionally, we coordinated in-services with the pharmaceutical company and on-site visits to another institution currently offering the treatment.

We created an interdisciplinary committee to coordinate infrastructure and supply requirements for this procedure. Furthermore, we consulted with the Radiation Safety Officer and trained all involved personnel to the proper handling of patients receiving radiopharmaceuticals. Moreover, we developed protocols for spill management and safety precautions as well policies and procedures for the administration Pluvicto. Lastly, we finalized the workflow, created a flowchart for the nurses, and held a mock infusion prior to go-live. Implemented a post-procedure huddle to discuss challenges and identify areas for improvement. Scheduled a follow-up committee meeting to review implemented plan and evaluate outcome.

Targeted radioligand therapy is a growing field. There are other radioligands under development as well as research investigating expanding the role of current radioligands. In the future, we will see more frequent use of radioligands, therefore, providing ongoing staff in-services and education are crucial to further optimize our nursing care and delivery of these treatments.

P416 MINIMIZING PATIENT’S RISK FOR EXTRAVASATION – A COLLABORATIVE APPROACH

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Patient Education and Safety

Outpatient infusion patients are at risk for extravasation when given chemotherapy peripherally. Not all patients receiving chemotherapy classified as vesicants or irritants present to their first infusion with central access and often state they were not educated about the potential need for it in the outpatient clinic. Furthermore, nurses administering vesicants and irritants have no way of confirming IV placement other than visualizing a brisk blood return. While extravasation rates remain at or below the 0.09% benchmark each quarter, identifying those at risk and preventing chemotherapy extravasations in the absence of a central line remains a top priority at an NCI Designated outpatient infusion department. The purpose was to reduce the risk of peripheral IV chemotherapy extravasation at an NCI Designated Outpatient Infusion Department. Steps taken included a two-part approach, including the implementation of the DIVA tool, an evidence based, standard screening assessment for patient’s receiving peripheral IV therapy, built into Epic and initiated in the outpatient clinic at the time of chemotherapy consent to determine the need for central line placement prior to first chemotherapy appointment, as well as the implementation of IV ultrasound to confirm IV placement for those patients most at risk for extravasation when receiving vesicant and irritant classified therapy. While at the infancy of this project, the results are to be determined. The DIVA tool, as well as clinic education, has been rolled out and the training program is being structured for the IV ultrasound device. This is a multi-department and multidisciplinary approach to patient safety. Including the clinic and provider staff to complete a peripheral IV assessment prior to first infusion better prepares the patient and infusion staff for a safe infusion. Implementation of IV ultrasound includes nurse anesthesia and our Clinical Practice Leader for proper education and training. Extravasation data is recorded monthly and will be trended after implementation of both interventions.

P417 THE VALUE OF A QUALITY MANAGEMENT NURSE IN A RESTRAINT QUALITY ASSESSMENT PROGRAM

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Oncology Nursing Practice

The use of restraints can both maintain a patient’s safety and put the patient at risk for physical harm. The oncology population faces additional clinical issues that might require restraints such as oncologic delirium. Governing bodies have highly regulated this patient care intervention to ensure patient safety. Constant evaluation of restraints ordering, placement, and patient monitoring are necessary for continuous...
performance improvement across the interdisciplinary team. A nurse-led restraint quality assurance program was created to adhere to all federal and local governing body regulations to monitor the ordering of restraints, the application of restraints, and the ongoing physical assessment and documentation required to ensure patient safety. All orders for restraints are reviewed by a quality management nurse and entered in an institutional restraint database. If the restraint was placed and de-escalation was not possible, further documentation of placement and monitoring is reviewed. These metrics are also stored in the database. When possible, real-time feedback is given to the nurse providing direct patient care as well as local nursing leadership to ensure patient safety is maintained and documentation meets regulatory standards. Institutional data is reported out at the Provision of Care Taskforce (Joint Commission Readiness) and brought back to frontline staff through the shared governance structure. In conjunction with interdisciplinary stakeholders a culture of de-escalation and low restraint usage has been maintained. Since implementing a nurse-led restraint QA program, we have reduced restraint usage by 86% from 2017-2022. Use of NQONQI reportable restraints (limb and vest) have consistently been 0% during this time period demonstrating a nursing culture of minimal restraint usage. Additionally, this role has led performance improvement projects to increase usage oversight such as the implementation of email alerts for every active restraint order to the appropriate stakeholders in leadership. The collection and dissemination of this data, in addition to having a designated clinician, keeps restraint usage in the forefront of the clinical team’s mind and the organization’s eye on patient safety. Nurses are uniquely suited for this role due to their knowledge of the application and documentation of restraints as well as familiarity of methods to maintain patient safety in those with altered mental status.

P418
INFUSION READINESS- I’M READY. ARE YOU READY?
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Oncology Nursing Practice
Patients arriving for infusion in outpatient department at a large academic cancer center without being infusion ready (unsigned orders, consents missing, recent hospitalization and no provider follow up after hospitalization for infusion clearance, etc.). The patient not being infusion ready at time of arrival causes delays for infusion patients which lengthens scheduled chair time. The purpose was to improve wait times for ambulatory infusion patients in a large academic oncology outpatient setting by improving patient infusion readiness. “No One Waits” workgroup which consists of infusion leadership and infusion staff meeting biweekly to identify barriers and potential solutions to optimize workflow. One barrier to infusion readiness identified was chart being ready at time of patient arrival (signed orders and complete consent for treatment). An identified solution was utilizing infusion nurses to chart check in advance of infusion visit. Nurses identified as “chart checkers” and these nurses completed chart checking all infusion patients charts 24-48 hours prior to infusion appointment specifically looking for consent, signed orders, lab results, and if patient seeing the provider prior to the infusion after recent hospitalization and this data was collected on data collection tool (spreadsheet). After reviewing data collection tool, disease-oriented teams were identified as having barriers to infusion readiness, so these disease specific clinics were partnered with to provide the data collected related to infusion readiness. Infusion leadership shared feedback with disease-oriented teams to provide deficits with infusion readiness. After partnership with specific disease specific oriented teams, there was improvement in infusion readiness as evidenced by reduction in patient wait times. “No One Waits” remains a work in progress, but this workgroup escalated issues and improved wait times and overall infusion experience for both the patient and infusion staff. The “No One Waits” workgroup also coincided with new role in infusion department. The new role was an infusion provider in attendance to address unforeseen issues with infusion patients without provider visits which benefitted the infusion readiness project.

P419
PERIPHERALLY INSERTED CENTRAL CATHERER TASKFORCE: PICC’ING UP THE PIECES
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Coordination of Care
At a cancer institute in the Northeastern US, numerous challenges existed when a patient was discharged home from the hospital with a peripherally inserted central catheter (PICC). Inadequate communication and collaboration between multidisciplinary outpatient and inpatient services resulted in significant gaps in care.
Current state analysis revealed confusion at the inpatient and outpatient transition of care specifically with the discharge process, including supply ordering, insurance coverage verification, PICC maintenance plan of care, and patient education content. A work group was developed to identify patterns in inefficient patient care and deviations from best practice. The five step Nursing Process was used to help identify the need for and creation of a multidisciplinary PICC line Taskforce (TF). Subcommittees were formed within the TF and met independently to analyze the specific problem and develop potential solutions. Follow-up monthly meetings via a video communication platform were scheduled to discuss progress, obstacles, and future discussions/plans. The formation of the TF helped streamline the discharge process, providing greater efficiency. A PICC supply ordering flowchart was created to direct nurses on the proper steps to take when discharging a patient home with a PICC. Home Infusion was able to re-format their progress note updating nursing on insurance approval/denial. If patients require dressing changes, the regional ambulatory teams agreed to have the patient scheduled at the clinic nearest home, eliminating drive time and inconvenience. The electronic medical record subcommittee was able to reformat provider order sets, eliminating confusion. To create a consistent approach with patient and staff education, a PICC dressing change brochure with flushing instructions was made along with video tutorials. A survey will be distributed to staff to evaluate changes followed by discussion of results in future bi-monthly meetings. The PICC TF identified specific problems and worked collaboratively to provide solutions, help restructure the discharge process, and create education to enhance nursing, provider and patient knowledge. Furthermore, a PICC nurse liaison within the Institute was identified as a potential need. Moving forward, the survey data will help identify additional areas for process improvement within the cancer center.

**Coordination of Care**

USC Norris outpatient oncology and bone marrow transplant clinic nursing care varied across the RN, LVN and assistant role. This inconsistency led to an opportunity to streamline an integrated approach to care with increased emphasis on patient-centered care to improve clinical outcomes and patient survival. Clinic staff are an intricate part of the process yet perform clinic tasks and responsibilities not specific to their job roles or scope of practice. RNs were not working to top of license while LVN and support staff were working out of role scope. This caused role confusion, lack of teamwork, breakdown of communication and burnout for staff. Additionally, clinic delays were common and patient satisfaction was below Press Ganey benchmark score on “Nurse assist”, 91 percentiles. The purpose was to improve vision of role clarity and delineation, patient care coordination, staff communication, teamwork to assist patients. Organized nursing leaders, nursing educators and staff to review gaps in practice. Utilized LEAN Methodology to understand current state process and the team to develop future state workflow. Nursing educator and clinical nurse specialist, educated to the nurses in weekly sessions and discussions of scope of practice, policies & procedures, assessment, delegation, and patient education. With the various new standard workflow, staff had a clear understanding of their role and improved patient satisfaction. The team focused on three main areas, 1) standardizing clinic preparation (pre=0%, current=84%), 2) process for providing & documenting patient education (pre=16%, current=88%), and 3) RN assessment review of intake with corresponding report of symptoms by support staff (Pre=0%, Current=80%). Press Ganey Score “Nurse Assist” improved from pre=91%, current=99% percentile. Utilizing weekly staff education & training on nursing practice & scope of responsibilities, the team developed a tightly coordinated, comprehensive care resulting in improved quality outcomes, efficiency, and patient & staff satisfaction. Nursing engagement and empowerment is informed by evidence-based methodology to enhance 1) roles and responsibilities delineations; 2) optimization of workflow and 3) standardizing clinic prep and 4) appropriate patient assessment by RN as identified by staff intake. Staff-led development of improving clinical practice and development of optimization of clinic workflow. Utilizing weekly education and process improvement meetings, staff improved patient preparedness and care logistics to support patients physically and emotionally through the continuum of care.

**P420**

**ONCOLOGY CLINIC NURSING TRANSFORMATION: IMPROVING NURSING PRACTICE TO IMPROVE PATIENT CARE COORDINATION.**

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P421
CREATING AN ELECTRONIC DOCUMENTATION TO MONITOR PATIENT LEVEL OF STRESS DURING CANCER TREATMENT UTILIZING MODIFIED NCCN DISTRESS THERMOMETER
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Psychosocial Dimensions of Care
Distress in Cancer is a multifactorial unpleasant experience of a psychological, social, spiritual, and/or physical nature that may interfere with one’s ability to cope effectively with cancer, its physical symptoms, and its treatment (NCCN, 2023). Quality Oncology Practice Initiative (QOPI) has set best practice for outpatient oncology practices to include assessment of patient on treatment. USC Norris Comprehensive Cancer Center adopted electronic documentation of a modified Distress Thermometer (DT) to assess patients’ level of distress. National Comprehensive Cancer Network (NCCN) DT Screening Tool is a validated tool for initiating screening that serves as an initial, single-item question screen, which identifies distress coming from any source, even if unrelated to cancer (Ownby, 2019).

The purpose was to create an electronic medical documentation for ongoing distress screening of patients during chemotherapy treatment and trigger for possible CSW assessment. Multidisciplinary teams were organized to review gap analysis in review of QOPI standard on-going distress screening during chemotherapy treatment. A group reviewed process for screening, gaps in current practice, review of policy, information technologist (IT) to develop electronic documentation, socialize with staff & physicians, planned for process change & pilot the new documentation tool, and developed auditing for continuous monitoring for documentation compliance. During the review of the current process, no distress screening was documented during patient recurring visits, however, a psychosocial assessment are completed utilizing PHQ2/PHQ9 for new patients and as a yearly assessment. PHQ2/PHQ9 is used primarily for suicide screening so DT was chosen document distress because it is a simple tool to use recurring visits (focused audit, initial go-live=35%; current 100%). In collaboration with CSW, clinic staff were educated on the new DT documentation and its purpose. Distress can occur anytime during the cancer experience and is associated with depression, anxiety, missed appointments, and adverse outcomes...(Ownby, 2019). Our Quality team is our partner to extract data for reporting on documentation compliance. It is important to document patient distress in EMR to be able to evaluate timely by our CSW. Our CSW are automatically electronically informed via message pool when patient score >4. At every encounter, clinic staff have an opportunity to discuss patients’ level of distress and inform the providers.

P422
AMULATORY NURSING COLLABORATION WITH INDUSTRY EDUCATOR TO IMPROVE STAFF KNOWLEDGE ON ONCOLOGY CARE, ABILITY TO PROVIDE PATIENT EDUCATION, AND IMPROVING PATIENT SATISFACTION
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Oncology nurses rely on nurse educators to stay updated as treatments and patient care constantly evolve—and that requires a multipronged approach. All aspects are covered when clinical nurse educators and pharmaceutical nurse educators come together to deliver training for today’s cancer therapies (Grandal, 2023). To effectively evaluate the impact of the educational sessions, a survey was conducted to the clinical staff before and after each session. In addition, baseline Press Ganey scores were compared to those 6 months during the project to evaluate if there is positive impact on patients’ perception. The purposes was to provide monthly education to clinical teams led by pharmaceutical and clinical educators to increase staff knowledge and ability to provide patient education by reviewing latest oncology treatment options, disease states, and health care landscape, which in turn can positively impact patient outcomes and improve clinical staff engagement. Monthly education was provided in collaboration with different pharmaceutical nurse educators who are highly trained in specific oncology specialties. They discussed specific oncologic treatment and disease states. Benner from novice to expert (1-5) survey tool were administered pre and post education. Pharmaceutical nurse educators provided monthly 30-minute sessions on either oncology drug overview or disease topics. The content of the Oncology drug overview discussed mechanism of action, adverse events and side effects management, and patient education. The disease types were on multiple various
oncologic and hematologic types which discussed disease state and care & management. Patient Press Ganey score showed improvement on “Nurses assist overall” (in percentile, pre-intervention=95%, current=99%). The cumulative score on the pre and post evaluation of education showed staff improved their knowledge of topic (pre=2, post=3) and on ability to educate patients (pre=2, post=3). The education project showed improvement in all metrics. Staff increased their knowledge of the topics discussed and indicated knowledge on ways to conduct patient education. The staff were engaged and participated in the education provided. The nursing staff were provided real time resources and education on drug/treatment modalities they are currently administering and are clinically relevant to the staff. Collaboration with industry educator allowed to supplement education on pre-planned topics that our clinical educator would not otherwise have allowed to supplement education on pre-planned topics that our clinical educator would not otherwise have time or information to provide the staff. Our own clinic educator also gained knowledge and gained additional resources.

**P423**

**CREATION OF NEW PATIENT INTAKE NURSE COORDINATOR**

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Coordination of Care

The creation of the Intake Nurse Coordinator position is the result of a 2-year pilot program placing an experienced Oncology RN as a clinical lead to triage new patient referrals. As our Cancer Center volume grew, a process needed to be developed to ensure new patients are seen in a clinically appropriate time frame while also having all necessary records or pre-consult testing completed. The purpose of our pilot program was to improve upon the organization, prioritization and completeness of patient records prior to the initial Heme/Onc Consult, thus providing a successful first visit for both the patient and provider. Nursing and Administration collaborated on defining the process, roles and responsibilities required to successfully triage a new patient. The workgroup created a shared document to track and process all new patient referrals, a shared email box, standard documentation templates, and standard communication to be shared with new patients. Nursing collaborated with the Medical Director to define the standard required elements of a new patient consultation; specific reason for referral, location of records, lab work, pathology and required pre-consult testing. Volume increase of 89% from 2019-2023 and the feedback from Physicians confirmed the need for ongoing clinical support with new patient triage. Providers noted the pre-visit work allowed for a more comprehensive and organized consultation. Patients reported appreciation for having an RN available to talk with prior to their visit which decreased pre-visit anxiety. The intake coordinator is able to redirect patients not indicated for Oncology directly to the correct specialist and become the liaison between the Beth Israel Deaconess Medical Center (BIDMC) main campus and our community off-site for all patients transferring care. It is evident our practice requires the New Patient Intake RN Coordinator. The expertise provided by an experienced Oncology RN to triage referrals translates to expedited patient care and decreases the potential physical and emotional burden a new diagnosis carries. We continue to improve our process with the development of a Standard of Practice Guide in collaboration with the Medical Director, Nursing and Administration. It is our goal to share this novel role for Nursing within the BIDMC Heme/Onc clinical locations to further standardize care all patients receive within BIDMC.

**P424**

**TRANSITIONAL CARE MANAGEMENT POST-HOSPITAL FOLLOW-UP**

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Coordination of Care

Post-discharge from a hospital or acute care setting, patients struggle to follow up with their physician in a timely manner, misunderstand discharge instructions, or have difficulty scheduling appointments with their oncologist. Purposes were as follows:

- Decrease time from discharge to hospital follow-up in the clinic
- Compliance with discharge instructions to help reduce readmission and complications
- Increase patient satisfaction
- Efficient use of resources

A pilot was conducted in 4 regions. The team consists
of TCM (Transitional Care Managers) & LPN Navigators identifying recently discharged patients. The team worked collaboratively with supportive staff to facilitate the coordination of care. Evaluation was as follows:

- 212 patients identified for TCM
- 146 patients scheduled within a 7-day window.
- 66 patients scheduled within a 14-day window.
- Patients received a post-discharge follow-up call for symptom management, discharge instruction clarification, and resource need within 2 days of discharge. Post-follow-up appointment with oncologist live scheduled.
- A majority of patients are scheduled within 7-day window.

Future goal is enterprise-wide expansion utilizing successful processes. The implementation of this pilot program utilizing LPN Navigators and Supportive Care staff has shown promising results in improving post-hospitalization follow-up care. By ensuring timely access to care and facilitating coordination between healthcare providers, this program aims to decrease the time from discharge to clinic follow-up, enhance compliance with discharge instructions, reduce readmissions and complications, and increase patient satisfaction. Further evaluation and expansion of this program across all offices may provide valuable insights into optimizing post-hospitalization care for oncology patients and improving overall outcomes.

- Creating a new workflow between the TCM LPN Navigators and the Supportive Care Specialists:
  - Remote team served as intermediaries between patients and clinics.
  - Expedited post follow-up visits.
  - Enhanced patient experience

Challenges:

- Physician Scheduling Availability
- Standardizing Length of Visit
- Timely communication with Offices
- Educating Clinical Staff on New Processes and Benefits

An increase in revenue is expected as we expand this process enterprise-wide. The codes used for TCM visits are 99495 and 99496.

**P425**

**DEVELOPMENT OF A WEB-BASED PATIENT DECISION AID FOR UNAFFECTED BRCA MUTATION CARRIERS**

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**Patient Education and Safety**

Women with a BRCA gene mutation have an elevated lifetime risk of developing breast and ovarian cancer. Future risk management strategies include a combination of surveillance and/or risk-reduction strategies. Decisions about risk management strategies can be complex, personal and multifactorial. Within the clinical environment, there may be variations in recommendations between clinicians that can leave women uncertain and less able to choose a risk management pathway. The overall aim of this project is the development of a web-based patient decision aid for BRCA gene mutation carriers that will improve the decision-making process by providing the user with information about their cancer risk, options for risk management and potential benefits and side effects.

Development of the decision aid was guided by the International Patient Decision Aid Standards (IPDAS). A mixed methods approach was used to identify suitable content for the decision aid. A decision-making needs assessment was conducted to identify the information needs of women with a BRCA mutation. Semi-structured interviews were held with unaffected BRCA mutation carriers (n = 16) and key stakeholders including healthcare professionals, policy makers and patient group representatives (n= 10). Data were analysed by thematic analysis. Systematic scoping reviews were conducted to synthesise relevant evidence on risk-management options, benefits, harms and the development and testing of patient decision aids in general. Content for the decision aid was refined using a Delphi process. A prototype patient decision aid was developed which included written information as well as visual depictions of risk, videos and photographs to enhance the patient’s information experience. A ‘values clarification’ activity was included to enable women to work through their own values and preferences relating to risk management interventions and their associated benefits and side-effects. Initial ‘sandpit’ testing of the prototype was performed and usability testing was conducted with BRCA mutation carries (n = 8) and healthcare professionals (n = 8) using quantitative surveys. The research team made final revisions to the decision aid based on participant feedback and committee consensus.

**P426**

**IMPLEMENTING MOBILE PHLEBOTOMY FOR GENETIC TESTING**

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**Screening, Early Detection, and Genetic Risk**

*Screening, Early Detection, and Genetic Risk*
Traditional in-office blood draws for unique genetic blood testing presents challenges to patients and providers, including incorrect labeling, delayed results, and increased workload for healthcare providers. In addition, patients with transportation needs cannot always make it to their appointment, making access to phlebotomy services and issue of equity. Engaging a genetic testing company that offers a mobile phlebotomy service to address these barriers is an innovative solution. This quality improvement project introduced mobile phlebotomy services in a clinic setting, with the goal of enhancing patient care quality, improving safety, and improving staff satisfaction by reducing workload. Inova required clinic staff to outsource mobile phlebotomy service. The cancer service line sent a letter to clinicians in September 2023 explaining the rationale of requiring this specific genetic test to be outsourced to their mobile phlebotomy company. Data is currently being collected and analyzed. The data expects to show an increase in patient utilization of mobile services, and a decrease in in-clinic draws for this unique genetic test. Quality improvement data will be evaluated from 3 months before implementation to 3 months after implementation: June 2023 to November 2023. Mobile phlebotomy improves lab specimen collection, timing, patient satisfaction, and staff satisfaction. Its integration benefits nursing practice by optimizing workflows and reducing the risk of incorrect specimen labeling. Nurses can allocate more time to patient assessment and coordination of services, leading to efficient and safer care delivery.

**P427 UNDERSTANDING THE REASONS PATIENTS CALL TELEPHONE TRIAGE: DESIGNING AND UTILIZING DASHBOARD TO SUPPORT QUALITY IMPROVEMENT EFFORTS**

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Oncology Nursing Practice

Oncology-dedicated telephone triage nurses in a large academic cancer system respond to high volumes of patient calls daily. However, there was no existing data reporting tool to easily monitor trends in common symptom, practical, and educational concerns routinely being addressed by oncology care teams. The purpose was to deepen understanding of oncology patients’ needs when calling telephone triage through their cancer continuum and to inform meaningful quality improvement (QI) efforts at both the unit and system level, an oncology clinical nurse specialist (CNS) proposed creation of a customizable, real-time and historical dashboard of telephone triage-specific patient call data. The CNS engaged with frontline nurses, clinical, strategic, and operational committees to explore the utility of a dashboard to improve complex gaps in care delivery. It was identified that standard electronic health record (EHR) documentation includes completing fields for patient’s “reason(s) for call” into a telephone encounter. Since these fields can be extracted into a dashboard, IT data analysts designed and built a dynamic dashboard providing access to valuable patient-level data. The dashboard uses telephone encounter reasons authored by designated telephone triage nurses. It supplies basic filters for reported symptom/reason, fiscal years, months, and authors. As review, validation, and interest piqued from multiple stakeholders, dashboard optimization was needed. The revised dashboard now hosts additional users and departments where documentation encounters reside. The dashboard also offers individual case encounter information for direct clinical inquiry and auditing. The Dashboard entitled “Triage Phone Call Reasons” presents data dating back to 2019. Data refreshes weekly and is exportable. It is shareable with internal staff and leaders and is maintained by IT data analysts. Filter functions offer volume snapshots for all reasons for calls and can be narrowed to specific symptoms in one department (i.e. Pain in Breast Clinic or Medication Management in Survivorship Clinics). It consistently shows high volumes of calls unrelated to symptoms, emphasizing opportunity for operational and strategic input for patients requesting administrative and scheduling support. This data-rich tool provides valuable insight into process and system improvement opportunities, patient and staff educational needs, and development of patient communications. The CNS has a vital role to continue promoting the actionability and accuracy of the data in interdisciplinary forums and encouraging groups to access this data for clinical, educational, and quality improvement initiatives.

**P428 MED ROOM SHUFFLE: IMPROVING WORKSPACE IN AN OUTPATIENT AMBULATORY TREATMENT CENTER**

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Physical design of a work place can influence the ability of nurses or staff members to perform tasks. Cabinet doors, cluttered shelves, and hanging hooks height can affect accessibility and visibility of supplies. The design of a workspace can also contribute to distractions and interruptions in the medication preparation process, which leads to patient safety concerns. The goal of our quality improvement project was to improve the medication room design while maintaining a safe environment for the nurses and patients. The objectives were to:

- Review the current outpatient Ambulatory Treatment Center (ATC) medication room layout
- Identify risks and safety concerns of the workspace
- Analyze nursing suggestions for improvements of the ATC medication room layout and implement interventions.
- Maintain a safe working environment in the medication room

The PDSA (Plan, Do, Study, Act) model was used to design and carry out this quality improvement project. A pre-survey was created to identify barriers in the medication room. Results were analyzed and interventions were created with efficiency and patient safety in mind. 93% (n=16) of nursing staff wanted to improve the layout of the medication room and 73% (n=16) reported that they could easily access supplies. The team collaborated with unit operations, infection control, facilities, nursing staff, and unit leadership. The interventions included removal of cabinet doors, coverage of one sink to increase workspace, addition of hooks for IV bags, rearrangement and labeling of supplies, and re-design of the communication board. The team monitored the changes and analyzed results from the post-survey. A post survey was administered to nursing staff after the interventions were implemented. 92% (n=14) of nursing staff felt the supplies were more readily accessible and 100% (n=14) were satisfied with representing improvements in the workplace environment. The team will continue to monitor the workspace efficiency through direct observation and peer feedback. Physical design of a medication room is crucial in maintaining a safe and workable environment for nurses. By ensuring a safe environment during the medication preparation process, we are promoting and assimilating an organization of safe and efficient patient care.

P429 IMPACT OF VIRTUAL TELEMEDICINE SUPPORT ON PATIENT SATISFACTION IN A COMMUNITY ONCOLOGY PRACTICE

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Coordination of Care

With the use of telemedicine gaining traction across many specialties since the beginning of the Covid-19 pandemic, clinic staff has been overloaded with additional responsibility. Medical assistants felt increased demand while juggling prepping patients in the clinic ready for their providers and attempting to room virtual telemedicine patients. Telemedicine, in the oncology setting, produces many unique challenges including the lack of technology literacy in our aging population leading to longer prep time for virtual patient appointments. The needs of the patients and clinics were falling through the cracks, with patients being overlooked or unable to connect virtually. Those who were successful in joining their calls often waited an extended period of time, with the average time to first contact with patient intake specialists taking an average of 18 minutes. The inefficiencies and disorganization were dissatisfying for patients. The aim was to reduce inflated wait times for patients. This, in turn, would decrease wasted time for medical assistants and providers, allowing them to focus their attention on the patients in front of them in the clinic while efficiently completing telemed visits. This support also reduced workload for in-clinic staff, allowing intake and patient prep for telemedicine patients to be completed by well qualified remote staff. A team of fully-remote patient intake staff and medical assistants was constructed. State-wide uniformity was established with one telemedicine platform and any other video conferencing software eliminated from use. Reports were pulled from the telemedicine platform to include wait and call times for each call before and after virtual support implementation, as were patient satisfaction scores from electronic patient feedback reports. Medical assistants at the site level were surveyed to collect feedback about impact of virtual telemedicine support. Improvements in in-clinic workload were significant with 68% of respondents reporting augmented time management daily, and 18% some of the time; 78% sharing that they’ve perceived a positive impact on reducing their workload; and 82% sharing that they feel they are better able to focus their time on the patients in front of them. Our telemedicine
patients are waiting less than three minutes to begin their appointments, down 85% from 18 minutes. In turn, this has enhanced patient satisfaction with appointment efficiency from a rating of 4.4 to 4.8 on a 5-point scale.

P430
EVALUATING THE EFFICACY OF NORMAL SALINE ONLY LINE MAINTENANCE FOR HEMATOLOGIC MALIGNANCIES AND CELLULAR THERAPEUTICS (HMCT) PATIENTS WITH TRIFUSIONS OR POWERLINES NOT ACTIVELY RECEIVING TREATMENT IN APHERESIS.
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Oncology Nursing Practice
The discontinuation of Heparin in ports, led to a review of our current practices in Trifusions and Powerlines. Nursing identified inconsistencies with patient education related to central line care. Some patients were sent home with instructions and supplies to flush their central line daily. Other patients would be packed with Heparin without instructions to flush daily. There is poor evidence to support either practice. The associated risks of Heparin Induced Thrombocytemia (HIT) and Central line Associated Blood Stream Infections (CLABSI) also outweigh the benefits as it could lead to increased health care cost, prolonged hospital admissions, and increased mortality rates in this patient population. A quality improvement initiative aimed to address several concerns: the lack of supporting evidence, the risk of CLABSI due to improper technique, Normal Saline availability issues, the risk of HIT, and Heparin usage in a patient population prone to thrombocytopenia. The goal was to evaluate if large bore lumen patency maintenance can be achieved with Normal Saline only, reducing flushing frequency without increasing Alteplase usage. The initiative began with a comprehensive literature review, examining recent journal articles, standard infusion practices, and manufacturer’s flushing recommendations. Based on this information, a new workflow was developed with a focus on patient safety, eliminating Heparin packing in Trifusions and Powerlines and reducing flushing frequency. This workflow excluded patients seen in Apheresis for Photopheresis or cell collections based on lumen patency standards. Education was provided to both inpatient and outpatient HMCT nursing staff, nurse practitioners, pharmacist, and presented to providers for continuity. Emphasis was placed on proper turbulent and positive pressure line flushing technique to prevent intralumenal clots. The evaluation of this initiative demonstrated positive outcomes. Patients and caregivers responded positively to no longer being responsible for flushing lumens, and line patency was maintained without increased Alteplase usage. Although data collection is ongoing, the initiative aims to reduce Central Line-Associated Bloodstream Infections (CLABSI) by eliminating non-healthcare provider home flushing and reducing line accesses. This initiative addressed challenges arising from current practices related to larger bore central line care, specifically Trifusions and Powerlines. Practice changes and comprehensive education efforts resulted in positive patient experiences, sustained line patency, and the anticipated reduction of central line infections, enhancing overall patient care outcomes.

P431
EFFECT OF SLEEP MENU ON PATIENT PERCEIVED SLEEP
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Oncology Nursing Practice
Sleep is a vital, healing process and hospitalized patients frequently report insufficient or inadequate sleep. Hospitalized patients undergoing hematopoietic stem cell transplantation (HCT) who experience sleep disruptions are at an increased risk of fatigue, falls, and length of stay. Despite the importance of sleep, it is not routinely assessed and there is limited action to improve perceived sleep quality. The purpose of this quality improvement study was to measure whether a sleep menu impacts perceived patient sleep compared to no sleep menu. Patients undergoing HCT February-October 2022 completed the Richard Campbell Sleep Questionnaire (RCSQ), which served as baseline data. A sleep menu was created, based on a comprehensive literature review, and introduced to patients June-October 2022. Nurses discussed the sleep study with patients and presented the menu and RCSQ form. Patients made their selections from the sleep menu each evening and unit staff provided the aid(s). The following day, day and night nurses entered patient medical record numbers, RCSQ responses, least and most helpful interventions, and any additional comments into Microsoft Teams electronic forms. Data were collected at admission, throughout hospitalization, and at
discharge. The sleep menu did not have a significant impact on perceived patient sleep. The most helpful interventions reported by patients included lighting, curtains, and temperature adjustments as well as lavender and pharmacological aids. However, in reviewing the comments, our patients state that the most helpful interventions in getting a better night’s sleep were decreasing lighting, noise, decreasing interruptions and temperature control. Pain, nausea, diarrhea and anxiety were common comments by patients for why they did not sleep well. Barriers in this study include not reassessing sleep perception with each patient that was offered an intervention and due to a delay in getting our sleep supplies we ended starting the intervention later than we hoped for. Which, therefore, could have led to less engagement in the project and taking a lot longer than we hoped for. Which, therefore, could have led to less engagement in the project and taking a lot longer than we hoped for. Which, therefore, could have led to less engagement in the project and taking a lot longer than we hoped for.

P432
PIECING TOGETHER THE PUZZLE OF INTRATECHAL CHEMO - OPTIMIZING CARE BY STREAMLINING SCHEDULING AND NURSING COMMUNICATION
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Coordination of Care
The ambiguous interdisciplinary scheduling and communication processes of lumbar punctures (LPs) for intrathecal chemotherapy (IT chemo) led to confusion and inconsistencies between the oncology, radiology and interventional radiology departments at a large academic hospital in New York City. The absence of a systematic approach for both inpatient and outpatient procedures underscored the need for process revision. The purpose of this project was to identify and rectify the gaps in the scheduling and communication processes for LPs across inpatient and outpatient settings. This was done by ensuring optimal utilization of a scheduling process and improved interdisciplinary communication to optimize the coordination of patient care. Interventions were as follows:

- Engaged key stakeholders, including inpatient oncology, interventional radiology, and radiology nurses, nurse leaders, advanced practice providers, physicians, and schedulers.
- Identified gaps and inconsistencies in scheduling practices and developed a combined email and telephone call process for the coordination of scheduling procedures.
- Established specific time slots with a 24 to 48 hours’ notice, and made provisions for six to seven slots per week as needed.
- Identified the absence of a standardized handoff process and implemented a process by which nurses in different departments communicate patient handoff via the electronic health record.

Implemented in August 2023, these interventions are under ongoing assessment by the quality team in collaboration with interdepartmental leaders to ensure their sustained effectiveness. Through monthly audits, we are diligently tracking the robustness of the scheduling system and the standardization of nursing handoffs. Thus far, the interventions have improved clarity, collaboration and consistency in the scheduling process by designating specified LP time slots for oncology patients and role expectations for each team member. Rectifying scheduling challenges for LPs holds immense potential for enhancing service delivery, minimizing staff confusion, and improving patient outcomes. Enhancements in nursing handoff are also evident. Future endeavors include ongoing process evaluation and refinements. The success of this revamped process hinges on the shared collaboration and adaptability of the involved stakeholders.

P433
PREMEDICATE OR NOT PREMEDICATE
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Oncology Nursing Practice
Transfusions play a major role in oncology. Chemotherapy and disease often cause anemia and thrombocytopenia. Transfusional support is often required to avoid symptoms of fatigue, dyspnea and bleeding. Historically acetaminophen and diphenhydramine have been administered prior to transfusions to prevent allergic and febrile non hemolytic reactions (FNHTRs). Literature, most of which is prior to 2020, does not support this practice. Several trials (462 patients) and Cochrane review (317 patients and 4444 blood products) have been analyzed and found that premeds do not prevent such reactions. Potential negative impacts include hepatotoxicity, urinary retention, altered mental status from diphenhydramine and masking...
neutropenic fevers by acetaminophen. A multidisci-
plinary QI project on the inpatient Oncology units was
developed at our center. The project was a collabora-
tive effort of APPs, RNs, and Blood Bank physicians.
The goal was to change practice based on evidence.
The project included a presentation of the literature
review, lecture by Blood Bank physician, and enforcing
that one reaction does not assure a reaction will occur
for all subsequent blood products. A review of transfu-
sions on the same units one month prior to initiating
the project revealed that 79% of 227 products received
premeds, and there were no reactions documented.
Data was collected for 3 months after implementing
the project. A list of all daily transfusions was obtained
and subsequently each product was reviewed to de-
terminate if premeds were administered or not. A staff
RN tallied the results. 1257 products were transfused
during the study period - 28% received premedications
with a 2.3% incidence of Blood Bank confirmed reac-
tions, occurring only with platelets. (1.6% received pre-
meds and 0.7% did not.) These results were presented
to all APPs, and data was collected for an additional 3
months. 30% of the 662 transfused products (a smaller
number due to covid surge) received premedications
with a 0.7% occurrence of reactions only in PRBC pre-
medicated infusions. This project proved that use of
transfusion premedications could be decreased by >
50% with no increase in reactions. This proved to be
cost effective and safe patient care. As a result, Blood
Bank physicians developed algorithms for FNHTRs
and allergic reactions now used routinely on the inpa-
tient Oncology units. The project underscores the ben-
efit of inter-service collaboration and communication
in delivering optimal patient care.

P434
TICKET TO RIDE: THE TALE OF TEAMWORK
TO DECEASE WAIT TIMES
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Coordination of Care
Waiting is a difficult component of being an oncology
patient that occurs often while under active treatment.
Patient satisfaction scores at one cancer hospital in-
dicated dissatisfaction with wait times in an infusion
setting. Nurses from the unit-based council (UBC) set
forth to investigate the main causes of delays to im-
prove patient wait times. This presentation discusses
the examination of primary causes of delays and as-
sest the effectiveness of an intervention to decrease
wait times for patients in infusion departments. Initial
data collection included survey distribution to infusion
center charge nurses (CN) to examine potential causes
of delays. These included unsigned orders, laboratory
values outside of ordered parameters, incorrect order
dates, and other. Unsigned orders emerged as a lead-
ning cause of delays which became the focus of this QI
initiative. Delays were measured in minutes to estab-
lish a baseline. The CN reviewed the patient orders for
discrepancies prior to admission to the unit. Delay was
measured as the time when the CN paged the provider
to reconcile orders to the time orders were amended
and signed. UBC developed an intervention, Ticket to
Ride (TTR), to remind providers in clinic settings and
exam rooms to sign patient orders before sending them
to their infusion appointments. The TTR was piloted
in one provider unit and placed in physician workspac-
es. Additional data collection periods were completed
30/90 days post-implementation to examine sustain-
ability. A significant reduction of delays occurred in
the number of unsigned treatment plan orders and
minutes of delay. Before implementation, there was
a total of 642 minutes of delay time, over a two week
period. Delay times decreased at each follow-up point
(30/90 days check in) from 344 minutes to 233 minutes,
indicating a 63.7% reduction in wait time from baseline
data collection period. We concluded the intervention
was successful in decreasing wait time for patients
when delays were related to unsigned orders. Nurses
will be able to replicate this QI initiative to tackle wait
times in their individual facilities.

P435
UTILIZATION OF THE PHQ-2 TOOL TO IN-
CREASE NURSE SCREENING COMPLIANCE
AND IMPROVE DEPRESSION SCREENING
FOR ONCOLOGY PATIENTS
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Gabriela Lacatus, RN, BSN, OCN®, PhD, UCSD Moores
Cancer Center, La Jolla, CA; Courtney Nelson, BSN,
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MPH, UC San Diego Health Cancer Services, La Jolla,
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Psychosocial Dimensions of Care
In an NCI-designated Comprehensive Cancer Cen-
ter consisting of five Ambulatory Infusion sites, im-
plementation of the Patient Health Questionnaire-2
(PHQ-2) screening tool for depression impacted nurse
screening compliance and streamlined the Social Work
(SW) referral process for oncology infusion patients.
With the previous Focused Psychosocial Assessment
tool, surveyed nurses stated reasons for low screening compliance included feeling uncomfortable with the assessment questions, forgetting to do the screening, and lack of knowledge about the referral process for positive screenings. The purpose of this project was to increase screening compliance and create a workflow for SW referral of positive patient screenings through the implementation of the PHQ-2 screening tool for depression. A multidisciplinary team consisting of nursing, quality, and information services convened to develop a workflow and add the PHQ-2 tool to the electronic medical record. Staff were educated on policy changes with the creation of a Tip Sheet and PHQ-2 Escalation Algorithm. Updates included screening only oncology patients on day 1 of each treatment cycle to align with national cancer survey standards versus the previous 28 days on all patients. To address nurses’ discomfort, scripts were developed to introduce the tool and communicate interventions for positive screenings with the patient. The PHQ-2 also excluded the question, “Over the last 2 weeks, how often have you been bothered by the following problems? Felt like hurting yourself.” To address “forgetting to do the screening,” a laminated card with the PHQ-2 in English and Spanish was placed at each infusion chair. A PHQ-2 reminder was also prepopulated in the nurse’s note. A PHQ-2 Escalation Algorithm along with a SW directory was developed to aid nurses in the SW referral process and incorporated a standardized smart phrase documentation for nursing notes and referrals. Average screening compliance percentage demonstrated steady improvements in 3/5 sites. Pre-implementation (December 2022-March 2023) to post-implementation (May-August 2023), (Site 1) 5.93% and 18.44%, (Site 2) 16.75% and 28.32%, (Site 3) 63.36% and 67.29%, (Site 4) 78.24% and 59.95%, (Site 5) 87.07% and 68.48%. New workflow for SW referrals, post intervention =44. The implementation of the PHQ-2 resulted in the optimization of oncology patient screenings during vulnerable stages of treatment and increased the number of SW referrals supporting patients’ further evaluation for depressive disorder. Frequent education is required to support increased compliance.

P436
PATIENT AND CAREGIVER PREPAREDNESS IN THORACIC SURGERY
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Patient Education and Safety
Patients scheduled for Thoracic surgery, and their caregivers, have unmet needs and sometimes lack experience associated with postoperative recovery at home. This leads to increased anxiety, feelings of lack of control, poor patient outcomes and decreased patient satisfaction. Nurses are in a unique position to improve their understanding on how to prepare for recovery at home prior to having surgery. The purpose of this quality improvement was to prove that nurse-led management interventions to prepare patients and their caregivers for postoperative recovery after Thoracic Surgery can decrease caregiver burden when discharged. Team members were educated on how to deliver and score The Preparedness for Caregiving Scale which is a self-rated instrument made up of nine questions that ask caregivers how well-prepared they believe they are for multiple domains of caregiving. A low score prompted a referral to a nurse navigator for education which included time-specific and situational relative information to prepare for surgery and included the post-operative unpredictability and management of post-operative symptoms. If time was limited, education was given by phone. A post survey Microsoft form was emailed to patients. If a patient didn’t want to fill out the digital form, post survey questions were asked during the 2-day post-discharge follow-up call. The baseline data from HCAHPS scores (Medicare and internal) show that although patients scores were high when acknowledging that they were given information about what to do during their recovery at home (87%), their understanding about their care when transitioning from hospital to home is much lower (32%). The baseline data obtained from the Preparedness for Caregiving Scale also supported this education gap. Pre-survey preparedness scores were much lower than the post-survey results. 72% of patients felt that they were somewhat or not prepared in the pre-survey. After intervention, 100% of patients felt that they were somewhat prepared or very well prepared. This project has supported the research that patients and their caregivers feel inadequately prepared to manage their recovery when transitioning from the hospital to the home setting. This project has also shown that with adequate pre-surgery self-management education, patients and caregivers will have a good understanding of managing the patients’ health and can approach the scheduled surgery and caregiving responsibilities with more confidence and less fear.

P437
IMPLEMENTATION OF A PROCESS TO REDUCE PATIENT SURGICAL WAIT TIME AND IMPROVE PATIENT SATISFACTION IN AN ONCOLOGY PERIOPERATIVE SETTING
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Oncology Nursing Practice

Surgical interventions are considered curative surgery for some patients; for others, it is a palliative approach. Patients undergoing oncologic surgical interventions are life-altering; therefore, ensuring patients and family members receive patient-centered information about their surgical journey requires clear and concise instructions. The Patient Surgical Path Card provides a source of communication. A quick reference serves as a physical reminder and navigator to ensure the patient and family members arrive at their surgical destination without impediments that may interrupt their throughput. This quality improvement project aimed to develop an efficient plan that ensures each patient receives patient-specific care and instructions. Surgical patients expressed frustration and confusion when a surgical intervention was delayed, negatively impacting their overall satisfaction. Other factors included scheduling mix-ups and incorrect arrival instructions, causing lagging patient surgical wait times. By streamlining patient throughput with an information card called the Patient Surgical Path Card, surgical wait times are decreased, arrival times and patient satisfaction improved, thereby providing patients with a positive experience. The nurse-led intervention included the development of the Surgical Path Card, which had a written explanation of their route, a map, and a quick response (QR) code to watch a short video to mirror the written information, providing a multimodality approach for patient inclusivity. Currently, only 64% of the surgical first cases start on time at or before 07:30 a.m. Furthermore, the data revealed that patients arrived for their surgeries on time only 30% of the time (formative data). The patients waiting to enter the operating rooms wait on time only 30% of the time (formative data). The data collected showed improvements in all areas after the implementation of the Patient Surgical Path Card. The project was accepted and appreciated, and the patients, family members, and frontline staff supported the Surgical Path Card project’s sustainability. The patients expressed constructive input and gratitude for the information card, which they can refer to as they anticipate their surgical destination without impediments that may interrupt their throughput. Open communication among the project manager and stakeholders developed a culture of change, collegiality, innovation, and engagement, empowering the multidisciplinary team to reflect on their practice and patient outcomes, question the status quo, and build a platform for change. Above all, to foster the spirit of inquiry through a culture of innovation and advancing nursing science through patient-centered care improvement projects.

P438
IMPLEMENTING MEDICAL SURVEILLANCE TO SCREEN ONCOLOGY NURSES FOR ADVERSE EFFECTS FROM CHEMOTHERAPY ADMINISTRATION

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Oncology Nursing Practice

Eight million healthcare workers in the United States are potentially exposed to hazardous drugs each year. Medical surveillance is a regulatory standard that includes baseline and ongoing screenings of employees with potential or known exposure to hazardous drugs. Oncology nurses are at high risk for occupational exposure to hazardous drugs during chemotherapy administration. Regular screening of oncology nurses allows early identification and treatment related to adverse effects due to occupational exposure. Our institution lacked a medical surveillance process, which affected compliance with our hazardous drug safety plan. The purpose was to establish a comprehensive medical surveillance process for inpatient and outpatient oncology nurses who administer chemotherapy. A multidisciplinary team of occupational health (OH), pharmacy, nursing, safety, quality, and regulatory professionals was formed. The team agreed to use a risk-stratification approach to operationalize a feasible process to screen existing and future oncology nurses. A total of 96 oncology nurses who administer chemotherapy were identified. Interventions consisted of screening existing oncology nurses followed by implementation of screening during the onboarding process. Screening components include a complete health assessment, bloodwork, and evaluation of personal protective equipment use. The 96 existing oncology nurses who administer chemotherapy will receive initial screening by OH within 30 days of October 2023 implementation of the medical surveillance process. Thereafter, incoming oncology nurses will receive baseline screening within 30 days of hire. Prior to identifying the process gap, zero oncology nurses who administer chemotherapy received medical surveillance. Goals of the multidisciplinary team include updating the hazardous drug safety plan, achieving 100% compliance with screening existing oncology nurses who administer chemotherapy, and sustaining baseline screening of incoming oncology nurses. Executive leadership of our healthcare system supported this multidisciplinary quality improvement initiative to promote and enhance employee...
safety. OH is implementing a comprehensive medical surveillance process and will maintain screenings in employee health records. The tiered approach to risk stratification yielded a practice change that requires screening of inpatient and outpatient oncology nurses who administer chemotherapy upon hire and annually. The implications of practice include the importance of ensuring oncology nursing and leadership awareness of the regulatory standard for hazardous drug screening, evaluating current medical surveillance process to reflect adherence, coordinating multidisciplinary discussions, and updating the associated safety plan to prioritize the safety of oncology nurses who administer chemotherapy.

P439
DEVELOPING AN ASSIGNMENT ACUITY SYSTEM THAT MEETS THE CHALLENGES OF PRIVATE PRACTICE INFUSION CENTERS
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Oncology Nursing Practice

Previously, nurse assignments were either based on first available in the moment or a distribution based on the number of chemo and non-chemo treatments. A midsize private practice infusion clinic struggled to divide patient care evenly between infusion nurses. Assignments were frequently unbalanced, hindering quality patient care and contributing to nurse burnout. An acuity criterion was developed to better capture the amount of care each individual patient requires. The point system assigns 1-5 points to each patient based on the type of treatment or care ordered, number of medications in the regimen, first or subsequent treatment, previous tolerance, and other factors such as psychosocial considerations. The original four-point acuity criterion was initially applied to the infusion clinic for one week. This system was found to be lacking because it did not allow for additional acuity points related to first time patients and high-risk drugs as it was based solely on the type of medication (oncolytic, therapeutic, or supportive) and whether the treatment was single or multi-agent. The acuity scale was reviewed, and treatments were further broken down into chemotherapy, biologic, therapeutic, and supportive; and a fifth point was added to allow for additional acuity related to first time treatments or higher risk medications. Assignments based on an acuity system are not novel in nursing. However, private practice infusion clinics face unique challenges such as scheduling around same day provider visits, limited internal resources, and fewer infusion chair hours daily. The nursing team desired to develop an acuity system that incorporates these challenges while prioritizing quality patient care and evenly distributing the workload. The system has now been in place for nearly three years. While there have been adjustments during that time to accommodate novel therapies, a five-point system continues to prove successful.

P440
“WHERE IS THE BICARB?” A MULTIDISCIPLINARY IMPROVEMENT PROJECT IN A TERTIARY MULTI-SPECIALTY INSTITUTION TO ENSURE THAT SODIUM BICARBONATE IS READILY AVAILABLE FOR HIGH DOSE METHOTREXATE PATIENTS
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Oncology Nursing Practice

High dose methotrexate chemotherapy is highly toxic to the kidneys. Urine output and ph are monitored very closely with every void for patients who have received this treatment. Sodium bicarbonate infusion is administered continuously to keep the urine alkaline for kidney protection. Frequent delays in the administration of continuous sodium bicarbonate infusion for patients who have received high dose methotrexate puts patients at risk for complications. Delays occur due to: Continuous infusion fluids do not automatically dispense. Nurses need to call to request each bag and can forget due to workload. Pharmacy frequently cancels the delivery thinking that it was a duplicate request based on frequency. Sodium bicarbonate cannot be stocked on the unit due to requirements in rate changes and base fluids specific to each patient. Nursing and pharmacy teams reviewed the current sodium bicarbonate dispensing process. The fluid base of sodium bicarbonate was updated from D5W to sterile water to prevent hyperglycemia. The sodium bicarbonate order frequency was changed from continuous to scheduled dosing every 6 hrs. A nursing communication was added that it is “okay to delay hanging the next bag until the previous bag is completed.” Evaluation: pending, start date 9/23. Providing intravenous sodium bicarbonate in a timely manner is critically important to protect the kidney function of patients receiving high dose methotrexate. Process delays in complex systems
can contribute to significant delays and must be mitigated for patient safety.

**P441**
**THE IMPACT OF KAMISHIBAI CARDS ON NURSE KNOWLEDGE AND ADHERENCE TO A CLABSI PREVENTION BUNDLE**
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**Oncology Nursing Practice**
Central line-associated bloodstream infections (CLABSI) pose a significant patient safety risk to oncology patients who often require a central venous access device (CVAD) to receive treatment. Over 30,000 CLABSI occur each year, increasing patient mortality by 12-15% and costing an average of $48,000. Although evidence based CLABSI prevention bundles have been well established for over a decade, nursing knowledge and adherence to bundles remain low. The purpose of the project was to examine the impact of a quality improvement tool, Kamishibai cards (K cards), on nursing knowledge and adherence to a CLABSI prevention bundle on an adult hematology/oncology/transplant unit. The K card process involves a combination of real-time audit and feedback process with easy data visualization. A knowledge assessment of the CLABSI prevention bundle was used to measure nursing knowledge before and after K card implementation. K card rounds were performed over six weeks. During a K card round, the nurse leader invited a nurse caring for a patient with a CVAD to participate. Together they reviewed documentation and assessed the patient’s CVAD at the bedside to determine if bundle elements had been completed. If all bundle elements were met, the K card was scored as green and displayed on the K card board on the unit. If a bundle element was missed, the nurse leader provided support to help the nurse correct the element. The K card was scored as red and displayed on the K card board with the missed element. The K card process demonstrated an increase in nursing knowledge and adherence to a CLABSI prevention bundle. The use of the K card process demonstrated an increase in nursing knowledge and adherence to a CLABSI prevention bundle. Education and compliance with a CLABSI prevention bundle have been shown to decrease CLABSI rates. K cards are an effective way to improve oncology and transplant patient outcomes by ensuring CLABSI prevention bundle knowledge and adherence.

**P442**
**ADDRESSING BARRIERS REGARDING TOBACCO USE AND COUNSELING WITHIN TRANSPLANT AND CELLULAR THERAPIES CLINIC**
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**Patient Education and Safety**
Within our transplant and cellular therapies nursing assessment questions there is a section directly related to substance history. This sections contents include a detailed smoking history, including a section for cigarettes, electronic cigarette use and smokeless tobacco products. In December of 2022, it was brought to my attention that our clinic was performing poorly in asking our patients about their smoking history and willingness to quit smoking or seek counseling to try and stop. Our rate of asking patients about smoking at each visit was only 70% and counseling 0%. I implemented strategies to improve asking in all areas of this section to raise our ask rate in our clinic. Within EPIC, there is a way to change the view in our nursing assessment to be able to more readily see these assessment questions. I implemented a tip sheet and disseminated this information to all of our nursing staff with the hopes of improving this process and our asking percentage. I created a tip sheet to change our nursing assessment view and sent this to the quality management representative overseeing this initiative which was called “Just Ask”. I presented the information in a staff meeting and encouraged staff to change their view to better capture this data. A survey was also sent out to staff to capture post intervention data. Our ask rate for tobacco use jumped from 65% to 83/3% initially in early 2023 and since launching the project has dropped back down to 65% once again. Our counseling ask rate went up 150% in early 2023 but has also dropped to 80% and now closer to 33%. Patients who are undergoing chemotherapy and also smoke can have a worse prognosis than patients who refrain. It is important we capture this information at every visit if possible and for a few months this project increased the asking rate for smoking and counseling. Through this project, our numbers.
In the future, I would want to discuss this topic more often to remind staff to complete this documentation. Our data also may contain outliers if patients populate the answers prior to coming to clinic and we are not readdressing questions in real time.

**P443**

**LET’S TALK ABOUT SEX**

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**Patient Education and Safety**

Nurses at community cancer centers affiliated with an NCI-designated comprehensive cancer center identified an opportunity to improve patient care in the realm of sexual health and intimacy. Cancer treatment can change body image and decrease libido, leading to changes in intimate relationships and self-confidence. These changes can negatively impact emotional and physical health. Patients may be uncomfortable bringing up the topic of sexual changes to nurses or providers. Issues of sexual preference and gender identification also need acknowledgement to assure equitable bias-free care. Sexual health is an essential component of human experience requiring health care teams to engage in open dialogue with patients to provide comprehensive care and education. The purpose was to describe an ongoing quality improvement project for care teams’ practices relative to patients’ sexual health needs. To detail program development addressing support services for oncology patients’ best care. Two frontline nurses, members of the Patient Education Advisory Committee, initiated work identifying the importance of conversations and offered tips on how to assess patients’ sexual health in a presentation. A committee was then established with an additional staff nurse, an Advanced Practice Nurse educator, and a Nurse Manager to plan an organization-wide sexual health awareness and education program. Intentional engagement with provider staff on best practices for sexual health assessment and content for patient education will inform survey design. Survey results from patients, nurses, pharmacists, and providers will provide base knowledge of comfort levels, recognition of personal biases, preferences in approach to discussing this topic and suggestions for topics and questions.

**Evaluation:** With the efforts to increase staff expertise in assessing sexual health and needs for clinical care and education, ongoing feedback of patients’ perceptions of confidence and trust in staff will be collected and changes incorporated as needed. Staff will provide ongoing analysis of proficiency to competently facilitate discussions and advocate for patients. Promotion of sexual health for oncology patients by health care teams mandates more than clinical knowledge. It requires self-reflection and awareness of biases and implications for comprehensive and inclusive patient care.

**P444**

**SERVICE EXCELLENCE IN ONCOLOGY: INTERNAL AND EXTERNAL ALIGNMENT OF CONSISTENT ORGANIZATIONAL STANDARDS**

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**Professional Development**

Healthcare today faces: A Large NCI designated cancer center, dedicated to state of the science care delivery, (n= 120,000 patient appointments annually), identified an opportunity following several significant care delivery modifications. Modifications ranged from EPIC adoption, major organizational restructures, and COVID response, leading to significant changes in staff and patient interactions. Recruitment and retention efforts were also adversely affected by these major trends. Analysis of national hospital rankings and Press Ganey scores demonstrated a need to rebuild a culture of reciprocity and relationship between staff to patients and staff to staff. Recognition that increasing overall confidence and positive experience for patients can lead to improved outcomes. The purpose was to enhance a workplace culture, centered on patient care, extending professionalism, satisfaction, trust, confidence, and relationship building. A workgroup of 20 people from across the organization convened to conceptualize and integrate service constructed on a foundational purpose, “We create hope.” The team was comprised of staff, and representatives of the patient advisory committee. Curriculum content was developed integrating service standards of the five key behaviors, safety, accessibility, collaboration, relationship, and inclusion. These key behaviors incorporate organizational commitment to diversity, equity, and inclusion. (DEI) A mandatory training across all staff was initiated in spring. In person attendance (n=20) allowed for dynamic interpersonal engagement of
participants. The program has ongoing continual evaluation to discern program achievements in the areas of patient satisfaction and staff recruitment and retention. Following the first month of program implementation, patient metrics from Press Ganey positive patient insights moved from 59% to 61%. Staff data will be analyzed for concurrent evaluation of areas success in the 5 key behaviors and organizational accountability to promote comprehensive sustainment of the initiative. An additional program to incorporate leaders into a formal familiarization with how to be present with staff, identify areas of change that can build trust and sustain strong inclusive relationships is underway. The recognition of leadership’s involvement is imperative to success.

**P445**

**THE ROLE OF SAFE HANDLING PATIENT EDUCATION TO INCREASE PATIENTS’ AND CAREGIVERS’ KNOWLEDGE OF SAFE HANDLING OF ANTINEOPLASTIC DRUGS TO REDUCE ANTINEOPLASTIC DRUG EXPOSURE IN HOME SETTINGS**

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Patient Education and Safety

Antineoplastic medicines belong to the classification of hazardous drugs. Safe handling techniques for managing antineoplastic drugs and waste have focused on the administration of antineoplastic drugs in inpatient/outpatient settings with minimal focus on the home setting. When patients receive antineoplastic drugs at home, it is vital to employ safety measures to reduce inadvertent exposure to the patient, cohabitating family members/caregivers, pets, and the environment. The purpose was to measure patient knowledge related to the safe handling of the antineoplastic drug in a home setting. This QI project was conducted in an academic medical center outpatient infusion department and oncology outpatient clinics over an eight-week period. A one-page patient education tool, “Patient and Caregiver Education for the Safe Handling of Antineoplastic Medications,” was developed. The education tool was reviewed and approved by the patient education council for use with patients receiving antineoplastic medications in an outpatient/home setting. A Qualtrics survey tool was used to collect pre- and post-survey data. The survey consisted of eight questions with a five-point Likert scale response option to evaluate the effect of safe handling education on patient and caregiver’s knowledge of antineoplastic safe handling. 62 patients/caregivers completed the pre-survey, and 61 completed post-survey. The study had a relatively equal distribution of participants between patients and caregivers, with most participants falling in the age groups of 41-60 and 61-80, and most participants were female.

Pre- and post-knowledge scores were compared using descriptive measures. Survey results indicate increased knowledge about safety guidelines when handling antineoplastic drugs in the home setting. The results showed that most participants (94.3%) understood the proper guidelines for storing anticancer medication at home (90.2%), the steps to safely discard anticancer waste at home (90.2%), and the proper guidelines for using the toilet when taking anticancer medication (85.2%). Also, Patients and caregivers could verbalize safe handling guidelines when handling antineoplastic drugs and contaminated bodily fluids at home. The survey evaluation indicates an improvement in patient and caregiver knowledge, which may help to decrease exposure to hazardous substances to caregivers and the environment. The Safe Handling patient education tool was easy to implement, efficient, and well-received by oncologists, nurses, patients, and caregivers.

**P446**

**REDUCING FALLS THROUGH GAMIFICATION**

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Oncology Nursing Practice

The Agency for Healthcare Research and Quality states “700,000 to 1 million hospitalized patients fall each year” (2019). Our 42 bed-medical-oncology unit, with an average daily census of 33.2, noted a serious spike in falls in February of 2023. In 2022, the unit had an average of 2 falls per month. In 2023 during a three-month period there were 12 falls, doubling the previous year’s average. Knowledge deficit regarding necessary actions for fall prevention was identified as a major issue and was most likely related to a high turnover of nurses. At the time of the spike in falls, 43% of the 30 nurses on the unit had been hired in 2022, and most were new nurses. The falls game was invented with the purpose of decreasing falls and increasing knowledge on the importance of fall prevention in oncology patients in an innovative and fun way. A hospital themed game board and five teams were created consisting of a balanced combination of experienced, novice, day, and night staff nurses, with one designated captain. Teams
moved ahead one space for each day their team had no patient fall and back five spaces for each fall. Teams could move forward for reading an article on fall prevention and sharing with staff what they learned. Additionally, they could complete a falls prevention education module. Daily huddle became the opportunity to highlight fall prevention education and unit progress in fall reduction. Challenges and successes were identified and discussed in an open forum motivating learning and efforts to endorse fall prevention actions. An assessment of fall rates for the three months following the start of the gamification intervention indicated a 58% decrease in patient falls. As a mechanism of the gaming rules, eight nurses presented on falls prevention to the staff and 20 nurses completed an online falls prevention module. For the three months following the gamification intervention there was a successful reduction in falls. Gamification tells us that competition can serve as a healthy motivator to achieve a goal. The success of the falls reeducation through gamification has led to other units participating in the fall reduction game, as an added outcome measure, it may be helpful to measure nurse’s knowledge of fall prevention strategies pre- and post- a fall game intervention.

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TRANSFORMING ONCOLOGY CARE: OVERCOMING CHALLENGES AND ACHIEVING SUCCESS WITH EVIDENCE-BASED PRACTICES
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Oncology Nursing Practice
Over recent months, the use of Alteplase (Cathflo) to maintain the patency of mediport lines had increased due to complications possibly to Heparin usage and improper flushing techniques. This upswing resulted in 1 out of every 53 patients requiring Alteplase, leading to care delays and heightened stress for both patients and caregivers. Recognizing the urgency for evidence-based care, we embarked on a phased approach to implement new care standards. The purposes was to implement a practice change of locking implanted venous ports using Saline instead of Heparin, and use of the push/pause method when flushing. The goal of reducing complications with mediports that result in the use Cathflo. Initially a literature review was conducted, and data was presented to two lead providers in one ambulatory oncology community center to isolate the patient population that data was collected. With their approval, their patient population was used to collect data and monitor use of Cathflo. After 14 weeks of preliminary data collected, staff were educated on the complications of using Heparin and how equally effective saline was when flushed properly. Patients were educated by providers and nursing on best practice. Staff had many concerns about the safety and patency of the intervention. Concerned were addressed. Implementation of locking ports using Normal Saline with the pulsatile technique was initiated. A few nurses still resisted the execution of the best practice. Preliminary data was shared with the nursing staff and additional steps were taken to limit nurses’ access to Heparin, thus yielding more accurate results of the pilot. Data was collected for 14 weeks before and after implementation. There was a two-week period in between that was omitted from data collection as patients were returning to clinic with heparinized ports. Nursing staff keep a count of how many patients needed Cathflo to obtain brisk blood return. The need for Cathflo dropped from 1 in 53 patients to one in a 108 patients. Patients were 50% less likely to need Cathflo with Saline flushing. However, we encountered implementation challenges. Starting at one location allowed effective education and preparation of nursing staff. Staff confidence in evidence-based practice is crucial. We will address concerns, provide continuous education, and ensure alignment with the latest best practice standards in oncology nursing as we move forward.

P448
POLICY CHANGE FOR CENTRAL LINE DRESSINGS IN PATIENTS RECEIVING THIOTEPA
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Patient Education and Safety
At Northside Hospital, there are a few bone marrow transplants which include the administration of a Thiotepa-based preparative regimen. Specifically, Thiotepa is given in dosages greater than 10 mg/kg for patients with central nervous system lymphomas and in dosages less than 10 mg/kg for patients with sickle cell disease. It is known that Thiotepa is partially excreted through the sweat glands, requiring that patients must be protected from prolonged exposure. Frequent bathing and dressing changes (anywhere between every 6 to 12 hours) are required in this patient population 3 hours prior to the first dose of Thiotepa and for 48 hours after the final dose. Unfortunately, skin toxicity was still being noted in patients on our blood and marrow transplant unit, despite the utilization of frequent dressing changes. The central line dressings which were being used were occlusive with
Tegaderm. Patients were noted to have hyperpigmentation, desquamation, and pain. A literature search was performed to find alternatives to occlusive dressings in patients receiving Thiotepa. Prior experience and interventions used at other institutions were also taken into consideration. The literature and processes at other institutions confirmed that occlusive dressings should be avoided during and after administration of Thiotepa. Additionally, CHG products were also not recommended, such as bio-patches and Tegaderm CHG. It was also well documented that only water and gentle soaps should be used for bathing, no wipes or lotions should be applied, light patting without rubbing should be performed to dry the skin, and only loose clothing should be worn. Given the initial problem and the above findings, a change plan was brought up in a supportive care meeting. It was proposed that during these frequent dressing changes, the central access site should be cleaned with povidone-iodine and sterile saline, and thereafter patted dry with sterile gauze. Additionally, it was proposed that a non-occlusive gauze with minimal tape be used to cover the central line. Once the proposal was approved, nursing resource guides were updated by the pharmacy team and inpatient clinicians. This updated guideline then underwent a final review and approval by nursing leadership. Inpatient clinicians were thereafter responsible in ensuring appropriate staff education. In the future, it would be interesting to perform a comparative safety analysis between the prior and current processes.

After received referral from doctors, trained nurses will approach to patients by face-to-face interview. Contents of pamphlet have been introduced including introduction of central venous catheter, complications, care of central venous catheter as well as helping hotline. During interview, stress level has been evaluated using Likert 5-point scale. When patients agreed for the insertion procedure, patients will be referred to doctors for informed consent and operation. After insertion procedure, trained nurse will be responsible for flushing and patient care. One month after insertion procedure, the nurse will conduct another face-to-face or phone interview to evaluate post-procedural stress level, satisfaction level and render patient education regarding prevention of complications. Fourteen patients have been enrolled in our study with 94% response rate (7% being illiterate). Mean age was 47.8 years (38-76). 97% of patients agreed that educational pamphlets clearly rendered relevant information about insertion of central venous catheter. The stress level has been significantly reduced after insertion of central venous catheter (4.01 vs. 2.56). Besides, the satisfaction level about insertion of central venous catheter has been recorded (Mean 4.32). It is worth noticing patients are satisfactory on patient education by nurse (Mean 4.46) and short waiting time for insertion of central venous catheter (Mean 4.01). The result showed that educational pamphlets improved patient’s satisfaction and did not reduce retention of central venous catheter related information. We are planning to provide educational videos with AR features in the future to enhance patient satisfaction.

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INTRODUCING EDUCATIONAL PAMPHLET TO PATIENTS PRIOR TO INSERTION OF CENTRAL VENOUS CATHER FOR INTRAVENOUS CHEMOTHERAPY: AN OUTCOME EVALUATION
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Patient Education and Safety
Insertion of central venous catheter have the advantage of minimizing pain from repeated peripheral vein puncture and hence protect the veins. Central venous catheter (PICC/Port-A-Cath) are widely used in medium- and long-term intravenous infusion in chemotherapy patients. In 2022, there are 40% increase of insertion for those central venous catheters within Department of Oncology. Therefore, two educational pamphlets (PICC/Port-A-Cath respectively) were designed by oncology nurses and the effectiveness of educational pamphlets has been evaluated. Patients who successfully inserted central venous catheter will be enrolled to our study using convenience sampling.

P450
KNOWLEDGE, UTILIZATION, AND SATISFACTION AMONG NURSES ABOUT AN IMMUNE CHECKPOINT INHIBITOR TOXICITY CLINIC
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Oncology Nursing Practice
Immune checkpoint inhibitor (ICI) therapies are a highly utilized therapy in the oncology/hematology population. Immune related adverse events are managed differently than traditional chemotherapy toxicities. Many registered nurses (RNs) have limited experience in recognizing, assessing, and managing patients that experience ICI toxicities. Our institution started an Advanced Practice Provider (APP) ICI clinic in 2020 to address these unique patient needs. RNs have been an integral part of this clinic since its inception. The
The purpose was to assess the level of knowledge, utilization, and satisfaction amongst RNs across our oncology practice in regards to the ICI clinic. Since the ICI clinic started in 2020, the clinic has had an RN who has worked alongside an APP to help evaluate and educate patients on ICI toxicity management. ICI RN assessments are also utilized in between in-person APP visits. ICI RNs provide continuity of patient education, arrange local labs, facilitate medication refills, assess medication compliance, and work collaboratively with the primary oncology team members. To evaluate the effectiveness, care team RNs completed a 14 question survey assessing the following: utilization, benefit, barriers, referral patterns, confidence in management, and educational needs. Of the 36 surveys distributed, there were 22 responses (60% response rate). Amongst those responding, 90% had referred at least 1 patient to the ICI clinic, with 100% finding benefit. Approximately 70% of RNs did not feel confident in addressing ICI toxicity. The RN’s role in the ICI clinic was found to be helpful by approximately 96% of respondents, and 95% said that they would refer patients to the ICI clinic again in the future. The ICI RN role within the ICI toxicity clinic has lead to consistent management of patients that have an ICI toxicity. While this was a small survey, there was a high rate of response. A majority of RN colleagues found it beneficial to have a team that is dedicated to addressing ICI toxicities with high rates of referral to the ICI clinic. This survey helped to confirm the value of the ICI toxicity clinic in the comprehensive management of patients. Our survey also uncovered the need for further education amongst RNs for both recognizing and addressing ICI toxicity.

**P451**  
**IMPROVING FLUID VOLUME MONITORING THROUGH TAILORED EDUCATION PROGRAMS IN THE INPATIENT ONCOLOGY SETTING**

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Oncology Nursing Practice

Fluid balance plays a crucial role in maintaining adequate hemodynamics and tissue perfusion. Volume monitoring to ensure net fluid balance is an important aspect of care for hospitalized patients as imbalance causing fluid volume overload may lead to poor patient outcomes (e.g., respiratory distress, heart failure, renal failure). Hospitalized patients with cancer are at especially high risk for fluid volume overload in the setting of large fluid inputs from chemotherapy regimens and blood products. Complications from fluid volume overload increase hospital costs, resource usage, length of stay, readmissions, and reduce long-term survival rates. The purpose of this quality improvement (QI) project was to evaluate if a discipline-specific education-based intervention for patient care technicians (PCTs) and nurses increases the completion of intake and output (I&O) and daily weight measurements on an inpatient leukemia unit. Education was given to PCTs on unit-specific volume monitoring indications, signs of fluid volume overload, and optimal measurement strategies. Nurses were given separate education focused on the significance of volume monitoring and key components of delegation and accountability. Fourteen PCTs and sixty-four nurses completed education. Post-intervention data was collected over four weeks. Post-intervention, I&O completion rates increased by 11% and daily weight completion rates increased by 23%. An education-based intervention tailored to the learning needs of PCTs and nurses improved I&O and weight completion rates. Engagement with PCTs, a group not typically involved in QI, was particularly essential to project success and represents an area of future focus.

Though time constraints limited data collection of sustainability, change efforts were supported by staff and leadership feedback, including a noticeable improvement in interdisciplinary communication and collaboration. Sustainability can be achieved by ongoing staff engagement, providing support to address perceived barriers, and through the development of standardized education for new staff members.

**P452**  
**PATHWAY TO EXCELLENCE: AMBULATORY ONCOLOGY NURSES IMPROVE THE QUALITY OF INTAKE DOCUMENTATION THROUGH EDUCATION AND AUDITS**

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The Patient Intake department for a large ambulatory oncology care center was launched to assist new patients to prepare for their first ambulatory visit with an oncologist. This pre-planning ‘intake’ process includes a comprehensive review of medical records and phone interview performed by a disease-site specialized oncology nurse. The nurse then synthesizes the patient’s
information into a rich narrative note describing the patient’s history of present illness, prior diagnostics and treatments, medical and social history, review of systems and other key clinical factors. Interdisciplinary team members across the oncology center use this assessment and summary to prepare for initial consultation. Effective oncology intake programs have the potential to increase provider efficiency and patient satisfaction, reduce administrative burden and symptoms of anxiety and distress in new patients and decrease clinical preparation time and time to first treatment. Intake Nurses identified an opportunity to improve the quality and consistency of our nursing narrative notes. This evidenced-based practice project aims to improve the quality of oncology Intake nursing narrative notes to better prepare patients and providers for the initial ambulatory oncology consultation and standardize nursing documentation across a large, remote nursing team. An expert group of Intake nurses reviewed the existing narrative template, baseline department audit data and clinic feedback. The narrative committee crafted a revised template, solicited peer feedback, provided education to all Intake nurses and implemented the use of dictation software. A review of initial audit data and peer recommendations was conducted. The committee revised the narrative template, provided additional education and implemented an ongoing monthly audit and review process to maintain quality. Our analysis showed an improvement between audit results and monthly focused re-education. Audited notes scored as fair/poor quality decreased from baseline 28.9% to 11.7% initially and further decreased to 2.1% after additional education. This project improved our team’s nursing engagement, professional autonomy and confidence while providing clear, standardized guidelines and reducing duplication of efforts. Our team encountered key challenges including the need to balance standardization versus customization, obtaining staff buy-in and nursing time needed to perform audits. Other cancer centers can improve the quality and consistency of nursing documentation by implementing nurse-led education and quality audits.

Oncology Nursing Practice

Ringing the bell after finishing chemotherapy has become something of a ritual for patients on their last day of cancer treatment. This signifies that active treatment is over and their cancer is under control. While most feel joy and hope, some onlookers are saddened by the knowledge that they will never ring the bell. We sought to determine patients’ and families’ responses to patients ringing the bell at the end of their treatment to help increase nurse sensitivity. The purpose was to increase nurse sensitivity to the bell-ringing ceremony by assessing patient and family responses. Using six survey questions based from literature review of prior studies, we surveyed 101 infusion patients and family members over a two month period using a 5-point Likert scale. We then compiled and compared the data from their responses. The results indicated that even though patients and families that were surveyed are not opposed to the bell-ringing ceremony, they recommended thru comments that having a dedicated room for this event will show more sensitivity. The bell-ringing ceremony is a tradition that has been practiced for around five years. On the last day of treatment, most patients bring their friends and families to celebrate their long and painful journey. Some patient comments were “I like the idea of the bell. It’s an indication of a positive community giving hope to all of us.”, ‘I don’t think it’s intimidating, but just not appropriate inside the chemo treatment room.” These findings are also similar to other studies conducted on bell-ringing ceremonies from the article. From this, we can attain a better insight into how to improve nurse sensitivity when infusion patients decide to ring the bell at the end of their active treatment. Based on the weighted mean from the data we gathered, the majority of the patients surveyed agree with the bell-ringing ceremony. However, majority also wrote in the comments that while the bell-ceremony is a significant milestone with their treatment journey, they prefer the bell placed in a private setting thus achieving uninhibited celebration of a treatment milestone.

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BELL RINGING CEREMONY - AGREE OR DISAGREE

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NUTRITIONAL SUPPORT IN BLOOD AND MARROW TRANSPLANT: UNDERSTANDING CHANGES TO STANDARDS OF PRACTICE

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Treatment Modalities

Blood and Marrow Transplantation (BMT) is a treatment that is reliant on supportive measures to impact prognostic complications of this life-saving interven-
tion. Nutritional support is a vital, malleable treatment area enhancing outcomes for BMT recovery. A project to evaluate evidence and current literature revealed standards of practice (STP) in nutritional support often differ from evidence supporting enteral nutrition as the preferred nutritional support method for this patient population. In a large NCCN designated Comprehensive Cancer Center, an inpatient BMT unit was the subject of an assessment comparing utilization of parenteral nutrition as the STP versus enteral nutritional support. Current literature suggests barriers to implementing a change in this STP include lack of education on enteral nutrition, staff attitude and perceptions, and staff confidence in implementing evidence-based practice (EBP). The purpose was to identify specific processes to improve enteral therapy initiation and utilization in BMT patients. A project was undertaken to deliver an accessible, interdisciplinary continuing education event to provide information on the benefits of enteral nutrition and identify resources to implement standardized enteral nutrition practices in BMT. The team included registered dietitians, nurses, and nursing leadership to inform curriculum development for enteral therapy in BMT. This curriculum was approved for CEUs and was delivered through webinar and live in-person presentations to staff across an inpatient and outpatient BMT system. Each presentation had process and content evaluation. In-person evaluations integrated the elements of the EBP Beliefs scale to evaluate confidence in incorporation of knowledge into practice. The curriculum was delivered three times, one webinar (n = 17) and two in-person classes at the hospital (n = 36). The evaluations received showed statistically significant results supporting personal engagement in an education modality was valuable for increasing ability to address barriers to implementing EBP, knowledge with EBP practices, and cultivating confidence in the processes of initiating enteral therapy. This work on implementing enteral therapy as a STP occurred as COVID restrictions were being lifted and the possibility of in-person teaching became possible mid-way through this quality initiative. The primary investigator found it was more meaningful to have in-person engagement during and after content delivery. Evaluations for personal achievement of confidence and acceptance of the changes in STP informed the conclusive utility of in-person education in addressing these barriers to implementing change.

ZATION OF SECURE CHAT TECHNOLOGY: AN INNOVATIVE APPROACH TRANSFORMING THE ONCOLOGY PATIENT JOURNEY
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Coordination of Care
The oncology patient journey is often blighted by prolonged wait times. Prolonged wait times negatively impacts treatment outcomes and patient satisfaction. Innovative solutions that streamline the admission process and enhance the overall patient experience are essential. Technological groundbreaking strategies within the electronic medical record (EMR) have revolutionized real-time communication between health care providers and the patient flow team regarding patient disposition. This approach leveraged secure chat as a mechanism to promote seamless communication of critical patient information between a health system’s emergency department (ED) in a community hospital and an oncology specialty hospital. This communication method affords expedited admissions process and elevates the care coordination for oncology patients, while incorporating the goal of decreasing the admission decision to accept time of 30 minutes or less. Clinical stakeholders, comprising of an ED clinician, inpatient medical hospitalist, and patient flow team, created a secure chat group. Once the decision to admit was made, a request is placed through the templated secure chat feature. The patient flow team member then acknowledges the request, while the accepting hospitalist reviews the request, and asks any pertinent questions to move forward with an acceptance or denial of admission. Next, patient flow asks any additional pertinent questions and after the patient is accepted for admission, the flow team follows through with appropriate bed assignment. Analysis of the admission wait times prior to implementation of the secure chat group and post-implementation demonstrate an increase in number of patients, from 64% to 70%, that have an accepted admission within the 30 minutes from initiating the request. Currently, the process is solely used with medical oncology admissions. Future expansion will include any admission across all emergency departments within the health system requiring oncology specialty care, regardless of service. Qualitative feedback can be collected via interviews with the clinicians and patient flow team, as well as patients assessing this vast positive impact in the oncology patient journey. Multiple phone calls and connecting physicians resulted in admission acceptance delays. Integrating secure chat has pioneered an expedited communication and
streamlined process for the unplanned, urgent oncology admission, coupled with a safer manner to do so. By leveraging technology, we have enhanced the patient experience, reduced wait times and facilitated clearer and more concise communication between health care teams.

**P456 RESEARCH ACROSS THE CARE CONTINUUM: BRIDGING THE GAP BETWEEN OUTPATIENT AND INPATIENT MANAGEMENT OF A RESEARCH PATIENT**

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**Coordination of Care**

As the number of oncology clinical trials grows, an increasing number of patients require inpatient care. This expansion has led to a greater involvement of healthcare providers, nurses, and specialists in the patients’ treatment and support. Novel therapies such as CAR-T cell therapy, Bispecific T cell Engagers and Phase 1 protocols are complex and it is imperative that compliance to the protocol is maintained. Education and awareness of clinical research protocols are critical components of inpatient management whether a patient is admitted for a research intervention or side effect of therapy. The purpose was to identify educational needs and identify barriers that inpatient team members have when caring for an admitted research patient. Surveys were distributed to inpatient oncology nursing staff to evaluate their experiences with research handoff, education, and continuity of care. A committee of research management, nurses, project managers and Advanced Practice Nurses was created to identify workflows to improve these areas and overcome barriers identified in the survey. Education sessions and workflows were rolled out through oncology research to improve inpatient nursing awareness of clinical trials being conducted, improve handoff and continuity of care across the continuum. Through staff interviews we have found improved knowledge of research protocol, study compliance, and continuity of care after implementing education sessions and handoff workflows. As research in oncology continues to grow patients will inevitably require a component of inpatient care. We have found through surveys and staff interviews that clear education, enhanced communication and handoff between these departments increases patient safety and research protocol compliance.

**P457 IMPROVING THE REACTION TO INFUSION RELATED REACTIONS**

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**Treatment Modalities**

The Infusion Center nurses administer highly reactive medications on a daily basis. On average nursing will encounter 2-3 reactions daily. The nursing team identified the need for improvement of the understanding, management and the response time of reactions. Developed a work group with nurses and pharmacy in order to address identified issues. Nursing identified areas of vulnerability in our practice of monitoring and managing hypersensitivity reactions. Through collaboration, education and advocacy we improved practice and confidence in our ability to safely manage these situations. As a result, we now have available hypersensitivity reaction kits as well as a standard protocol to manage reactions. As we continue to educate and evaluate reactions with debriefing sessions we will continue to learn and identify new obstacles.

**P458 CELLULAR THERAPY INFUSION REACTION GRADING – A QUALITY IMPROVEMENT INITIATIVE**

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**Oncology Nursing Practice**

Patients undergoing autologous stem cell transplant receive previously collected, cryopreserved hematopoietic progenitor cells. Patients may experience an adverse reaction during infusion, often related to the...
preservative used in the cryopreservation process. Adverse reactions should be systematically assessed and documented for regulatory adherence and identification of potential causal elements. Precise assessment of reactions has great significance in the treatment, documentation, and analysis of adverse infusion reactions. To achieve and maintain accreditation in cellular therapy, the quality program performs an annual audit on infusion reaction grading. With this audit, the Program Nursing Leadership sought to identify variations in adverse infusion reactions grading, develop a plan for improvement, and assess the success of the quality improvement initiative. The Quality Manager designed an audit tool to facilitate the review of documentation. The Program Manager performed a single-center, retrospective documentation review of 19 patients who underwent autologous stem cell infusion between February 2022 and July 2023. The review included flowsheet documentation, nurses’ notes, provider progress notes, and vital sign reports. Documentation was reviewed for accurate grading of symptoms, consistency in grading amongst providers, and subsequent reporting to the cell processing facility. The team used the Plan, Do, Study, Act (PDSA) method to guide the initiative. The audit identified the lack of a consistent reaction grading tool and incongruities in documentation amongst clinicians. The quality improvement plan addressed these findings and included: updating the current policy, case study-based education on the Common Terminology Criteria for Adverse Events (CTCAE) grading system, and subsequent audits to assess for improved compliance. The initiative examined 20 reinfusion days involving 124 bags for 19 patients. A total of 34 reinfusion reaction symptoms were observed. The assessment grading accuracy by providers increased from 0% to 100%. RN adverse reaction documentation improved from 80% to 100%. Alignment between nursing documentation and Infusion Flowsheet rose from a low of 33% to 100%. Alignment between Provider documentation and the Infusion Flowsheet increased from 71% to 86%. RN and Provider documentation alignment improved from a low of 33% to 71%. This initiative not only increased compliance to accreditation standards, but also anecdotally improved clinical confidence in grading infusion reactions. This quality improvement initiative can be applied to many areas of oncology nursing in which there are inconsistencies in provider assessment and documentation.

P459 MOVING THE NEEDLE TO CHANGE: OUR JOURNEY TO A NEW HUBER

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Oncology Nursing Practice

In a large academic health system, it can be challenging to get approval for, and buy in on new products. In 2019, we had an initiative to reduce CLABSIs with daily line rounds in oncology. This constant observation of ports provided heightened awareness of certain attributes of the current Huber needle that were not favorable. Historically, the needle we used was rigid and bulky. There was also consistently dried blood lodged in the cannula immediately attached to the Huber that could not be cleared with flushing. The implication of this issue is unknown, but it prompted us to do some research concerning different brands and styles of Huber needles. The purpose of this project was to choose a new port needle to be used across the health system with front line feedback and related to ergonomic and mechanical issues observed over time. We partnered with key stakeholders to find quality needles to trial at our sites. This included infection prevention, nursing education, and nursing leadership. We reviewed multiple different Huber needles. In February of 2020 we were ready to trial the new needle but were faced with a global pandemic. Fast forward to 2023 and we were finally ready for the needle trial. Subsequently, the health system had voted to move to a new CHG impregnated transparent dressing, so we included this dressing in the needle trial. The trial started in June 2023 across 2 inpatient and 4 outpatient sites across the health system. Educational material was provided to staff. The needle trial was evaluated with a QR code survey consisting of 8 questions pertaining to accessing the port with the new needle and dressing. The survey showed favorable results for the new needle and dressing from the front-line staff. We are currently rebuilding our central line pre-packaged kits with our vendor in preparation of a system go-live of the new Huber needle and CHG impregnated dressing. We plan to be live by November 2023 and will continue to evaluate to ensure that we are utilizing the best products to safety take care of patients.

P460 DOES THE TIMING OF PATIENT EDUCATION FOR RADIATION TREATMENTS MAKE A DIFFERENCE IN PATIENTS RETENTION OF INFORMATION

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Patient Education and Safety
A Radiation Oncology Department at a cancer center in the Northeastern US is comprised of five sites, including four satellite locations. The main facility has a higher acuity of inpatients, outpatients, and procedures. Due to the acuity and volume, the workflow requires nurses to meet the patient for the first time after their simulation to complete patient education. When patients return for their initial treatment, about two weeks after the simulation appointment, many report not remembering the information provided. This project will evaluate our current processes, identify gaps, and implement potential change. The purpose was to evaluate if the timing and delivery of patient education makes a difference in patient’s understanding and retention of information. A questionnaire will be presented to patients to assess the efficacy of our current process of educating patients in person on the day of the simulation. In addition, for one month, we will institute a practice change of educating patients by phone within seven days of starting treatment. The same questionnaire will be administered to these patients on their start date. For nurses to know who to call, a document will be provided that includes the patient, date of simulation, start date, and date call completed. The data collected from both groups will be reviewed and evaluated. Based on responses, practice change will either be implemented or stay the same. We hope to find that educating patients closer to their treatment start date, will help them to remember what side effects they might experience during their treatment. Research has shown some increase in patient satisfaction with telemedicine visits before simulation appointments. With the collection of the results, we will determine if the timing of patient education influences understanding of side effects and/or retention of information.

P461
RESEARCH CARE COORDINATION ACROSS INPATIENT AND OUTPATIENT SETTING FOR COMPLEX ONCOLOGY TRIALS
Julie McCluggage, RN, OCN, UCSF, San Francisco, CA

Communication between research and clinical teams is crucial for patients enrolled in complex oncology studies that require hospitalization. Poor handoff throughout patient’s care transitions can increase risk of research-related adverse events and prolong patient length of stay. Leveraging existing EHR notes may improve communication related to research-related care. A cancer Immunotherapy program at a large academic health care system on the West Coast specializes in Phase 1 research studies that often require hospitalizations for step dosing and transition to outpatient care. Clinical Research Nurses (CNRs) need to share research-related information with hospitalists, inpatient nurses, lab, pharmacy, bmtl and ambulatory nurses. A previously utilized Research Tab in the EHR was not viewable to all care team members which lead to issues with patient care and prompted this quality improvement (QI) project. Objectives were to develop a templated care coordination note in EHR that conveys critical research information for hospitalized study patients. The five “whys” QI method was used to first identify the needs for communication across inpatient and outpatient teams, including hospitalists, inpatient NPs, BMT lab managers, inpatient unit leaders, and outpatient infusion clinic managers. CNRs led a series of collaborative virtual workgroups to mockup a research care coordination template and iterated it based on feedback. The final Patient Care Coordinator Note included research treatment plan for CAR-T or immunotherapy including step-up dosing, admission and discharge criteria, link to clinical trial website, and study team contact. It is easily located in Summary table that can be viewed by inpatient and outpatient teams. The note was instituted in 2022 for all of our patients/studies. Qualitative feedback from 10 stakeholders revealed improved communication between the research team and care providers, especially for discharge planning. Ongoing training with inpatient nurses identified redundancy with paper research nursing orders, which will be addressed in the next iteration. Future work will focus on evaluating the effect of this communication tool on reducing research-related adverse events.

P462
STANDARDIZING APPROACHES FOR DISTRESS SCREENING IN NEWLY DIAGNOSED PANCREATIC MALIGNANCY
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Psychosocial Dimensions of Care
A new diagnosis of pancreatic adenocarcinoma (PDAC) not only produces significant physical symptomology, but can also cause particularly devastating psychoso-
cional distress, resulting in negative clinical outcomes. Assessing distress levels and specific emotional problems at initial consultations is not only mandated by the American College of Surgeons’ Commission on Cancer, but also critical for providers to expeditiously address and treat. The project’s purpose was to utilize the National Comprehensive Cancer Network (NCCN) Distress Thermometer (DT) and Problem List (PL) on patients with newly diagnosed PDAC before and after an initial pancreatic tumor multidisciplinary clinic (PMDC) visit. Objectives were to characterize the source of distress at initial visit, determine the degree of continued severe distress post PMDC evaluation, and analyze the difference in distress scores (DS) based on NCCN DT/PL facilitation methods. This single-center, quality improvement project electronically delivered the NCCN DT and PL to all new PDAC patients before and after initial PMDC evaluation after detailed discussion with a surgical oncology nurse practitioner. DS were analyzed using a paired t-test and emotional problems were categorized by prevalence. These clinician-led scores were compared to scores taken at the time of PMDC check-in by the front-desk staff, per Beth Israel Deaconess Medical Center Cancer Center institution policy. Mean initial DS (N=29) was 5.29 (SD 2.67). Mean post-clinic DS (n=24) was 4.67 (SD 2.81). A documented within-person mean change (-.625) of clinical significance was noted while these results were not statistically significant (p=.1262). Only a slight change in severe distress pre (34.5%) and post (33%) was noted, with small attrition seen. Emotional problems (Table 1) were most prevalent with eight referrals to social work. A majority (72.4%) of patients had documented distress at their first screening (4+), while 34.5% of patients had severe distress (7+) at their initial PMDC visit. Although there was no significant difference in DS following initial visit, this project still supports the need to proactively screen patients after PMDC evaluation, especially for those with sustained high DS. The predominance of emotional problems additionally highlights the need for standardization of psychological referral mechanisms after comprehensive treatment planning session. Discordant DS between pre-clinic and day-of visit evaluations, taken by ancillary staff, were inadvertently exposed. Implications of this discovery prompt the need to review distress screening facilitation methods (clinician-led) and delivery modalities (electronic).

**P463**
**ENHANCING PATIENT EDUCATION FOR AMBULATORY INFUSION**

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**Patient Education and Safety**

Objectives were to improve the patient education process and Press Ganey survey scores in the area by focusing on medication education reviewed with patients by their nurses and the discharge instructions provided within a hospital outpatient ambulatory infusion center. Patient education within hematology and oncology is essential for optimal patient outcomes. Providing adequate medication education has been proven to have positive patient outcomes. Nurses are essential in providing beneficial medication education to patients within the discharge process. Being conscious of a patient’s perspective of medication education has been associated with decreased patient anxiety, improved results for patients, and improved patient satisfaction scores. The purpose was to standardize the process of patient education to enhance patient experience and medication safety. The goal is to enhance the workflow of our discharge teaching to improve Press Ganey Scores. Interventions: to provide an enhanced standardized patient education process upon discharge for hematology/oncology patients in our outpatient community hospital infusion center. Medication information from Meditech/Lexicomp will be provided upon discharge, as well as medication cards when applicable. We will be reconstituting patient discharge workflow and measuring our success outcomes based upon our Press Ganey scores. Interventions will include what to expect during treatment/therapy, instructions on how the patient should care for self at home, and potential side effects that could result. We will be reconstituting patient discharge workflow, and measuring success based upon our Press Ganey scores. We will be measuring our results within a three-month period, including November, December, and January. We are collaborating with our data analyst within our hospital who will provide our Press Ganey scores and clinical nurses along with nurse leaders will review the results amongst the team.

**P464**
**ONCOLOGY NURSE NAVIGATOR: PRELIMINARY EXPERIENCE OF A NOVEL PATIENT-CENTERED PROJECT IN A GENERAL SURGERY UNIT IN CENTRAL ITALY**

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The role of oncology nurse navigator (ONN) is a specialized nurse offering personalized care to oncologic patients to help them throughout the healthcare system. In our general surgery unit in Italy, we have started such project since January 2023, aiming to enhance the diagnostic-therapeutic and assistance pathway of each oncologic patients. Primary outcomes are reduction of time interval between the first contact with patient and each phase of diagnostic and therapeutic pathway. Secondary outcomes assessment of the number and frequency of contacts between the patient and his ONN, as well as of the quantity and type of procedures organized and patient satisfaction assessment.

Prospective cohort study has been conducted with a control group represented by the parameters measured in 2022 for the oncologic patients treated in our same surgical unit not followed by ONN. Both groups consisted of 30 patients. Contacts have been recorded with a dedicated cell phone number. Patient-Satisfaction-With-Cancer-Care (PSCC) questionnaire has been given to the patients in a blind way by third party to avoid biases. The study group included 30 cancer patients, out of them 18 had colorectal cancer, 6 liver mets and 6 pancreatic cancer. Average time from first contact to the primary diagnostic test was 8 days vs 20 days in 2022 (control group, p<0.001). All patients underwent MDT discussion and time to Multidisciplinary Team meeting (MDT) was not different between the two groups. All patients were considered not fit for surgery and average age of referral to medical oncologist was 5 days in the study vs 10 days in the control group (p<0.001). 25 patients were fit for upfront surgery and average time from first contact to surgery was 23 days after ONN establishment vs 45 days in the control group (p<0.001). Each patient had on average 10 phone calls with ONN. For patients led to first cancer diagnosis, ONN organized an average of 4 test. Questionnaire about patients’ satisfaction reached a response rate of 100% with a mean score of 85.2/90. These results showed that ONN proved to be effective and to enhance quality and outcomes of the management pathway of surgical oncology patients. Further studies are required to identify possible improvements within oncologic pathways and have the ONN professional role recognized also from Italian health system.
results in higher accruals to oncology clinical trials. Institutions utilizing more interventions reached accrual goals quicker with those utilizing 7 or more interventions having the most significant increase in clinical trial accruals. Future research is required to determine the most effective intervention bundle to implement in order to increase accruals. Multi-disciplinary teams should be formed within each institution including clinicians, research staff, marketing, and patient and family groups in order to select and implement interventions. Applicable metrics such as referral and accrual rates should be tracked to evaluate efficacy of implementation.

P466
OUTPATIENT ACUITY BASED STAFFING MODEL
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Oncology Nursing Practice

Outpatient oncology infusion centers are faced with scheduling large volumes of patients with often-limited clinic resources and unpredictable patient status or level of need due to side effects from treatments. Currently, staffing in the Outpatient Oncology Infusion Center is based on the number of patients scheduled based on treatment time. This has proven to be an ineffective and inefficient method. Not accounting for needed care, education, assessment (physical, emotional, and social) and the unpredictable side effects associated with these treatment regimens has led to longer chair waits and decrease nursing and patient satisfaction. Due to the recent increased shift of oncology treatments from inpatient to outpatient, ambulatory infusion settings are burdened with potentially compromised patient safety, inferior quality of patient care due to over-scheduling of unexpected complex patients, limited resources related to nurses and infusion chairs, the dissatisfaction of patients and family members, and infusion nurses' burnout. The acuity-based staffing model seeks to determine if staffing based on patient acuity would lead to increased nursing satisfaction, and in turn decrease nursing burnout in the outpatient oncology infusion center setting. The project was conducted over a 5-months. A treatment-based acuity scale was developed and built into EPIC for documentation and report purposes. Nursing was educated. Based on literature and a two-week evaluation of an acuity per nurse was established as 18-21. When possible, staffing numbers considered the daily acuity level and an average acuity per nurse. Based on the suggested 18-21 acuity per nurse, the charge nurses were responsible for adjusting staff accordingly. During this time staff numbers were adjusted as needed, staffing up when acuity was high and reducing staff when numbers were low. To assess the impact of the acuity-based staffing model, the pre- and post-intervention survey completed by all nursing staff was analyzed and compared. Results showed that when considering acuity in staffing, shifts were more manageable. Additionally seen was an increase in patient satisfaction scores and no financial impact when staffing for higher acuity. We found that implementation of an acuity-based staffing model was able to provide optimization of staffing, improve safety and quality care, and results in increased patient and nurse satisfaction. Much work is required and buy-in from all stakeholders involved is needed to sustain this model.

P467
PUSH/PULL ASSIGNMENT METHODOLOGY
Danielle Miller, MBA, BSN, RN, Miami Cancer Institute, Miami, FL
Oncology Nursing Practice

On July 12th, 2023, the Infusion Department at the Miami Cancer Institute went live with a new nurse assignment methodology known as the push/pull assignments. The department changed the nursing assignment from a fixed, pre-assigned format to day-of self-assigning completed by the nurses as the patient’s check in for their chemotherapy appointment. This methodology can:

- Significantly improve patient flow, workflow efficiency, and chair utilization
- Eliminate last minute changes in nursing assignments due to patient requests, appointment cancellations, no-shows, or late arrivals
- Empower nurses to make decisions about their assignments and improve RN satisfaction
- Decrease lobby wait times and medication start wait times
- Improve patient satisfaction

“Real-time assigning” overseen by triage nurse leaders that can delegate, solve systemic therapy readiness deficiencies, and escalate to the according provider if needed. The triage leader can also “push” or assign patients to a nurse with an open chair if the queue or lobby starts to get backed up. Evaluation (from go-live 7/12/23 to 8/12/23 the data is as follows). Infusion wait times projected to decrease over several months post implementation. Drug wait times have decreased from 43 minutes to 38 minutes. Number of chair turns...
(average number of completed appointments per day) has increased from 2.1 to 2.2 turns. Average appointments/patients per nurse have increased from 7.5 to 8.2 per 12-hour shift. Infusion time in chair (total time patient is in claimed infusion chair) has decreased from 152 to 146 minutes on average. The process is still new and has opportunities for improvement, but the immediate findings have concluded: Increased satisfaction from the nursing staff, “more control over their day,” “I don’t feel rushed to take a patient when I’m not ready,” “It’s a fun competition with our colleagues and comparing assignments.” Lobby has decreased the amount of extensive patient wait-times requiring leadership notification and intervention. Decreased drug wait times. Increased patient satisfaction.

P468
ASSURING CONSISTENT ONCOFERTILITY CARE IN THE COMMUNITY ONCOLOGY SETTING
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Patient Education and Safety
Oncofertility preservation discussions with patients are crucial to facilitate early in the treatment process. Without early awareness and intervention, fertility preservation treatments can be missed or have decreased efficacy if pursued after patients have begun chemotherapy. Providers and nurses must be prepared to discuss the patient’s individualized plan and have awareness of the urgency in timing of fertility services. At an NCI-designated comprehensive cancer community cancer center, a young patient diagnosed with recurrent breast cancer asked for assistance with issues of her own fertility before starting treatment. The nurse recognized the immediate call to address this patient’s fertility concerns, but also identified a need for clinic-wide standardization of oncofertility dialogue with patients. The purpose was to describe current provider and nursing practice for oncofertility care at a community clinic and outline recommendations to implement standardized workflow and education. Frontline nurses partnered with the Community Sites Advanced Practice Nurse (APN) and the Nurse Manager and a committee was convened. Nurses reviewed care team documentation to evaluate current practices. A review of the literature for oncofertility best practices was completed and a plan to implement a clinic-wide oncofertility awareness and education program was initiated. Key stakeholder engagement consisting of patients, nurses, pharmacists, and providers was established for survey development to assess knowledge, comfort level, and preferred approach for oncofertility dialogue. Program development commenced for an educational program to prepare the care teams to facilitate oncofertility discussions and advocate knowledgeably and compassionately for patients’ timely provision of services. Post-surveys are administered to key stakeholders after intervention to measure effectiveness and analyze for potential needed changes in processes. Oncofertility best outcomes can be achieved with utilizing the model of continuous quality improvement (CQI) promoting best outcomes for each unique oncology patient. Oncofertility is a personal and integral part of cancer care management. As the effective interventions are identified, findings and processes will be disseminated to the rest of the organization for standard implementation.

P469
IT’S TIME TO GO: IMPACT OF AN ONCOLOGY DISCHARGE LOUNGE
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Coordination of Care
Throughput delays have a negative impact on patient care and satisfaction. Decreasing wait times for admission to the inpatient unit requires a process that identifies and removes discharge barriers. On average, discharge ready patients on acute care oncology units, were waiting approximately 45 minutes for transport to arrive. In addition to hospital transport delays, approximately 20% of oncology patients were waiting up to 3 hours for their family to arrive before they could be discharged from the room. The project’s purpose was to reduce the time from discharge ready to complete discharge from room by implementing an oncology-specific discharge lounge waiting area and
discharge transportation service. Through the utilization of Lean principles, oncology nursing leaders identified the necessary people, processes, documentation, equipment, and space that would reduce waste and improve workflow efficiencies. Peak periods of discharge activity helped define the hours of operation (M-F, 10am-6pm). A Plan, Do, Study, Act methodology was implemented over a twelve-week period. The concept of an oncology specific discharge lounge was developed. Over the course of 100 days of operations, 620 patients passed through the oncology discharge lounge. Approximately 80% of those patients had less than a 15-minute stay in the lounge prior to departing, improving patient satisfaction. An average of 4.65 bed hours were gained each day, improving the throughput of patients being admitted from the emergency department, PACU, clinics and outside hospitals. An oncology specific discharge lounge with a dedicated transporter facilitated improved wait times for discharge transport and room turnover. Early in the development it was determined that the term discharge lounge was perceived by patients that they would have to wait for discharge, so it was renamed the transportation station which improved patients’ willingness to utilize. Concerns from patients related to prolonged discharge times were notably decreased on patient satisfaction surveys. Additionally, we improved PACU and ED wait times for inpatient admission. Strategies aimed at improving efficiencies and decreasing waste, such as the implementation of a discharge lounge, have implications for improving the throughput of cancer patients.

P470
“NAVIGATING OBSTACLES: ACUTE DISABILITY IN THE OUTPATIENT SETTING”
Emily Minoff, RN, University of Texas Southwestern Medical Center, Dallas, TX
Co ordination of Care

Many patients experience acute changes in their mobility throughout their cancer journey as a result of their disease and/or side effect of their treatment. Upon meeting patients, they are generally in a seated position in the exam room. Currently our rooming practice does not include an in-depth assessment on mobility or how a physical disability may impact their care. For example, our PET imaging department cannot accommodate a patient that cannot transfer from a wheelchair to the exam table. This includes patients that may need to come in on a stretcher due to paraplegia caused by a rapidly growing tumor or a patient that cannot stand due to peripheral neuropathy. An ongoing assessment of physical mobility that may leave a patient disabled is pertinent in provided inclusive care. If assessed early arrangements of accommodation can be made thereby decreasing delays in care and increasing patient satisfaction. Equipping nurses with tools needed to facilitate an accessible and inclusive healthcare experience. Assessment tool development ongoing. Recommendations for the PET department to obtain lift equipment have been made to leadership. Creating an assessment tool that not only identifies physical mobility concerns, but also considers the psychosocial, emotional, and cultural aspects that may impact patients with disabilities, ultimately contributing to improved outcomes and quality of life. Nurses have a pivotal role in championing inclusive healthcare for patients with disabilities. Recognizing the unique needs of this population with the use of a targeted assessment is crucial in breaking down the barriers to healthcare access. This paper encourages further research and education in creating policy initiatives aimed at advancing inclusive nursing practices.

P471
MAKING THE PATIENT THE CENTER OF PATIENT ADVOCACY
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Psychosocial Dimensions of Care

To develop targeted advocacy efforts, a well-known global non-profit advocacy organization conducted an extensive patient and caregiver survey; this brought to light that a shift in resource allocation was needed. The purpose was to develop a strategic action plan for the foundation and its stakeholders based on the needs of the patient and caregiver population served. Interventions were as follows:

- Conduct an online survey for patients and caregivers impacted by the specific field of oncology to which the foundation is devoted.
- Analyze data and determine the top three areas of need identified by respondents.
- Present results of the survey to major stakeholders including foundation staff, healthcare providers at Centers of Excellence, and the Nurse Leadership Board at the foundation.
- Carry out action items with plans to evaluate success via a repeat survey.

Evaluation was as follows:
- The Patient & Caregiver Survey was conducted from 2015-2023. A total of 602 responses were received.
- The top three areas of need were determined to be the following: emotional support (23.2%),

WWWN.ONS.ORG/ONF

WWW.ONS.ORG/ONF
improved delivery of information (21.8%), and a focus on advances in the field (16.7%).

- On August 23, 2023, the results were disseminated to foundation staff.
- On September 20, 2023, contacts from the Centers of Excellence were invited to a meeting for result review. Meeting is pending scheduling.
- Plan for a meeting with the Nurse Leadership Board is underway.

The following interventions, which target the areas of need, have been implemented:

- Patient Forum presentation now includes information on support groups.
- The foundation partnered with another organization to develop a new clinical trial portal.
- The foundation website is undergoing updates.
- A Center of Excellence community is being formed which includes development of a distribution list, monthly foundation highlights, and tracking volume of patient referrals.
- Quarterly patient interaction metrics will be collected and distributed.
- An updated survey will be used to evaluate effectiveness.

Eight years’ worth of data from patients and caregivers has been analyzed, organized, and distributed to key stakeholders including patients. A focused action plan has been developed; effectiveness will be determined via future surveys. All patient advocacy groups are dedicated to meeting the needs of the patients; however, those needs change with time. By surveying patients and using those results to allocate resources, this foundation is keeping the patient at the center of patient advocacy.

P472
A SHARED GOVERNANCE APPROACH TO STANDARDIZATION ACROSS MULTIPLE INFUSION SITES

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P473
BRIDGING THE COMMUNICATION GAP IN FALLS PREVENTION: REPHRASING HOW WE SPEAK WITH PATIENTS

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Patient Education and Safety
A cancer diagnosis increases risk of falls by 33-50%. Conditions during a perioperative encounter can compound risk. Perioperative leadership formed a staff driven task force aiming to reduce falls. The purpose was to reduce falls across the main perioperative campus by 10%. Six-year retrospective review of data showed compliance with high-risk interventions, especially assistance with activities of daily living (ADLs), as an area of needed improvement. Of note, patient refusal of assistance was commonly reported in falls debriefs. Literature confirmed high-risk activities, patient knowledge deficit regarding fall risk, and patient reluctance to burden staff with additional tasks when busy, as contributing factors. Assistance with ADLs and increasing staff/patient engagement were recommended. Falls debriefs were conducted following each event. The root cause was ineffective communication surrounding interventions. Staff reported discomfort responding to patients’ refusals of assistance, citing the patient’s right to refuse. In addition, auditors observed a breakdown in communication of purpose. Thus, staff were re-educated to present interventions as an explanation of what you will do to help keep the patient safe, not as an offer of assistance. Scripting was created to support staff confidence and consistent messaging. Simulation scenarios were used to reinforce education. The task force created an educational video to debunk patients’ misconceptions about requesting and accepting staff assistance, increase understanding of risk, and improve cooperation. It details interventions used during the perioperative encounter and how different factors impact risk. Monthly audits completed in third quarter of 2023 for a total of 218. Improvement from 80% to 100% sustained over last two months for Post Anesthesia Care Unit (PACU). Three patients initially refused assistance, then accepted after re-education. 50% reduction in falls realized across the perioperative department year to date. Scripting empowered staff to implement interventions, especially our support staff. Our organization endorsed the video adding it to the Patient and Community Education library. It is now displayed in patient waiting rooms, patient portals, and bedside monitors. Organizational acceptance of our scripting includes plans to incorporate into Nursing Orientation Patient Safety Day. The patient education video increased patients’ understanding of risk and acceptance of interventions. Ongoing audits will monitor compliance, engagement, and impact on falls.

P474
ROLE CLARITY AND CLINICAL EXCELLENCE COMBINED FOR ONCOLOGY CARE DELIVERY

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Coordination of Care

Clinical research is a pivotal component of care for oncology patients and the complexity of implementation of clinical trials mandates organizational commitment to clarity in expectations. The interface between clinical care, protocol management, clinical trial monitoring, adverse event tracking and interventions to best support patients requires collaborative teamwork across disciplines. In a large National Cancer Institute (NCI) designated comprehensive cancer patients in the Genitourinary department analysis of clinical care and research study coordination was examined for opportunities for improving the combined care provide by various team members including research coordinators, clinical nurse coordinators, and a newly introduced role of research nurse. A significant degree of confusion surrounding purpose, scope, and role of research nurses was involvement in patient’s care was identified as a workflow gap in need of addressing to improve patient clinical and research care. The purpose was to outline the development of standard workflow that clarified roles and responsibilities of support staff in clinical trials to facilitate a collaborative care team ensuring comprehensive clinical care, patient safety, and optimizing state of the science study implementation. A work group was established, consisting of clinical nursing leadership, research nursing leadership, clinical nurse coordinator, and the research nurse to delineate roles and responsibilities between the various research support teams. A full review of the needs of research implementation, monitoring and decision making relative to study progression as well as the intersections of clinical team care of the GU patient was examined. A model for engagement was designed, vetted with all collaborative team members to initiate the new work. For ongoing quality improvement a survey was completed with research nurses and clinical nurse coordinators to evaluate understanding and satisfaction. This collaborative project successfully resulted in guidelines clearly delineating the expectations and responsibilities of all roles and has established better communication in the process of caring for patients on clinical trials. As research is an ever-changing practice clinical care and state of the science new modalities of care must strive to ongoing dialogue and integration of new roles and expectations in shared care to promote best outcomes for oncology patients.
SPARKING EXCELLENCE BY DEVELOPING A STANDARDIZED PRE-VISIT PLANNING PROCESS

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Oncology Nursing Practice

Expediting high quality interdisciplinary clinic visits within a short appointment time is challenging with complex oncology patients. Pre-visit preparation varies by Provider and Nurse and does not always get completed. Implementing a standardized pre-visit planning process improves clinic efficiency, reduces unnecessary delays in care at the time of service, improves satisfaction and experience for both patients and staff. Prior to implementation, preventable delays in care experienced were inaccurate treatment plan dates, missing or unsigned orders, and missing results needed for the visit. Providers were challenged navigating the electronic health record in a timely manner, to find the right information, to ensure the most productive appointment. The purpose of this project was to implement a standardized process for pre-visit planning for patients seen in the oncology clinic to allow for more timely, productive, and meaningful visits. Feedback was obtained from the interdisciplinary care team on pre-visit planning practices. Presented were issues that created interruptions during clinic, inability to provide timely meaningful care, or last-minute appointment cancellations. Patient Satisfaction data, balanced score cards, and event reports were reviewed. A task force was created to innovate a documentation tool and to develop a standardized, streamlined process for completing and documenting pre-visit planning. Provider specific customizations to relevance of the disease-oriented team exist. Hyperlinks to results are available for many tests allowing staff to quickly find the results relevant to the visit. Our clinic team reports increased satisfaction from being better prepared for the visit. The team now has the ability to find relevant results and reports more easily, minimizing delays in care from time spent looking for needed information. Clinic wait times for in person visits have improved. Press Ganey scores for “Recommended Provider” has averaged a seven-point improvement from fiscal year 22 to fiscal year 23. There is a true complexity to oncology patients. The tasks of the registered nurse are increasing, as expectations of our patients are increasing, and as our workforce struggles with staffing challenges. Thinking outside the box and developing innovative ideas to ensure we are having productive, value-added and meaningful visits was critical to work towards continuous improvement. This ensures that oncology patients are receiving timely care at the right time while reducing delays in oncology care.

IMPROVING PATIENT SAFETY BY IMPLEMENTING FORMAL HANDOFF BETWEEN APERHESIS AND INTERVENTIONAL RADIOLOGY

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Patient Education and Safety

Our BMT Apheresis department is frequently sending patients to Interventional Radiology (IR) for temporary line placement on patients that are undergoing collections for CAR-T or Hematopoietic Stem Cell Transplant (HSCT). Since the BMT Apheresis department is considered an outpatient department, we did not have a formal nurse handoff process set up like we do in the inpatient setting. We experienced a few safety events and quickly recognized the importance of creating a new tool and workflow that enhances the communication between the two departments. The purpose was to improve communication and patient safety amongst the two departments that frequently share patients; BMT Apheresis and IR. We created a communication tool that is used when the two departments call each other when transferring a patient. This serves as a prompt for the questions that should be asked. We also have a Smartphrase that the nurses use to document that handoff was completed. Nursing staff have expressed positive feedback on getting a more complete report when transferring patients. Since, implementing the handoff, we have not experienced any further safety events related to communication between the two departments. More work is needed in the evaluation process of ensuring that a handoff is complete every time. Discussion: Both IR and our BMT Apheresis departments are outpatient departments. Because of this, there was never a formal handoff report between the two departments. However, with the high volume of patients transferring back and forth between the two departments, we felt that developing a formal handoff process was necessary. The goal of this process is to improve patient safety and eliminate communication errors. We are still developing a way to audit this process,
However, we feel confident that this has already made a difference in the care we provide.

**P477**

INTEGRATION OF CLIMATE CHANGE EDUCATION INTO NURSING CURRICULUM, PATIENT EDUCATION, AND BEYOND

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Patient Education and Safety

Climate change in the past decade has become a topic of focus to integrate into nursing education as health impacts are consistently being linked to different climate factors. Although encouraged to be integrated into nursing curriculum, it has been challenging and been met with some resistance due to restraints in current curriculum structures in nursing schools. Recent publications and studies have linked certain cancers to climate events, such as wildfires. Additionally, the healthcare system itself has a tremendous impact on climate due to the large amounts of carbon emissions produced by medical care each year globally. This highlights the significance and importance of not only educating nursing students, but to continue providing resources to clinical nurses already working in the profession. The purpose of this presentation would be to educate nurses on the impact climate has on health and ways to integrate climate education into different nursing courses. This presentation would strive to provide nurses with different ways to integrate climate education into their nursing curriculum or in hospital education for practicing nurses. The Center for Climate Change, Climate Justice, and Health has a mission to integrate concepts of climate change into education, clinical practice, scholarship, and policy. Working with the center, education was provided to nurses through the development of an eLearning module and education for the greater community is provided through free webinars. Using different platforms and methodology of communication has been helpful in capturing different audiences about important and relative climate topics. These topics covered have included heat, wildfires, vector-borne illnesses, mental health impacts, and climate impact on food supply. Online learning used in hybrid learning has been shown to be effective in educating nurses on oncologic care and should be explored further to incorporate climate education. The information of the eLearning has been presented to the public and healthcare community locally. The information was received well and we received positive feedback. Nurses are eager to learn more about climate change as not only does it impact the health of their patients, but also personally impacts them. Everyone should be involved in emergency preparedness through education and advocating for better practices to reduce the carbon emissions from the healthcare field. Utilization of interactive, online, and free sessions must be explored further by more institutions.

**P478**

DESIGN AND IMPLEMENTATION OF A COMPREHENSIVE ONCOLOGY CLINICAL RESEARCH NURSE ORIENTATION PROGRAM

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Professional Development

Oncology nurses report the transition to the role of research nurse remains a challenge as it requires a combination of clinical and research skills. An effective orientation program is paramount to ensure the success of this transition. The purpose was to develop an orientation program that would standardize onboarding and ongoing research nurse education, provide a clear orientation map for preceptor, preceptee, and manager, and familiarize the research nurse with the tools, software, and technologies used in managing clinical research studies. A needs assessment pre-survey was used to identify gaps in our current program. Based on the responses the following were implemented: 1) comprehensive training program inclusive of clinic exposure, 2) clear orientee objectives with weekly milestones, 3) scheduled meetings with preceptors and leaders, 4) mentorship and peer support program, 5) orientation checklist, 6) employee handbook for reference 7) group chat for real-time communication 8) quick access toolkit with links to institutional resources and contacts. A total of 9 new research nurses have completed the program and a post orientation survey. The results showed significant improvements, with 83% staff satisfaction and 100% feeling prepared to complete orientation (compared to pre-survey 37.5% staff satisfaction, and 90% feeling adequately prepared). Only 22% reported having to ask a lot of questions post-orientation (compared to 70% prior to new program) noting that orientation doesn’t cover all possible clinical scenarios. Ultimately, the training and orientation program had a high positive impact, enhancing staff readiness and job satisfaction. The post orientation survey feedback shows that the Oncology Clinical Research Nurse Orientation program objectives were met. Execution of the program was a concern due to some nurses working from home as a result of the COVID-19 pandemic. However, virtual training proved effective when added to the comprehensive training program. The Oncology
Clinical Research Nurse Orientation program bridged the gap from novice to advanced clinician and effectively prepared the oncology nurse with the tools needed for clinical trial management and patient care.

**P479**

**HEPARIN VERSUS NORMAL SALINE (NS) FOR PATENCY OF CENTRAL VENOUS CATHETERS IN ADULT PATIENTS**

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**Oncology Nursing Practice**

Complications related to Central Venous Catheters (CVCs) can be mechanical, such as obstruction (5-29%), infections (5-26%), and thrombosis (2-26%). These are the major causes of dysfunctions. To prevent them, proper flushing protocol is necessary and considered a primary intervention. A database search in Cochrane Library and Pubmed, using free-texts and MeSH-terms Heparin, NS, CVC, flushing (years 2013-2023) revealed 23 articles, 7 providing evidence. Heparin flushing has been employed, but its use is controversial. The effectiveness is unproven, complications may appear, and the potential for nursing errors are higher. EBP guidelines identify best practices for CVCs maintenance and prevention of CLABSIs, confirming that adverse events are reduced using NS-alone, and NS-alone is as effective as heparin. The use of positive-pressure lock and push-pause techniques are essential in maintaining patency. The protocol update has been approved by the Institution. This update and education regarding the new protocol and practice will be implemented at end-of-2023. At Oncology Infusion Unit (Parkland Health), 23,197 heparin-porcine-100 Unit/mL/5 mL-syringes were used in a 12-month period (March 2022-February 2023, US$10,776). The benefits of NS-only include decreased costs for patients and institutions, as heparin is more expensive and frequently not covered by insurance. There is no evidence of decreased rate of occlusion, nor differences in catheter duration, thrombosis, infection, mortality, bleeding rates, or HIT using heparin. NS can prevent fibrin buildup and does not lead to side effects caused by heparin. Tissue plasminogen activator usage was not statistically significant. Administration of anticoagulants for prophylaxis is not recommended.

**P480**

**REMOTE ONCOLOGY NURSE TRIAGE TEAM AS A SHARED RESOURCE ACROSS AN ORGANIZATION**

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**Symptom Management and Palliative Care**

Remote oncology triage nursing teams can have tremendous benefits and utility for patient care and staff satisfaction when used as a shared resource among many providers across multiple sites of service. As oncology professionals, we have a duty to address patients’ symptoms in an effective, safe, and timely manner. However, a lack of staffing added to an increasing lack of experienced oncology nurse candidate pool makes this task challenging. Over a year ago, we piloted a concept of pooling current triage nurses into a centralized team to cross cover and manage patients’ symptom management calls to ensure timely access to care, quicker resolutions, and improve the patients’ experience. By doing this project, we not only improved our customer service and patient satisfaction, but we also directly contributed to a reduction in ED utilization and helped prevent avoidable admissions. Triage nurses were relocated from physical sites of service and allowed to work from home to now cover multiple sites and more providers. Guidelines were created and revised throughout the initial pilot period to set clear expectations and scope of work parameters. Each triage nurse was expected to field 25-40 calls per day with a call creation to resolution goal of 80 minutes or less. We employed a care management platform, called Navigating Cancer, to log patient phones calls, document assessment, record interventions, and capture call resolution times by the remote triage nursing teams. This platform also gave us the ability to monitor, track, and report out on number of calls, types of calls/issues being addressed, individual nurse call volumes, and what the resolution times were for those triage nurses. An additional benefit of this concept was the creation of a WFH position, which is a rare and highly sought after commodity for an oncology nurse. This role has allowed us to recruit and retain oncology nurses all around the country. Our pilot was so successful that we implemented remote nurse triage across the entire organization less than a year later. This team has grown into approximately 75 nurses who cover calls for over 600 providers from roughly 200 sites of service daily. In July 2023, the remote triage nurses resolved over 24,000 symptom management calls with an average resolution time of 61 minutes.
P481
COLLABORATIVE DEVELOPMENT OF AN ONCOLOGY PATIENT EDUCATION BUNDLE
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Patient Education and Safety

Health literacy is the degree to which individuals can obtain, process, and understand basic health information and services they need to make appropriate health decisions. Components of adult learning theory include self-direction, orientation to learning, and motivation. Many factors must be considered when educating a patient about their disease and treatment. Medications given to treat cancer are complex with significant toxicities. Educating a patient on the risks and benefits of these medications supports the ethics of consent. Empowering the patient to manage potential side effects will palliate their symptoms and lead to better outcomes. The purpose was to collaborate on a comprehensive approach to educating adult oncology patients and engaging them in their treatment. Nurses at a cancer center took a class on adult learning theory and oncology patient education. A team developed a comprehensive educational booklet given to patients at their consultation, at a class, and on day one of treatment. A treatment class was developed with a slideshow presentation for patients to attend before starting treatment. The class was highly interactive and encouraged questions from attendees. Patients were asked to bring at least one person with them. A tour of the infusion center was included. The class lasted approximately 1-hour. Documentation was standardized with use of a template in the electronic medical record. Further, a pamphlet on implanted chest ports was created to go along with the other handout. The content was strongly influenced by common questions patients have had prior to and after having a port implanted. Attendees completed a five-question Likert scale evaluation with space for comments. Scores averaged 4.8 out of 5 for positive outcomes. Comments were all positive and appreciative of the cancer center for offering the class. Anecdotally, nurses in the infusion center commented on their patients being knowledgeable about their treatments and had little to no questions. Adult learners need to be motivated and engaged in their learning. Information should be presented multiple times in different ways such as in writing, verbally, and in a class format. Creating a comprehensive and standardized bundle for patient education will lead to the best outcomes for a patient. By standardizing this process quality is ensured.

P482
INCREASE LAB DECOUPLING APPOINTMENTS AT UCSD KOP BREAST HEALTH CENTER
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Coordination of Care

At UCSD KOP breast health center, patients prefer to schedule the lab, the doctor visit and infusion appointments on the same day. If one appointment is delayed, another two appointments are also delayed. One infusion patient is delayed, and multiple patients’ appointment are affected. The breast health center has 10 infusion chairs and 2 Fast track chairs. Due to the small size of capacity and unpredictable lab process time, the decoupling lab appointment is proposed to implement. However the decoupling lab appointment is still only 70% since last year. Why? The purpose was to increase lab decoupling appointments, which facilitate a timely manner of patient care and enhance patient’s satisfaction. Interventions were as follows:

- Gap analysis by fishbone and five why to find out the root causes - phase 1; The staff doesn’t understand the rationale behind the decoupling lab appointments, so they don’t proactively bring this information to the patients; Patients are assumed that they don’t like to come to the clinic more than once, so they’re not aware they have the option to do the lab prior.
- After the root causes are identified, the action plans are brought in: Increase staff awareness through DES, rounding and staff meeting; Created patient hangout to let them know where to do the outpatient lab

After the phase 1 interventions is implemented, the decoupling lab appointments increase from 70% to 85% in three months. Root cause is important. Don’t assume people’s actions based on individuals’ interpretation. A proposal won’t turn into a successful action without solid communication and plan.

P483
INNOVATIVE SOLUTIONS: A MULTIDISCIPLINARY APPROACH TO TACKLING PSYCHOSOCIAL BARRIERS IN ONCOLOGY
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Psychosocial Dimensions of Care

In the unique landscape of Austin, cancer patients grapple with multifaceted psychosocial barriers. Navigating the city’s sprawling geography for treatment/
resources poses a significant hurdle for those with transportation barriers. The extreme rise in costs of living have left many with housing insecurity. Moreover, the financial strain of a cancer diagnosis often intertwines with emotional and logistical burdens, creating a web of complex psychosocial challenges. St. David HealthCare’s Psychosocial Oncology Conference, an initiative in the greater Austin area, is dedicated to untangling complex psychosocial patient barriers through collaboration between the healthcare system and community non-profits. It’s overarching goals include identifying referrals for St. David’s cancer patients, fortifying ties between St. David’s and community partners, and increasing resource awareness for oncology colleagues. Attended by professionals from both St. David’s and community non-profit organizations, this monthly virtual meeting can be broken into 2 parts:

- 15-minute resource presentation: This highlights services and referral pathways, each classified as a healthcare system resource, Austin-area resource, or national patient resource.
- Patient case presentation: The team reviews 1-2 de-identified, HIPAA compliant patient cases. These cases highlight complex barriers to care, spanning multiple psychological and social areas: diagnosed medical/psychological comorbid diagnoses, family environment, insurance barriers, psychological barriers (undiagnosed), social barriers, functional barriers, and spiritual barriers.

A quarterly program evaluation, spanning from baseline in June 2022 to March 2023, measures awareness of patient resources (St. David’s, local, national), confidence in finding patient resources (for inpatients and outpatients), and average time to find resources for one patient and their family. Responses are assessed using a 5-point likert scale. Participants demonstrated an 8% overall increase in awareness of healthcare system resources. Notably, higher-level awareness categories (4 & 5) of local resources rose, while minimal awareness of both local and national resources decreased. Moreover, there was an 8% surge in the “extremely confident” level for finding inpatient psychosocial resources, and an overall 4.8% confidence increase in finding outpatient resources. Regarding time efficiency, baseline data showed 44% took 1-4 hours to find resources for one patient/family. In March 2023, this dropped to 30%, with no respondents reporting 3-4 hours. Notably, there was a 38% increase in the lower time intervals, with 70% indicating it took only 30 minutes to 1 hour to find patient resources in March 2023.

**P484 MIDLINE MILESTONES: NAVIGATING CATHERTER CARE WITH TIMELY INTERVENTIONS**

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**Coordination of Care**

Midline catheters (MC) are beneficial for patients with cancer due to ease of insertion and significantly lower rates of device-related bloodstream infections (BSI) when compared with peripherally inserted central catheters (PICC) and central venous catheters (CVC). Line care for MCs, including timely removal of the line, is critical to minimizing infections and improving patient outcomes. A recent safety event at our institution involved an MC that remained in-dwelling past the 29 days designated by policy, putting the patient at a greater risk for infection. When reviewing this event, we learned that the flowsheet where MC care is documented does not show the number of days the line has been in place, making it difficult for nurses to determine dwell time. The purpose of this project was to improve adherence to midline removal, at or before the dwell time limit, to minimize the risk of device-related BSIs and other complications. Three interventions were key to the success of this project. First, a “Midline Catheter Days” column was added to every inpatient nurse’s schedule. Visibility of dwell days on the main screen of the electronic health record increased awareness of the day count. Second, we collaborated with nursing informatics to have the “Midline Catheter Days” column turn red when the 29 day dwell limit is surpassed. Lastly, the MC policy was revised, allowing trained bedside RNs to remove MCs. All oncology nurses received competency training. There have been no reports of MC-related adverse events since the implementation of these interventions. Bedside nurses and nurse leaders have shared positive feedback on the features of the “Midline Catheter Days” column and the changes to practice and policy that allow nurses more direct involvement in MC line care. Midline catheters offer many benefits to patients with cancer when compared to PICCs and CVCs, and line maintenance is critical to preventing BSIs. Increasing visibility of MC dwell days and alerting nurses when the dwell limit has been reached improves adherence to line removal as guided by institutional policy. Authorizing nurses to discontinue lines allows them to practice at the top of their license. Overall, monitoring dwell days and removing lines when their dwell times have been reached optimizes patients’ outcomes and experiences and can contribute to decreased lengths of stay by limiting infection risks.
P485
PATIENT EDUCATION AND CANCER: “A CROSS-CAMPUS INTERDISCIPLINARY APPROACH”
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Patient Education and Safety
Patient education has been identified as essential to improving healthcare outcomes. The purpose of patient education is to effect change in the knowledge, attitudes, and skills necessary to manage illness. In the oncology setting, patient education is vital in helping individuals cope with their diagnosis and treatment. Such education assists patients in navigating the life-long journey of cancer diagnosis initiatives and improves resilience in managing their disease. A collaborative, team-based approach to patient education can ensure care of the whole individual and ease patient distress.

The purpose was to foster an interdisciplinary cross-campus committee within our health system to standardize and ensure quality control related to patient education for our cancer patients, their families, and caregivers. Our health system leadership recognized that treating the whole patient required an interdisciplinary patient education committee with representatives from across our multi-site system. The committee develops, reviews, and revises patient education materials regarding cancer and its treatment for use across the enterprise. The committee meets monthly, and membership includes nursing, library science, nutrition, social work, and health literacy. Physician consultation is provided for specific clinical recommendations. Divisions represented include infusion, radiation, diagnostic radiology, HSCT transplant, and surgery.

The committee utilizes health literacy best practices and proven approaches to adult learning. Guidelines are in place to ensure quality in the educational content created, shared, and reviewed with patients. Our committee has created, revised, and shared numerous patient education handouts, videos, and booklets to provide to patients. In coordination with the Patient & Family Education Department, these materials are translated into multiple languages and added to the electronic health record, ensuring continued patient access to the content. We also provide staff education on how to access and share these materials with patients online. An interdisciplinary, cross-campus approach to creating and navigating patient education materials for cancer treatment ensures standardization of the quality of education provided to patients, while also allowing the flexibility to provide customized content for specific patient populations. This committee helps to ensure that all patients across the enterprise have equitable access to health education materials in the languages and formats that address their unique barriers and learning needs. The interdisciplinary nature of the committee ensures a holistic approach to the educational needs of the patient living with cancer and their family.

P486
IMPROVING SAFE DELIVERY OF ANTI-NEOPLASTIC MEDICATIONS: STRATEGIES TO PREVENT INFILTRATIONS AND EXTRAVASATIONS IN OUTPATIENT ONCOLOGY INFUSION
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Patient Education and Safety
Infiltrations of non-vesicant solutions and extravasations of vesicant solutions into surrounding tissues are important risks of intravenous (IV) administration of antineoplastic agents, as they can cause severe tissue injury and potentially delay further treatments. While immediate action can include using appropriate measures (e.g., dilution, extraction, antidotes, and supportive treatments), many injuries can be prevented by understanding the root cause of these occurrences and implementing appropriate procedures to prevent more serious adverse outcomes.

The outpatient oncology infusion center has seen an increase in the number of infiltrations and extravasations (I&E) in the past two years. First, a multidisciplinary root cause analysis was implemented to investigate contributing factors to I&E events. All infiltrations and extravasations in 2022 and 2023 were documented through our hospital safety reporting system from January 2022 through September 2023. The information was evaluated on diagnosis, regimen type, place, and time of IV access, previous IV access recommendations, and time of infiltration. A total of fourteen events occurred from January 2022 to September 2023. Results showed that I&E events were evenly spread among patients with breast and gynecological cancers, with patients receiving a range of treatment regimens. 10/14 (71%) patient had provider visits after their line was placed with a time between IV placement and treatment start of around 2 hours. 5/14 (36%) patients had IV placed in hand, 7/14 (50%) were placed in the forearm and 2/14 (15%) were placed in...
the antecubital fossa. Regarding timing of events, 9/14 (70\%) occurred after the halfway point of the infusion, 3/14 (14\%) within 10 minutes from start. Our limited sample showed a correlation between the timing of IV placement and potential risk for an I&E event. While patients require lab draws prior to treatment, we found that the average 2 hour wait time to start infusion may be contributing to I&E events as line function may be compromised while patient is undergoing visit and/or exam by provider. As a result, clinic workflow was updated in our first plan-do-study-act cycle to have patient complete lab draws prior to provider visit, then have peripheral IVs immediately prior to the start of infusion. We are continuing to monitor whether this is an optimal workflow. Education and reinforcement of the importance of the signs and symptoms of an I&E event were incorporated into patient education.

P487 UTILIZING PRE-CONSULT PATIENT EDUCATION TO FACILITATE GREATER PATIENT ENGAGEMENT IN THE ONCOLOGY AMBULATORY SETTING

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Oncology Nursing Practice

Referrals to an oncologist can create undue anxiety and worry for the patient; therefore, resulting in care and treatment for these patients being delayed if the patient does not understand the diagnosis and purpose of the referral. Our quality improvement project was designed to determine the percentage of patients that were not aware of the reason they were being referred to our specialty oncology liver clinic. The goal was to increase patient understanding by targeting early up-front education prior to the patient’s initial appointment with the oncologist and then assessing the impact of the education on patient understanding, patient compliance to appointments, and patient participation. Prior to the specialty oncology provider visit, the nurse coordinator contacts the new patients by phone and/or in person. At this time the Oncology Initial Nursing Assessment is completed with focus on patient’s understanding of diagnosis and reason for referral. If the patient answers “yes” further questions are asked to patient to target understanding until patient is able to verbalize back proper understanding. If a patient answers “no” then extensive education is provided to the patient, including review of referral, imaging findings, lab results, and pathology until patient verbalizes back proper understanding. Patients were selected randomly through the electronic medical record (EPIC) system and a review of the completed Oncology Initial Nursing Assessment was used targeting two questions regarding patient understanding of reason for visit and diagnosis. Our preliminary data found that 70\% of the patients were not aware of the reason for being referred. System generated data and manually tallied data will be collected over a 6 month period using a pre-visit and post-visit survey. Extensive up-front patient education and communication with new patients through nurse led initiatives was found to not only increase patient understanding of their diagnosis and reason for referral, but also decrease patient anxiety and stress. Studies demonstrating the impact of improved patient engagement and health literacy in liver disease remain sparse (Gulati, Nawaz and Pyrsopoulos, 2018). Future interventions with this patient population should consider the impact of providing education prior to initial consult.

P488 EMERGENCY TACKLE BOX: A NEW APPROACH TO HYPERSENSITIVITY REACTIONS FOR AMBULATORY ONCOLOGY INFUSION SITES

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Patient Education and Safety

Hypersensitivity reactions to medications can manifest at any time during a patient’s treatment, and can range from mild to severe. Oncology patients are at increased risk for developing hypersensitivity reactions due to increased exposure to antineoplastic medications. Hypersensitivity management at ambulatory infusion locations require special considerations due to the limited access to resources such as RRT/ Dr. Cart, therefore nurse response time to reactions is critical. The purpose of this project was to improve response times for hypersensitivity reactions within Orland Park Infusion Therapy (IVTH). Methods were as follows:

- Identify ways to improve response times for reactions, a literature search was performed
- Keywords “Hypersensitivity,” “chemotherapy,” and “reaction management” in the CINAHL and PubMed databases.
- Articles were evaluated for relevance and relationship to our purpose.
- Analysis of hypersensitivity reactions resulting in 9-11 calls before and after implementation was completed based on event reporting data.
Survey of RNs post implementation conducted to evaluate kits effectiveness of the emergency tackle box

Creation of virtual tackle box in Omnicell for ease of access and tracking

Analysis of virtual tackle box utilization underway

Our literature search uncovered 10 articles; major themes include:

- Support for immediate treatment of hypersensitivity reactions
- Reasons for why lack of standardization increases risk of patients experiencing infusion related hypersensitivity reactions
- Consistent treatment recommendations for responding to hypersensitivity reactions
- Evidence for instituting infusion hypersensitivity protocol into nursing practice to improve response time for interventions

Analysis of Event Reports:

- In 2021 and 2022, 22 hypersensitivity events were reported for Orland Park IVTH, seven of which resulted in 911 being called for patient.
- As of August 1, 2023, five hypersensitivity reactions have been reported, none of which resulted in 911 being called for patient.

Discussion is as follows:

- Findings suggest that RNs in IVTH are able to respond quickly emergent hypersensitivity reactions
- Increased RN confidence in hypersensitivity management
- RNs can find the emergency kit in the Omnicell easily
- Patient’s able to be re-challenged- without calling 911

Next steps are as follows:

- Continue monitoring infusion reactions on a monthly basis within Orland Park IVTH
- Disseminate information to other network infusion sites, which may have similar support structures for their own use and implementation if appropriate.
- Create a SIM experience to run through infusion reaction protocols, for new nurse onboarding/education

P489

USING SIMULATION FOR EASE AND INCREASE IN DOCUMENTED HEALTHCARE POWER OF ATTORNEY FORMS

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Coordination of Care

The Healthcare Power of Attorney (HPOA) is an Advance Directive document that is discussed with patients as part of the larger Advance Care Planning process. Advance Care Planning (ACP) conversations can be uncomfortable to initiate with patient, and not all clinicians see ACP as part of their role. However, the Patient Self-Determination Act (PSDA 1991) requires all healthcare institutions to inform patients of the right to participate in healthcare decisions, specifically citing advance directives. Purposes were as follows:

- Increase comfort among staff in asking about and talking about HPOAs with patients.
- Increase documented HPOAs in patients’ charts and understand current workflow of HPOA documentation in EPIC.
- Create an ongoing process of communication with patients, family members, support systems, and Health Care Providers.
- Pilot a simulation-based training intervention with nursing and desk staff at Orland Park Hematology/Oncology clinic.

Interventions were as follows:

- Initial assessment of knowledge and resources available to IV Infusion nurses at Orland Park
- Designed and implemented Pre/Post Surveys to measure success
- Created process map (attached) to identify best practices and gaps
- Designed and implemented both a didactic and a simulation using standardized patients
- Complete initial simulation (Mar 2023) and utilized debriefing to drive improvements to the curriculum.
- Complete second simulation of the updates from the initial sim (Jun 2023)
- Reviewed total results to measure impact on nursing comfort/confidence & increased volumes of HPOA document completion

Evaluation was as follows:

- Continued optimization of process within workgroup to create replicable workflows
- Updates to ACP EPIC site
- Education and roll out of the Outpatient Advance Care Planning Documentation dashboard to larger audience
- Clinical teams at Hyde Park, and other locations,
looking to replicate processes in their ambulatory clinic setting

- Increased levels of confidence in discussing HPOA from 53% (not at all) to 73% (very or extremely)
- Increased levels of comfort in discussing HPOA from 62% (not at all) to 67% (average or very)
- Increase in documentation
- Pre-SIM #1: January & February 2023 averaging 7.3%
- Post SIM #1: March, April, May 2023 averaging 8.7%
- Post SIM #2: June & July 2023 averaging 9.15%
- July showing the highest volumes to date at 9.6%

Discussion was as follows:

- Continue partnership with the Simulation Center to implement simulations at other clinics that have expressed interest in implementing
- Continue to educate staff about HPOAs, Goal Concordant Care and Advance Care Planning discussions
- Shifting the conversation to working ‘well’ populations

**P490 IMPLEMENTATION OF A FAST TRACK SUB-UNIT IN AN OUTPATIENT ONCOLOGY INFUSION CENTER AS A STRATEGY TO INCREASE EFFICIENCIES AND PATIENT SATISFACTION**

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Oncology Nursing Practice

University of Miami Sylvester Comprehensive Cancer Center (SCCC) is a National Cancer Institute (NCI) designated cancer center located in South Florida with 14 individual infusion sites providing care throughout a bi-county area treating approximately 500 patients daily. SCCC provides services to the community focusing on convenient and high quality care; however, the wait times and satisfaction scores reflected negatively. SCCC infusion nurses care for patients with a variety of complexity. Patients with short, lower acuity visits would experience delays as nurses were treating patients with increased complexity on treatment regimens with multiple medication administrations, hypersensitivity reaction management, and education. The integration of a sub-unit, “Fast Track”, into an established outpatient oncology infusion center is an innovative approach designed to mitigate extended wait times, elevate patient satisfaction, and optimize resource utilization, including serving as an alternate assignment for pregnant nurses. SCCC defined what visit types would be considered as a “fast track” visit. Designated chairs, staff and scheduling resources were established to treat “fast-track” patients. Interdisciplinary coordination occurred with pharmacy and patient access to expedite these patients. Patients and staff were educated as to the new process. SCCC’s Plantation site experienced high wait times, strained capacity and lower patient satisfaction scores which prompted the implementation of a “fast track” unit. The overall average wait time was 18 minutes pre-implementation and was reduced to 12 minutes for treatment and 10 minutes for “fast track” post implementation, exceeding our institutional goal; a 33% reduction. Post implementation, the site increased capacity by 8 patients per day, a 10% increase. Since the implementation of the Fast Track unit, Plantation has achieved higher Press Ganey scores. Some of the greatest increases include likelihood to recommend, extend appointments began on time and overall rating of care. There was a 4% increase in treatments beginning on time from 88% to 92%. Overall access increased 4%, from 91% to 95%. Likelihood to recommend increased from 96% to 98%. This has proven to be a successful strategy to optimize patient throughput while being a staff and patient satisfier. Fast track process implementation began in 2020 and has evolved as our standard practice. Volume was increased by adding an average of 10% more visits to increase capacity and wait times decreased by 33% with current site implementation.

**P491 CLINIC-BASED TECHNOLOGY ASSESSMENTS CAPTURE ADDITIONAL SYMPTOM MEASURES AND SUPPORT CARE INNOVATIONS**

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Coordination of Care

Fever neutropenia is a significant driver of morbidity, mortality, and cost in cancer care. Continuous temperature monitoring (CTM) identifies fever earlier than the standard of care.1 Earlier, faster, data-informed patient interventions can potentially reduce healthcare-related costs.2 Symptom detection and documentation is improved using electronic Patient Reported Outcomes

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Patient engagement also improves with the use of ePROs which can, in turn, improve clinical efficiencies and outcomes. As patients are increasingly being treated in the outpatient setting, there is an increased need to find fevers earlier and understand the symptoms patients are experiencing with fever. The use of wearable technology along with ePROs currently has limited research, even though the benefits could be impactful. The purpose was to identify value and barriers of using remote symptom monitoring innovations including continuous temperature monitoring and ePROs on oncology patients and providers. Patient data was measured through their engagement with the ePRO and CTM platforms. The platforms provided care team member displays of the patient data to support clinical decision making as desired. The longitudinal displays of these symptom and fever data were not available historically or within the EMR. The displays were available on-demand and were responsive to patient inputs in real time. Data was reviewed further to assessed for episodes of fever. Feedback on the feasibility and value of CTM data in conjunction with ePRO monitoring from both clinician and patient perspectives was collected. 226 days of CTM data and 138 ePROs questionnaires were available for consideration. Seventy-one reports (days) of fever were captured by CTM and ePRO, overall. Overall feedback from both patients and physicians was positive indicating limited impact on daily activities and workflows. Participation in the pilot demonstrates patients’ and providers’ willingness to engage with innovative technologies and provide feedback. New opportunities for understanding important implementation and well-being factors previously unknown and unmeasured were identified. As this was a small pilot project, the results highlight the need for additional research related to the use of wearable medical devices in conjunction with ePROs.

P492
A NURSE PRACTITIONER LED INITIATIVE TO IMPROVE PROSTATE CANCER CARE: CREATION OF AN ADVANCED PROSTATE CANCER CLINIC
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Coordination of Care
Louisiana’s high prostate cancer mortality rate may be attributed to healthcare disparities, educational deficiencies, and insufficient monitoring of adverse effects of androgen deprivation therapy (ADT), which can exacerbate existing conditions. To address the irregularities in prostate cancer treatment within her institution, a genitourinary (GU) nurse practitioner (NP) at a large academic hospital in Louisiana took the initiative to establish an advanced prostate cancer (APC) clinic, aiming to enhance the quality of prostate cancer care. The APC clinic aspires to provide a comprehensive, multidisciplinary approach tailored for men with advanced prostate cancer, defined as men who are undergoing ADT treatment for greater than 6 months or had a bilateral orchectomy. Standardized protocols will be observed that draw from the latest guideline-based care. Simultaneously, vigilant monitoring will be in place to track disease-related side effects and associated comorbidities, which are known to exert a significant influence on survival rates. Lastly, patients will have access to vital resources including a nurse navigator, clinical trials, genetic testing, psychosocial support, monitoring cardiovascular and bone health, and nutritional counseling. The APC clinic is staffed by a genitourinary NP, oncologist, and nurse navigator. A multidisciplinary group convened in March 2023 to develop standardized protocols for APC, including the ordering and documentation of ADT, use of second-generation hormonal therapies, and the management of adverse events associated with ADT. Reporting mechanisms were created to gather patient data for outcome correlation. Prostate cancer patients seen in 2022 at our hospital established the APC baseline data. In 2022, EPIC’s SlicerDicer identified 2,548 eligible men for APC, ranging from 42 to 106 years old. Monitoring rates were suboptimal, with only 30.1% having a hemoglobin A1C, 19.7% having documented cardiovascular disease risk scores, and 6.6% undergoing DXA scans. Patients are referred to APC and scheduled by the nurse navigator. Each patient’s record undergoes a review against APC protocols to identify needs and uses standardized documentation. Future goals include assessing clinic achievements and expansion opportunities. The APC clinic began operating on July 7, 2023, and served 137 patients in two months. This project illustrates how oncology nurse practitioners and nurses can identify healthcare discrepancies and work to make a change. As frontline professionals, they possess the expertise to improve the quality of care and should be empowered to drive positive transformations in cancer care.

P493
IMPLEMENTING A MULTIDISCIPLINARY APPROACH TO ASSESS FOR MALNUTRITION IN CANCER PATIENTS
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Coordination of Care

The Oncology Nurse Navigator ensures care coordination, minimizes delays, and provides timely access to care for patients with cancer. They provide assessment and interventions to address barriers to care and promote high-quality care and optimal outcomes. Malnutrition is prevalent among oncology patients and often presents prior to beginning cancer-directed therapy. Negative malnutrition implications include impaired immune function, delay in anticancer treatment, and postoperative complications. Malnutrition represents a poor prognostic factor resulting in reduced quality of life. Navigators often coordinate resources or referrals early in the patient’s journey. The lack of standardized methodology for nutrition assessment led to the opportunity to improve identification and resource use for nutrition consultations and provision of early interventions through interdisciplinary collaboration. The purpose was to standardize criteria for a nutrition consult generated by Nurse Navigators based on a validated screening tool and identify malnutrition in newly diagnosed patients for early nutrition intervention prior to cancer-directed therapy. Patients with lung, colorectal, head/neck, gynecological cancers, or hematologic malignancies were assessed by an oncology nurse navigator utilizing the 3-question validated Malnutrition Screening Tool (MST). The MST evaluates the presence and degree of unintended weight loss and lowered intake based on decreased appetite. The tool was built into the electronic navigator assessment. Navigators placed a nutrition consult for patients scoring 2 or more. Registered Dietitians (RD) contacted patients within one week for a comprehensive nutrition assessment and provided tailored interventions including education, oral nutrition supplements and/or referrals for community-based free meal services. Over 1 year, 227 patients were assessed with the MST tool. 40% (n=91) resulted in nutrition referrals. 39% of referrals (n=36) met malnutrition criteria and 11% met criteria for severe malnutrition. Nutrition interventions to address malnutrition or risk were implemented a median of 21.5 days prior to treatment start (n=42). Interdisciplinary coordination is crucial in providing patient-centered care. Developing a standardized approach to consulting RDs creates an efficient, innovative system for Nurse Navigation while ensuring that the patient is connected to essential services. Identifying patients at risk ensures the most effective use of cancer center resources. The MST is an efficient tool that Nurse Navigators can implement to increase interdisciplinary collaboration and improve patient outcomes. MST screening decreased time to nutrition intervention for patients starting treatment, potentially leading to improved outcomes from treatment.

P494
ENHANCING PATIENT COMMUNICATION IN OUTPATIENT CLINICS THROUGH WHITEBOARD INTEGRATION

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Oncology Nursing Practice

In ambulatory healthcare settings the need for efficient patient communication is extremely important but can be hampered by the fast-paced clinic environment. Whiteboards offer a visual and interactive platform for conveying information, fostering engagement, and enhancing patient understanding. A whiteboard can be a simple yet impactful tool to improve patient communication in outpatient settings. By utilizing whiteboards, outpatient clinics can facilitate clearer explanations of wait times, treatment plans, and instructions, resulting in increased patient satisfaction, patient safety, and overall improved patient experience. The staff and patients were surveyed regarding what information would be helpful on a clinic whiteboard. Based on the responses, a white board mockup was generated to be made custom to fit patient and staff needs. Included on the whiteboard were names of the members of the care team, any known delays in the clinic, a time stamp to add when the patient was roomed, a section for patients to identify questions for the care team, and room for the care team to make notes. The boards were created and installed in all the clinic rooms throughout the ambulatory care setting. The efficacy of the whiteboards was measured using Qualtrics. Patient satisfaction scores focusing on communication of delays were used, and subjective data collected by the care team to define success. The utilization of a brief survey evaluating the boards and their efficacy in improving patient engagement was also considered post implementation. Whiteboards are valuable tools in outpatient clinics, offering several advantages including improved communication, patient engagement, and time management. These boards served as a hub for displaying essential patient information such as goals of treatment, contact numbers, and can communicate clinic delays or
wait times. Patients could utilize the information on the boards to orient themselves to clinic workflows, identify members of the healthcare team entering the room, thus decreasing anxiety, and improving overall communication.

P495
**CALL IT WHAT IT IS! CHEMOTHERAPY OR IMMUNOTHERAPY? PROVIDING NURSES SPECIFIC TOOLS TO EDUCATE ONCOLOGY PATIENTS**

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**Patient Education and Safety**

Therapeutics available to oncology patients have expanded well beyond the traditional cancer treatments including surgery, chemotherapy, and radiation therapy. Cancer treatment regimens can now include immunotherapy alone or in combination with one or more of the traditional cancer treatments greatly increasing the complexity of side effect assessment and management. Patient understanding of expected and unexpected side effects as they relate to prescribed therapies is critical to the safety of patients, however patient comprehension of treatment can sometimes be a challenge due to multiple factors associated with cancer diagnoses and treatment such as fatigue, fear, stress, and being overwhelmed. It was noted at UPMC Hillman Cancer Center in Pittsburgh Pa that oncology patient education materials use the word chemotherapy when describing the medical portion of the treatment plan. The use of the word chemotherapy was causing confusion for patients who were receiving an immunotherapy and nursing staff expressed difficulty in supporting the patient’s educational needs without the appropriately worded materials. Since the use of non-antineoplastic therapies has become increasingly more common in cancer therapeutics, the need to have patient education specific to the type of medical therapy prescribed is evident. On an annual basis the oncology patient education materials are reviewed by multiple disciplines including, research, dietary, pharmacy, nursing, and social work. A nursing sub-group was formed to provide input on immunotherapy patient education material develop. It was decided by the group that the materials for immunotherapy should be mimicked to the chemotherapy materials for both patient and staff ease of understanding. The education department then worked with the UPMC system to design materials while meeting the UPMC requirements of patient literacy, branding, design, and for review by the UPMC patient experience committee review for patient feedback prior to implementation. The resources were implemented July 2023 and patient education understanding will be evaluated using monthly press ganey scoring, while nursing satisfaction with materials will be completed late fall using a simple electronic questionnaire.

P496
**STANDARDIZING ONCOLOGY TREATMENT PROTOCOL BUILD AND VALIDATION IN THE ELECTRONIC-MEDICAL RECORD**

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**Coordination of Care**

Oncology treatment requires multiple cycles of care, with complex high-risk medications, necessary monitoring and supportive medications to mitigate side-effects and adverse reactions. To ensure safe delivery of care, each unique treatment option should have a custom-built order set, which contains all required components. Our healthcare system currently has over 800 treatment plans built into our electronic medical record (EMR). As evidence and options evolve, maintenance of existing plans and new plan builds are required. This requires time and effort from oncology pharmacists, nurses, providers and analysts. The purpose of this project was to improve the original process utilized when the hospital system converted from paper chemotherapy order sets, to an electronic version in the EMR. In the EMR, all orders are electronic and standardized into a Treatment Protocol. An updated process to improve the build and efficiency of the validation process and required review, was needed to ensure standardization and quality of care for patients receiving chemotherapy. A full review of the original process was written up, then additional layers of review were added to ensure accuracy of content prior to submission to the analyst team for build of the order set in the EMR. The additional layers of review minimized edits after plans were built. Additionally, standardization of communication orders, acceptable abbreviations and time for infusion durations were added to improve consistency and provide ease of understanding for the clinicians who were ordering, preparing, and administering these complex chemotherapy regimens. The additional layers of review and standardization have improved efficiency of build, reduced the quantity of edits, increased consistency, and organization of treatment protocols, enabling improved ease of ordering for providers, and improved patient safety through consistency of order sets. Adding layers of review to the build process has improved efficiency, decreased training time for oncology providers, nurses and
pharmacists, and enabled standardization of care for patients.

P497
AN INNOVATIVE FALL PREVENTION PROGRAM IN INFUSION SERVICES
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Patient Education and Safety
Oncology patients are at increased risk for falls for a variety of reasons (e.g., cognitive status, fatigue). While successful in inpatient settings, with the shift in oncology care to outpatient settings, the efficacy of a Fall Prevention Program warrants evaluation to increase quality and safety. Adult infusion centers are one of the areas with the highest fall rates across ambulatory services. Compared to FY22, in FY23, the number of falls increased 150% (i.e., 4 to 12 falls). The aim of this quality improvement project was to reduce falls by 25% in the outpatient infusion center. Solutions to decrease falls were developed following an evaluation of fall prevention tactics across eight adult infusion centers. These centers have over 110,000 annual visits. Evaluation of current practice indicated:

- Variability in adherence with universal fall precautions.
- Inconsistent practices related to assessments, interventions, and post-fall procedures.
- No visibility of fall data to assist with decision-making.
- No visibility of fall risk status at the patient level in Epic to support patients through transitions in care.
- Proposed solutions for infusion services included:
  - Adopting the three-step fall prevention process.
  - Adopting the Fall TIPS (Tailoring Interventions for Patient Safety) toolkit.
  - Developing a zero-harm dashboard to support decision-making.
  - Build Epic functionality for a fall icon.

Fall TIPS toolkit is an evidence-based patient-centered toolkit that uses a formal risk assessment to tailor each patient’s plan of care. It is the only toolkit that has reduced falls by 25% in acute care hospitals. Adopting Fall TIPS in the outpatient infusion setting is an innovative approach to fall prevention. The project’s primary outcome was a decrease in falls. In April 2023, five infusion centers implemented an updated fall risk screening survey and the Fall TIPS toolkit. In the six months since implementation (April through September 2023), there have been zero falls. At this rate, all centers will achieve the goal of reducing falls by 25% over 12 months. Nursing care drives quality outcomes. An innovative approach to prevent falls results in improvements in patients’ experiences and outcomes and associated decreases in costs. This intervention will prevent injury-related co-morbidities, reduce emergency department visits and length of stay (LOS), and prevent hospital admissions. It reflects the implementation of an evidence-based practice intervention and opens new paths for clinical inquiry in outpatient oncology care.

P498
CENTRAL LINE PROCESS CONFIRMATION BUNDLE FOR REDUCTION OF CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS IN PATIENTS WITH ONCOLOGY CONDITIONS
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Oncology Nursing Practice
Central line-associated bloodstream infections (CLABSI) have proven costly to healthcare systems; however, more importantly, they result in thousands of deaths each year (CDC, 2010). CLABSI are particularly detrimental to patients within the oncological services as their immunocompromised state creates an opportunistic environment for bacteria to grow, which can lead to serious complications. Within our campus, there was an observed increase in CLABSI rates in 2022, which paved the way for a quality improvement action plan through a process confirmation bundle. This quality improvement initiative aimed to address the growing rate of CLABSI by decreasing impact to our patients. In October 2022, the leukemia and bone marrow transplant units piloted a daily process confirmation for effectiveness and sustainability. These two units are each composed of 22 beds with many patients, if not all, having a central line. The process confirmation bundle entailed an interactive board as well as an audit form that two nurses would complete together at the patient’s bedside during handoff report. The piloted process confirmation bundle was successful and distributed across the entire campus for use on all
inpatient units in November 2022. Other interventions included focused collaboration on central lines during plan of care visits and concerns were escalated immediately to leadership. Line rounds with the bedside nurse and clinical stakeholders also took place weekly. Non-tunneled lines were reported out during daily tiered huddles as these lines have an increased association with CLABSIs (Haddadin, et al., 2022). A monthly review of current CLABSIs was also enacted. This was a collaborative multi-disciplinary approach to deep dive into opportunities and best practices to take back to the unit level. This process confirmation bundle and collaboration continues today and has been expanded across the enterprise due to its success. With the aid of this high reliability process and commitment to our patients, our campus CLABSI rates have decreased to 0.61 as of July 2023 from 1.12 in October 2022. The CLABSI process confirmation bundle is a nurse-led intervention at the unit level which we have seen great success with in reducing CLABSIs. The interventions above and increased collaboration has further empowered our nursing teams to bring forward any central line concerns to nursing and physician leadership further enhancing a culture of patient safety.

P499
BEHAVIORAL HEALTH THERAPY TELEHEALTH: EVALUATING THE EFFECTIVENESS OF IN-PERSON CLINICAL PROMOTION AND OUTREACH
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Psychosocial Dimensions of Care
Mental health symptoms such as depression and anxiety are common in patients navigating a cancer diagnosis and treatment journey. Having access to supportive services such as behavioral health therapy (BHT) via telehealth during and after cancer treatment has been shown to improve treatment outcomes (1). This abstract explores the benefits of marketing and promoting telehealth BHT in oncology clinics to increase referrals, thus increasing the number of patients accessing this valuable resource. During the COVID-19 public health emergency, patients needed psychological support and behavioral health therapy more than ever due to isolation from the pandemic. When a large multi-clinic community oncology practice transitioned behavioral health services from in-person to remote telehealth during the pandemic, the number of BHT telehealth referrals from the clinics were lower than expected. Leadership identified a need to increase awareness and access to BHT for both healthcare providers and patients in clinics. Department leadership and BH Therapists planned and completed visits to thirty clinics where they met with clinical and ancillary staff. Verbal and written education on behavioral health services was provided, including ordering instructions for referrals. Marketing materials were delivered and distributed throughout clinics. By placing BHT posters, Therapist bio cards, and flyers in the clinic lobby, exam rooms, infusion room, and check-out desk, patients were provided with easy access to information and made aware of the availability of virtual mental health support. Additionally, nursing staff were provided with education and flyers to include in new patient paperwork, giving patients the option to self-refer through our Care Coordination department if desired. Study results showed a marked increase in patient referrals for BHT. Data was collected sixty days prior to clinic outreach and compared to data sixty days post clinic outreach. Patient referrals increased by 19%. To support patients in their cancer journey, ensuring access to behavioral health services is vital. It is apparent there is a need to build cohesion with providers and clinic staff, particularly in the remote-worker telehealth scenario. Considerations for future outreach include evaluating understanding of services before and after clinic visits. This abstract demonstrates the effectiveness of establishing connections with clinic staff and providers and how these steps can assist patients in accessing and obtaining behavioral health support during their cancer journey.

P500
A MINUTE OF MINDFULNESS TO IMPROVE NURSE BURNOUT
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Oncology Nursing Practice
Oncology nurses have a higher rate of compassion fatigue compared to other nursing fields, leading to alarming levels of burnout. This is due to higher encounters with emotional stressors including patient and caregiver navigation through prognosis, treatment, and end-of-life. Therefore, it is crucial to address compassion fatigue and burnout to prevent negative patient outcomes. Currently, there are no consistent interventions to reduce nurse burnout during the shift in the adult inpatient oncology unit at our healthcare...
The purpose of this study was to determine if practicing mindfulness during working hours on the oncology unit could reduce compassion fatigue and burnout. HeartMath is a set of techniques that help guide the nurse connect the mind, body, and heart. The “Quick Coherence” technique was used which involves a breathing exercise and reflection on positive thoughts. These techniques improve well-being, enhance job satisfaction, and reduce the risk of emotional consequences of caregiving. However, there is limited evidence showing the impact of this meditation when it is practiced by nurses during work hours. A one minute HeartMath meditation was recorded. The charge nurse received the recording via email and was designated to play the recording at every shift huddle. Additionally, a QR code of the recording was provided throughout the unit to maximize accessibility. The intervention period was conducted from April - July 2023. Outcomes were measured using the Maslach Burnout Inventory (MBI) survey. Pre-intervention (n=26) data showed an average score of 25.23 in “emotional exhaustion”, 24.12 in “professional accomplishment”, and 5.23 in “depersonalization.” Post-intervention (n=25) data showed “emotional exhaustion” improved to 21.29, “professional accomplishment” improved to 35.56, and “depersonalization” remained in the low burnout score category with an average of 5.88. A non-paired t-test did not suggest statistical significance. Our findings support use of HeartMath meditation during working hours improved emotional exhaustion and personal accomplishment.

Limitations of the study included limited time frame, small sample size, and ensuring the meditation was played during every shift huddle. However, our experience is in alignment with other studies that have shown decreased emotional exhaustion, which is the most impactful category associated with fewer patient adverse events. Further research exploring meditation during working hours and the direct impact on patient and organizational outcomes may be beneficial.

P501
CREATING A MULTI-FACETED, STANDARDIZED PROCESS TO IMPROVE COMPLIANCE WITH ACO-S-COC STANDARD 4.2 AND TRACKING DOCUMENTATION ELECTRONICALLY
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Professional Development

American College of Surgeons - Commission on Cancer (ACoS-CoC) is a consortium of professional organizations dedicated to improving survival and quality of life for cancer patients by setting and raising standards. In 1/2020, CoC implemented “Standard 4.2: Oncology Nursing Credentials”. This new standard applies to RNs/APRNs who provide direct oncology care in the accredited facility for at least one calendar year.

Per Standard 4.2, each oncology nurse, who provides direct patient care, is required to have either:
- Current cancer-specific certification in their specialty by an accredited certification program, OR
- Proof of 36 oncology-specific Nursing Continuing Professional Development (NCPD) credits per three-year accreditation cycle

Because this was a new standard, nursing leadership needed to establish a reliable process for tracking certification status and NCPD credits for 160 oncology nurses. In Fall 2022, we recognized significant challenges related to meeting compliance by 12/31/2022, including identifying oncology nurses throughout our organization, and tracking three years of their NCPD/certification. During our facility’s ACoS-CoC survey (8/2023), the surveyor stated: “Compliance with Standard 4.2 has been a big challenge for many cancer facilities.” The purpose was to improve oncology nurses’ tracking and compliance related to meeting the new CoC standard 4.2. Oncology nursing leadership has designed and implemented multiple strategies to improve tracking and compliance related to meeting Standard 4.2, including:

- Created / implemented standardized work process for Standard 4.2:
  - Created Tracking Form for oncology certification/NCPD hours earned, mirroring CoC’s PRQ template
  - Created TEAMS channel for each dept and APRNs to maintain tracking forms
  - Conducted quarterly audits; shared results with oncology leadership
  - Added compliance with Standard 4.2 to individual nurse’s evaluation
  - Communicated about Standard 4.2 monthly to oncology leadership
  - Communicated to oncology staff nurses about Standard 4.2 via staff meetings, huddles, oncology nursing newsletters
  - Provided variety of oncology NCPD programs in our organization

Although our organization was successful related to meeting compliance with Standard 4.2 (2020-2022 accreditation cycle) in 8/2023, the struggle in achieving compliance in 12/2022 was significant. In 1/2023, oncol-
ogy leadership implemented additional actions to improve standardization and error-proofing of Standard 4.2 process. In 2023, Managers use results of quarterly audits to make improvements in a timely manner. Creating standardized work processes, adding Standard 4.2 to nurse’s annual evaluation, and sharing best practices among our oncology leadership team has improved compliance with Standard 4.2.

**P502**

**LGBTQ+ INCLUSIVE CARE STRATEGIES: COMPARING URBAN AND RURAL CLINICAL CAREGIVER ENGAGEMENT AND PERCEPTIONS**

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**Psychosocial Dimensions of Care**

It is estimated that approximately 7% of adults in the United States identify as LGBTQ+ and literature suggests that sexual and gender minorities experience disparities in care. Barriers to quality care may include a lack of medical provider expertise, fear of discrimination by the care team and a lack of knowledge from care providers regarding LGBTQ+ healthcare disparities or resources. In 2021, our health system implemented a sexual orientation/gender identity history section in the electronic health record and completed a project to provide focused education to our oncology service line caregivers in our urban and suburban settings. Given the success of the initial campaign, our teams felt it would be beneficial to expand education to our freestanding, rural oncology centers. Administrative, clinical and community outreach team members from our main campus and freestanding centers collaborated to provide training to help caregivers learn LGBTQ+ terminology, understand why sexual orientation and gender identity is important in the care of oncology patients, identify common disparities in care, and health risk factors in this population. Education included a review of the establishment of a welcoming environment, the use of inclusive language and the implementation of programs, services, and data collection to provide inclusive care. Pre and post education surveys were carried out to the teams using a Likert scale to determine respondents’ attitudes and views. The response rate to the post education survey decreased by 50% from the pre survey. There were significant improvements in the understanding of sexual orientation, gender identity, and the importance of using appropriate pronouns, however, survey results showed minimal improvement regarding equitable level of quality care and comfort in working alongside LGBTQ+ colleagues. When comparing the rural to urban education, we observed a decrease in survey engagement in the rural setting for post education. We also noted that caregivers in our urban area seemed to be more receptive to education than our rural area. The rural colleagues expressed some negative comments on LGBTQ+ inclusive care which, while discouraging, reinforces that there is an opportunity for further education to provide high quality, inclusive care to our LGBTQ+ patients at our centers.

**P503**

**EMPOWERING ONCOLOGY NURSES: COLLABORATIVE STRATEGIES FOR BURNOUT PREVENTION**

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**Professional Development**

Burnout results from physical and emotional exhaustion experienced by nurses. The literature show that more than 90% of oncology nurses feel burnout. When not addressed, burnout leads to “silent quitting,” negatively impacting the care given. Understanding and addressing this is necessary to ensure the best quality care. Maintaining a stable nursing workforce by ensuring the physical and mental well-being of the nurses is essential. A wide range of approaches to provide support include offering a positive work environment, resources, and recognition amongst staff. As an NCI-designated Cancer Center, we have taken the initiative to offer resources for a positive work environment to prevent burnout in the ambulatory setting. Here are a few strategies that have been implemented:

- **Peer Support Groups**—Informal meetings to express feelings without
- **Self-Care Accountability and Stress-Reduction Initiatives** -- Nurses set reminders to take breaks, organize or engage in stress-relief activities, and maintain a healthy work-life balance without leadership involvement.
- **Rotation of Tasks/roles** -- Nurses can rotate tasks or responsibilities among themselves to ensure a
more equitable workload distribution and reduce burnout.

- Positive Reinforcement-- Recognize and appreciate each other’s efforts through small gestures like notes of encouragement or expressions of gratitude. Peer Recognition Programs allow nurses to acknowledge and celebrate each other’s contributions and accomplishments.

A pre and post-survey for evaluation will be collected for feedback, recommendations, and measure progress. Addressing burnout and “silent quitting” requires a holistic approach by each organization and its nurses. Even small, everyday actions within the nursing team can make a significant difference in maintaining the well-being of each team member. By taking small steps daily, we as a team will climb over the “burnout mountain” with no one left behind.

P504 PROTOCOL PARTNERSHIPS: BENEFITS OF HAVING COMPLEMENTARY RESEARCH NURSING ROLES ESSENTIAL IN PROTOCOL IMPLEMENTATION AND PATIENT OUTCOMES

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Oncology Nursing Practice

At a large comprehensive NCI designated cancer center dedicated to providing patients with access to novel therapies, challenges existed in early identification of implementation concerns and opening trials to accrual in a defined window of time. Research protocols can be designed without full understanding of the clinical operations necessitating analysis and problem-solving from specialized staff. A standardized system with interdisciplinary, novel, and distinct roles was initiated with the creation of the Clinical Trial Nurse (CTN) role in 2020. Gaps continued to exist and in 2022 a new role, the Clinical Research Nurse (CRN), was integrated to research practices. Close collaboration between Principal investigators, research, clinical care teams & investigational pharmacy are essential for successful implementation and completion of novel oncology therapies. The purpose was to identify collaborative, yet specific, research nurse practices that ensure continuous clinical expertise throughout the protocol lifecycle to improve outcomes and the patient experience. At a Clinical Readiness Meeting (CRM) CTNs meet with key stakeholders prior to patient enrollment to identify operational challenges and any concerns are addressed. CTNs are also integral to the research orders process for end-users (providers, pharmacy, nursing, study team). CRNs participate in the CRM, bridging expertise from start-up planning to enrollment. Once the study is open, CRNs provide research education to patients and provide ongoing nursing support with research processes. Team partnership between CRNs, CTNs, and clinical cancer care teams has allowed for continuous quality improvement (CQI) whereby identification of barriers and changes are made in real time. The CQI process has demonstrated measurable efficiencies resulting in best research outcomes for patients, study compliance, and data analysis. CRNs, CTNs, and key stakeholders meet regularly to continue the improvement process as new issues arise requiring a deeper dive and potential workflow adjustment. Study review procedures ensure feasibility analysis & identifies where protocol specific support may be required. The transfer of oversight from CTN to CRN ultimately provides the clinical care teams with protocol preparedness facilitating compliant and specific implementation as well as overall supportive oncology research patient care.

P505 CLINICAL NUTRITION VIRTUAL OUTREACH PROGRAMS: EVALUATING THE IMPACT IN THE ONCOLOGY PATIENT POPULATION AND COMMUNITY AT LARGE

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Patient Education and Safety

Nutrition plays a critical role in cancer care. Malnutrition occurs in up to 80% of cancer patients (1). Negative outcomes of malnutrition include longer hospital admissions, higher infection rates, decreased tolerance to treatment, and increased mortality. Beyond cancer care, nutrition plays a vital role in reducing the risk of chronic diseases, managing illness, and weight management to improve overall quality of life. Oncology nurses play a pivotal role in identifying patients’ nutritional challenges and referring to appropriate clinicians and outreach programs. This abstract will explore the impact and effectiveness of virtual clinical nutrition outreach programs. Our virtual nutrition outreach programs are currently targeting 2 different audiences. The Virtual Survivorship Wellness Series was designed for cancer survivors, not in active treatment, to address long term nutrition and reducing risk of recurrence.
with lifestyle and behavior change. The Virtual Wellness Series is a larger outreach effort to improve nutrition and wellness in our community. Engaging participants to improve dietary habits encourages them to take ownership of their own health. By providing virtual programs the nutrition team can cover a larger geographic area, including rural areas, work around busy schedules, and increase participation over in-person programs. The virtual survivorship wellness series is offered twice annually, an hour weekly for six weeks, and the virtual wellness series is a 30-minute session monthly, alternating between webinar-style lunch and learns or teaching kitchens. A 10-question survey was emailed to all participants for any of the events offered between August 2022 and August 2023. The survey questions assessed changes in dietary habits pre and post virtual nutrition education. 76% of respondents reported improvements in at least one category. Notably, the most improvement was seen in overall diet and frequency of physical activity. Results of the survey show an overall improvement in healthy lifestyle habits from participating in virtual nutrition outreach programs. Of note, the original sample size was relatively small with 17 of 60 surveys returned. In the future, it may be worth examining findings over a longer period, thus increasing the number of respondents.

P506 IMPLEMENTING CONTINUOUS CARE PROGRAM AND STREAMLINED CARE TEAM COMMUNICATION TO REDUCE HOSPITAL READMISSION AND EMERGENCY DEPARTMENT VISITS

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Coordination of Care
Hospitalizations account for one-third of the total money spent on health care in the US. A substantial fraction of all hospitalizations are patients readmitted within 30 days of discharge. These rehospitalizations are considered costly, harmful, and avoidable. This project was conducted at a specialized cancer hospital to reduce hospital readmission and Emergency Department visits post-chemotherapy which are reportable quality measures. The purpose of this quality improvement project is to improve readmissions and Emergency Department (ED) visit performance metrics established by the organization to meet CMS reportable quality metrics. The hospital in fiscal year 2022 had a readmission rate of 10.91% against the target goal of 10.35%. Similarly, the ED visit rate was at 6.55% with a goal of 4.50%. The objective was to develop a standardized process to reduce variations in care by enrolling patients in the hospital’s Continuous Care Program. Moreover, the care team postulates that if patients are attributed correctly and the provider is timely notified, follow-up care will be expeditious, and readmissions will decrease. The interventions included a three-pronged approach to the management of patient care post-treatment. First is a standardized process for Continuous Care Program patient enrollment and follow-up for outpatients. It offers an additional layer of support for oncology patients with chronic conditions. The patient who qualifies for the program is assigned a nurse who establishes a care plan and tracks progress toward goals. Secondly, a better communication process between the clinics and ED. This involved enhancing a system process of communication by utilizing Secure Health Messages in the EHR by the ED staff to the clinic. Lastly, is the utilization of an Inpatient discharge follow-up call and referral to criteria-based management. The project design was a pre and post-intervention analysis. Results showed a reduction of readmission rate by 28% and an ED visit rate of 53% in Q1 2023 from the 2022 baseline. The interventions allowed for additional patient comorbidities management and support not always directly associated with cancer diagnosis, hence, contributed to improved quality of life, decreased complications, and reduction in hospital visits. The development of multicomponent interventions reduces readmissions through improved care discharge planning and care transition, and enhanced patient education/support for self-management. The standardized processes and streamlined communication allowed for better management of patients’ medical conditions that commonly precipitate readmission.

P507 WHO IS RESPONSIBLE? DEVELOPMENT OF A COMMITTEE FOR EXPIRATION MANAGEMENT OF MEDICAL SUPPLIES IN AN AMBULATORY CARE SETTING

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Cancer Center, Phila, PA

Efficient management of medical supplies is crucial for ensuring quality patient care and controlling costs within healthcare facilities. It was identified that a comprehensive approach to establishing par levels for medical supplies and implementing a systematic process for monitoring expiration dates was needed after disposal of copious quantities of expired supplies. Supply management prevents the use of expired medical supplies, which could compromise patient safety and regulatory compliance. Ambulatory care clinics span three clinic locations and house an excess of fifty clinic rooms. The potential of ten different disease sites, both medical and surgical, practicing out of these clinical areas happens daily. Some clinics do planned procedures including scopes and internal exams, while others accommodate post-operative surgical issues. Due to the variety of clinics sharing space, the rooms were often overstocked with supplies leading to expired and wasted items. Multiple workflows were attempted for the supply management. A schedule of twice weekly checks with a two-person sign-off on clinic rooms was first attempted. This process quickly became cumbersome, and staff became noncompliant. The next step was to invest in locked supply carts to house all the medical supplies. Evaluation of the project demonstrated the same problems existed within the carts after moving supplies from the rooms to the carts. In response, a team of medical assistants (MAs) and RNs assembled to discuss ideas on management of the supplies and producing a system of checking the carts and preventing overstocking. The team consisted of majority MAs with an RN resource. They developed a workflow in which the carts were checked once a month, and supplies expiring by the end of the month were placed in a separate bag for first use. Supply Carts are currently checked once per month and recorded in a central location. Each cart has a team member assigned, and compliance is measured by our weekly regulatory checks on random carts. The maintenance of carts supplies expiring by the end of the month were placed in a separate bag for first use. Supply Carts are currently checked once per month and recorded in a central location. Each cart has a team member assigned, and compliance is measured by our weekly regulatory checks on random carts. The maintenance of carts has been established and has shown improvement in supply expenses, staff satisfaction, survey readiness, and of most importance, patient safety. Through this committee’s development, we have removed the risk of using expired items on patients and drastically reduced wasted medical supplies.

P508

UTILIZING AN INTERNAL NURSE FLOAT POOL PROGRAM TO MEET STAFFING NEEDS IN A

COMMUNITY ONCOLOGY PRACTICE: A PILOT PROJECT

Jennifer Sassano, MSN/MHA, MSP-BH, RN NE-BC, OCN, Texas Oncology, Dallas, TX; Lance Ortega, MBA, BSN, RN, OCN®, Texas Oncology, Keller, TX; Rhonda Boren, BSN, RN, OCN, Texas Oncology, Dallas, TX; Sabrina Q. Mikan, PhD, RN, ACNS-BC, Texas Oncology, Austin, TX

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and implementation of the FPRN program is empowering clinics to meet the needs of their nursing staff and patients while still maintaining a cost conscientious budget. Additionally, at less critical times, clinic RNs are able to take time off, ultimately preventing burnout and improving job satisfaction. This program is ongoing and has built trust and positive experiences.

P509

CLINICAL TRIALS INFUSION NURSE LIAISON: BRIDGING THE GAP BETWEEN CLINICAL RESEARCH COORDINATORS AND NURSES TO IMPROVE WORKFLOWS AND INCREASE JOB SATISFACTION
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Oncology Nursing Practice

Oncology Clinical Trials Infusion (CTI) treatment plans are complex, and nurses must be able to interpret and initiate orders in a timely manner. In an NCI-designated Comprehensive Cancer Center, fifteen CTI nurses treated between forty to fifty clinical trials patients per week in addition to oncology / non-oncology infusions which averaged around 100 per day. Non-nurse clinical research coordinators (CRCs) built CTI treatment plans in the Electronic Medical Record (EMR) and had creative freedom over layout and wording. Variability in treatment plan builds led to more errors and nurse burnout from clarifying orders several times per day. In-services were not routinely part of CTI nurses’ training, and nurses expressed frustration at the lack of education. Nurses were increasingly dissatisfied and requested a program redesign. The purpose of the CTI Nurse Liaison is to coordinate education and facilitate standardization of CTI treatment plans which is essential to the successful implementation of study protocols and increased CTI nurse satisfaction. In collaboration with the Clinical Trials Office, Investigational Drug Services pharmacy, informational technology (IT) team, and the CTI Nurse Liaison, a new CTI treatment plan template was designed to assist CRCs in a more standardized treatment plan build aimed at preventing errors. Once treatment plans were built, a designated CTI Nurse Liaison bridged the gap between CRCs and nursing by reviewing orders and providing feedback before the treatment plan build was finalized. Institutional Review Board (IRB) Nursing Fact Sheets were centralized in an electronic location that was easy for nurses to access and in-service training protocols were restructured to meet the demands of new clinical trial protocols. Prior to project implementation, 8% (N=13) of the CTI nursing team reported feeling satisfied with the existing treatment plans; 0% reported feeling satisfied with the education they received prior to new trial rollouts. After redesign, 75% of nurses (N=12) reported feeling very satisfied with new education processes while 100% of nurses were very satisfied with the direction in which the treatment plan rebuild and standardization was moving. The implementation of the CTI Nurse Liaison improved the treatment plan build process and education readiness resulting in increased satisfaction of the CTI nurses. Additionally, the program redesign increased the collaboration between CRCs and CTI nurses and consequently strengthened the CTI program.

P510

LET’S TAKE A POLL...CAN BI-WEEKLY CHART AUDITS AND STAFF EDUCATION DECREASE CERTAIN QUALITY INDICATORS?
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Oncology Nursing Practice

From a Mid-Atlantic Oncology Hospital which is part of a larger urban health system it was noticed that CLABSI, CAUTI and Patient Falls were on the rise. Many interventions had been tried to assist with decreasing these rates, including “Bundles” of interventions to support reducing these Quality Indicators. The overall Purpose is to decrease CLABSI, CAUTI and Patient Falls by implementing intervention bundles to increase awareness. Bi-weekly chart and patient audits began in November 2022 by the Clinical Practice Leads (CPL). Chart audits reviewed the documentation of the staff regarding these quality measures. Values including date of central line dressing change, current assessment of Fall Risk, application of a Chlorhexidine Gluconate (CHG) bath if the patient has a Central line, a urinary catheter or patients in Critical Care are some of the bundle items that are collected in the audits. Once the medical record review is complete, actual patient audits are performed to determine the accuracy of the records. What does the central line dressing look like? Are there dependent loops in the urinary bag tubing, or is the urinary bag on the floor? Does the patient have a yellow “Fall” bracelet or yellow anti-skid socks...
on if they are a High Fall Risk? One of the items that is interesting is asking the High Risk Falls patient, do they understand what High Risk means. Many of the patients do not feel or understand why they would be considered High Fall Risk. The facility also made these three quality measures part of every nurse’s annual evaluation. Nurses recognized that the CPLs were on the units to complete audits and would proactively have central line dressings changed, urinary catheters discontinued and CHG baths completed. Everyone in the Nursing Department is aware of what is required in each “Bundle” and are sharing the responsibility to maintain the patient’s care regarding these quality measures. Chart and patient audits continue bi-weekly in pursuit of improving the Quality measures. The Nursing Department is hoping to find the answer for the increase in those Quality Measures and are anticipating a favorable outcome within the year.

P511 PREVENTING MYELOSUPPRESSION: STANDARDIZING THE PROCESS FOR PATIENTS INITIATED ON PARP INHIBITORS
Alison Schmitz, DNP, FNP-BC, Stanford Health Care, Palo Alto, CA
Oncology Nursing Practice
PARP inhibitors are increasingly becoming a more common form of therapy in the first line and recurrent setting for ovarian cancer patients. These oral chemotherapy agents are taken long-term and require ongoing evaluation and monitoring for side effects and toxicity, particularly in the first four weeks of initiation. The setting where this quality improvement project was conducted currently has a standardized process for providing education to patients receiving IV chemotherapy, but lacks an adequate process for oral treatment. A standardized process is critical to ensure patients do not experience the negative side effects of PARP inhibitors which could potentially include fatal myelosuppression. This project aimed to create a standardized process to prescribe outpatient oral chemotherapy to improve patient safety. Oral chemotherapy prescribed in the outpatient setting does not currently have the same level of monitoring as chemotherapies delivered in the inpatient or infusion treatment area. A chart review of patients on PARP inhibitors was performed. A standard workflow was developed for prescribing oral chemotherapy and roles were assigned for each step in the process. A checklist was developed within the electronic medical record which could be utilized by all team members and allowed clear visualization of which actions had already been completed and what still needed to be done for patients initiated on PARP inhibitors. Due to the limited number of patients on this medication, thirteen charts were reviewed prior to the intervention, and five were post-intervention. Of the sixteen categories reviewed for the chart review, there was a positive result in ten categories post-intervention, no change in two, and a negative result in three. The results were promising for overall improvement of patient safety. For the categories there was a decrease in post-intervention, including week two and four labs, the chart review revealed there was a delay in labs as therapy was held due to toxicities, showing the tool was actually effective in preventing continued use when harmful. In creating a standardized process for patients initiated on oral PARP inhibitors, standard work was assigned to each team member, and a new chemotherapy checklist and flowsheet were created for the electronic medical record. Documentation quality improved and increased visibility across team members, as well as improved patient safety.

P512 CAR OF ONCOLOGY PATIENTS WITH BARIATRIC NEEDS
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Coordination of Care
The care of patients in a large NCCN designated cancer center is complex and demanding relative to the oncologic diagnoses. Patients for whom there are bariatric needs face increased challenges to achieve the best health outcomes. Literature confirms this population often suffer increased admissions to the hospital with subsequent morbidity and mortality. Organizationally patient safety as well as staff safety should be equally prioritized to decrease risks of injury. The purpose was to assess and acquire appropriate bariatric supplies and equipment in support of patients’ safety and ease of mobility as well as promote assurance of staff best practices for safe handling. A patient safety event brought focus to the complexity of care delivery for patients with bariatric needs. An organizational team was convened to assess opportunities for provision of oncology care that included members from Infusion, lab, physical therapy, patient safe handling team members, nurse leadership and purchasing and equipment procurement team. Nurse led assessment across the comprehensive cancer center yielded analysis of changes needed and recommendations for safest practices for patients and staff. A policy was created with location and equipment specifications detailed. A strategy was
adopted of consolidation of care delivery within the center to streamline patient movement in the clinic. Guidance was developed to standardize how to arrange for required equipment acquisition. A plan was established for emergency response and transport practices for best mitigation of urgent patient needs. Dissemination of new policy and implementation standards was shared across operational areas. The efforts of planning for care needs of bariatric patients evidenced the broad range of disciplines and areas of administration essential in providing a safe environment with regulatory and facilities implications for equipment use. Cross disciplinary team consultation provided assurance of accordance with national safety standards and facility safety.

P513 IMPLEMENTATION OF A PHARMACY/NURSING WORKGROUP TO PROMOTE INTERDEPARTMENTAL COLLABORATION AND ADDRESS BARRIERS TO SAFE AND EFFICIENT PATIENT CARE

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Patient Education and Safety

Interdisciplinary collaboration is critical for safe and efficient patient care in oncology. The Pennsylvania Hospital Infusion Unit, with 27 chairs and an average of 60 patients/day, sees rare oncology types requiring unfamiliar and complex protocols and sequences of chemotherapy administration. Administering these unusual protocols and sequences was a barrier to safe and effective patient care because nurses needed to frequently take time to read up on the protocols to understand what they were doing. The Oncology Nursing Society encourages nurses to elevate their problem-solving skills to develop innovative solutions to the challenges they face. The Infusion Unit nurses, with the support of clinical leadership, developed a nursing-pharmacy workgroup to increase collaboration between the disciplines to improve safety and increase the efficiency of care. Pharmacists and clinical nurses on the Infusion unit began to meet monthly. Unit leadership ensured that involved staff was able to convene with dedicated time, free from patient care thanks to the unit’s existing culture of covering staff for shared governance work. Ideas and concerns along with proposed solutions are elicited from all members of staff via huddles, staff meetings, and email. Solutions and improvements are found utilizing evidence-based practice with the help of an oncology educator and librarian. A process was designed to standardize communication of infrequently seen regimens utilizing an electronic medical record feature. It has been useful in improving the quality of patient care on a unit where complex and ever-changing toxic drugs are given. This workgroup has led to more than 5 additional quality initiatives including negotiating a safe way to increase automated drug dispensing technology to increase efficient medication dispensing while ensuring safe stocking and labeling practices. Since it began in January 2022, this workgroup has driven change in patient care and improved processes on the unit. Nurses with ideas to improve their workflow had no outlet to bring their solutions to practice. By creating this workgroup, a formalized outlet was provided for safety concerns. This patient safety initiative has demonstrated the importance of sustained teamwork. It has shown that everyone around the table must share knowledge about safe patient care to provide an immediate and positive impact on patient safety outcomes.

P514 A COLLABORATIVE APPROACH TO REDUCING ONCOLOGICAL MEDICATION NEAR MISSES

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Patient Education and Safety

Imbert Cancer Center is a thirteen-chair outpatient infusion center which is a part of the Northwell Health Cancer Institute. This site averages 738 treatments per month, annually about 9000 treatments. Medication safety is at the forefront in all of healthcare, however, with the high risk medications like chemotherapy this becomes a primary patient safety initiative. Near misses could potentially cause significant detrimental events, especially when linked to prescribing chemotherapy/immunotherapy. Our purpose is to significantly reduce the frequency of prescribing near misses to mitigate the potential harm to patients. In the first quarter of 2023 a problem was identified at Imbert when the site was averaging 5% of near misses. The team began to drill down on the data at both the site level and up through the Cancer Institute’s Medication Safety Committee which highlighted medication prescribing as an area of opportunity. Data was electronically collected...
and collated by the type of prescribing near miss category. Omission of any element of the medication order showed as the area of highest incidence. Data was tracked and trended from January through June 2023. Some immediate corrective actions were implemented at the site which included protecting time for prescribers who were on hospital service to enter orders and to have the practice nurses play a more pertinent role in the order prep and review of patient cycles. In addition, a weekly multidisciplinary huddle was implemented for medication ordering review, which is inclusive of providers, pharmacists, nursing, advanced care providers, and operations. The Practice nurse would lead the huddle as each patient was reviewed and discuss any discrepancies at that time. This allowed the provider to review in real time and either discuss the change of order or revise the order in real time. Prior to any of the interventions being implemented the site was averaging 5% of orders meeting near miss criteria. April near misses peaked at 6.8%, therefore, the intervention plan was developed and implemented. Implementation of the corrective action plan commenced mid-May which yielded slight improvement to 4.56%. Through consistent revisions and team buy in June was successful having the rate of near misses drop significantly to 2.75%.

P515
MELANOMA PATIENTS’ PERCEPTIONS OF HOSPITAL AND HEALTH MAINTENANCE ORGANIZATIONS (HMO) RELATIONSHIP
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Cooperation of Care
The advancement in melanoma treatments like BRAF-MEK inhibitors and immunotherapy over the past decade has significantly enhanced survival rates for stage III and IV melanoma patients, shifting much of the oncology management from hospital settings to community clinics due to reduced toxicity and less frequent hospital visits. This study explores melanoma patients' perspectives on the competency of community clinic medical staff in managing treatment toxicity and follow-up. A total of 65 stage III-IV melanoma patients (19 males, 36 females, average age 67) undergoing immunotherapy or BRAF inhibitors between April 2020 and July 2023 from the Ella Lemberbaum Institute for Immuno-oncology participated. They completed a 5-item questionnaire assessing their experiences and expectations from community clinic staff regarding oncology care, and the services utilized during their treatment. The study received approval from Sheba Medical Center IRB (approval #SMC-6822-20). Patients largely viewed the coordination between hospital and HMO clinics as minimal to moderate, scoring an average of 2.5 out of 4. They reported limited engagement of HMO doctors and nurses in their oncology treatment, with a score of 2.4 out of 4. A desire for enhanced involvement of HMO medical staff in their treatment process was expressed, averaging a score of 3.5 out of 4. Primarily, HMO services were used for blood test referrals and form completions. Patients acknowledged the benefits of having HMO staff address melanoma-related concerns for better availability and holistic treatment. A notable communication gap exists between HMOs and hospitals, encompassing both systemic/technological and clinical aspects. The systemic issue relates to disjointed medical files and inadequate information transfer, often burdening patients, while the clinical aspect includes HMO family doctors and nurses' insufficient knowledge and confidence in handling oncology patients' needs. Addressing these gaps is vital for enhancing melanoma patients' care experience. It's recommended to form multidisciplinary teams to understand and mitigate these gaps, and extend this study to non-melanoma cancer patients to map their needs and perceptions further.

P516
OPTIMIZING BLOOD TRANSFUSION ADMINISTRATION FOR STEM CELL TRANSPLANT PATIENTS
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Oncology Nursing Practice
An important component of supportive care for stem cell transplant (SCT) patients is blood transfusion. On an inpatient, academic SCT unit there were several barriers identified that lead to delays in transfusion administration. These barriers include delays in obtaining consent with each hospitalization, delays with administration of premedications prior to platelet infusion, and communication between blood bank staff and unit staff. Current communication practice consists of blood bank staff calling the unit to notify any
registered nurse who answers that a blood product for a particular patient is ready to be transported to the unit. However, often these notifications are not reported to the primary nurse leading to the blood product arriving without warning or the knowledge of the nurse and delaying blood product administration. The purpose of this project is to implement and evaluate the effectiveness of blood transfusion process improvements on an inpatient SCT unit. Multicomponent interventions include a new “Hematology/Oncology Diagnosis & Treatment - based Consent” to cover all transfusions given as part of a treatment course in an outpatient or inter-system hospital setting lasting one year. An evidence-based policy change that omits the current practice of Tylenol and Claritin premedication prior to platelet transfusions unless the patient has a history of multiple allergic transfusion reactions (ATR) or ATR with moderate symptoms. Lastly, an exploration of a new direct communication method between blood bank and unit nurses that utilizes the electronic medical record “secure chat” feature or secure Vocera Vina phone app chat feature. Outcomes measurement will include the frequency of documented transfusion reactions with omission of routine premedications, time between release and administration of blood products at bedside, and satisfaction with the new processes between blood bank and nursing staff.

**P517**

**IMPROVING TIMELINESS OF CARE FROM BREAST CANCER DIAGNOSIS TO TREATMENT**

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**Coordination of Care**

Timely diagnosis is critical to oncology care and support. Post pandemic, scattered and ineffective support and coordination of breast cancer patients increased average time from diagnosis to treatment to 148 days. One breast center in our system, NAPBC accredited, had the support necessary to provide coordinated care from diagnosis to treatment in 86 days. The purpose of this program was to evaluate and implement a comprehensive program that delivers coordinated services for screening, diagnosis, and therapy. This program emphasizes the delivery of accessible, high-quality services, accessible across the continuum of care and our system. The secondary purpose, to advance our oncology navigation program and increase breast cancer patient access to navigation services. Each program was evaluated using patient journey mapping and feedback from patient focus groups. Multidisciplinary teams were designed to address areas of impact and goals. Members consisted of individuals from all areas of our system, primary care to oncology. The Lean system was used; one parent, five plan, and twenty-four project A3s were developed to achieve the objectives. The Patient Journey team focused on timing of oncology navigation, patient access and feedback. Patient and Family Support team focused on education, DME access, complementary care, lymphedema surveillance, survivorship, and support groups. Imaging team focused on improving access and timeliness to breast imaging services and diagnosis of breast cancer. Infrastructure team evaluated clinical trial process, development of high-risk breast clinic, NAPBC accreditation, system education, and breast conference advancements. Using Epic, a Breast Program Dashboard was created and used to monitor 25 KPIs. All KPIs had significant improvement. Timeliness to care was most significant, down to 83 days in 8 months. The placement of oncology navigators at diagnosis instead of the cancer centers had the most impact on timeliness. Placing the navigators earlier in their journey improved coordination of care, timeliness of services, and relationship development. This program, and supporting KPIs, showed the value of a multidisciplinary team working together to evaluate and improve processes and systems. Ultimately, the importance and impact of nurse navigation and the significance of human connection and support through an oncology journey no matter the processes in place became undeniable. The second most significant impact on timeliness was the development of a same day process for screening mammogram to diagnostic and biopsy if needed.

**P518**

**CLOSING THE LID ON STAFF EXPOSURE TO HAZARDOUS DRUGS AND MULTI DRUG RESISTANT ORGANISMS**

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**Patient Education and Safety**

In 2019, the Centers for Disease Control (CDC) updated guidance on the prevention of healthcare-associated infections. One strategy for lowering hospital acquired infections includes reducing the risk of spread from water sources. Multi-drug resistant organisms
(MRDOs) stick to pipes forming biofilms and can live in drains for an extended time. Patients and staff can be exposed to these MRDOs through splashing water. The CDC recommends installing toilet lids in patient bathrooms to prevent spread of MRDOs. Additionally, for patients receiving hazardous drugs (HDs), toilet lids provide additional protection to staff from splashing water. Based on the above CDC recommendations, hospital epidemiology determined that inpatient bathrooms in our institution have toilet lids installed. At our institution, bathrooms did not have toilet lids and did have a rinsing wand for nursing staff to rinse patient waste containers. Installing toilet lids interfered with using the rinsing wand. In order to proceed with the Toilet Lid Project, the Oncology Clinical Nurse Specialist and Educators, in partnership with Hospital Epidemiology, Facilities, and the Nurse Liaison for Central Hospital Supply, developed plans for proceeding with installation of the lids, removal of the wand, and use of biodegradable products. This project consisted of two phases. The first phase evaluated the biodegradable waste containers. These products were single use only except when using a plastic liner with the bedpan or bedside commode container. After this pilot was completed, a second pilot evaluated using our current plastic products for a limited period of time and then disposing them in the biohazard trash. Daily huddles were used to gain support for this change and educate staff on expectations; posters were deployed as reminders and standards for frequency of disposal was written into policy. Nurses, patient care technicians, and housekeeping were asked to provide feedback on both pilots. The biodegradable pilot was met with dissatisfaction by nurses, housekeeping and patients. In addition, concerns were raised that the products would clog the sewage system. The second pilot was met with better success and this plan is the one currently being implemented in the hospital. Toilet lids have been installed and rinsing wands removed. The decision to keep the plastic waste containers and dispose of them on a schedule has been sustainable.

P519
CYTOTOXIC MEDICATION SAFE HANDLING POLICY REVISION AND IMPLEMENTATION PROJECT AT THE BUGANDO MEDICAL CENTRE IN MWANZA, TANZANIA
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Oncology Nursing Practice
In Tanzania there are approximately 60,000,000 people, 50% of whom live on $1.90 per day, qualifying Tanzania as a low-or middle-income. Low-middle income countries (LMICs) experience greater disparities in cytotoxic medication safe handling practices and higher staffing shortages when compared to high income countries. Bugando Medical Center (BMC) is experiencing high nurse staff turnover and is difficulty hiring new staff secondary to fear of cytotoxic drug (CD) exposure and lack of education on safe handling practices. The purpose of this presentation is to describe the site assessment and unique process in creating the cytotoxic medication safe handling policy revision for BMC. The implementation and evaluation are future steps in the process and will not be a part of this current discussion. The first author did a site assessment of BMC in January 2023 to evaluate CD safe handling practices and resource availability. Staff were handling CDs without use of PPE, mixing CDs at the patient’s bedside, handling and disposing of excreta and emesis from patients without disposal or cleaning protocols. A policy was written specific to BMC capabilities, needs, desires, and resources. The policy includes a definition of, and risks associated with, handling CDs, as well as the PPE types required per activity, procedures on cytotoxic drug preparation, administration, disposal, linen/excreta/spill management. Procedures detailed in the policy are derived from current and safe handling guideline recommendations as well as input from four content experts. The plan is to implement the policy in the Spring of 2024 following a staff educational session on the practice changes such as medication handling, oncology pharmacy procedures, administration and mixing protocol, drug labeling, surface cleaning, and spill recommendations. To evaluate (which will not be presented) the educational session and policy implementation there will be a pre/post survey adapted from the revised Hazardous Drug Questionnaire (2012). This policy and its implementation will constitute a significant change in practice for BMC staff throughout the hospital. The challenge with any project on safe handling, especially in an area where resources may be limited, is to make sure staff are staying as safe as possible by following current policy but also making it attainable to the daily resources available at the institution; this ensures the adoption and sustainability of the policy.

P520
MONITORING ORAL CHEMOTHERAPY ADHERENCE AND BARRIERS TO TREATMENT
As the number of available oral oncologic agents continues to increase, more patients are self-administering treatments at home. With this shift, we potentially lose guardrails and monitoring systems that are present when patients receive treatments in the infusion suite. Lack of ongoing assessment may lead to increased symptom burden, unplanned admissions, or noncompliance with treatment. The purpose was to increase the frequency and accuracy of adherence monitoring for patients receiving oral chemotherapy. By utilizing ongoing and thorough assessments side effects, toxicities, and other potential barriers to adherence can be identified and addressed. As our organization was switching to a new medical record system, we identified an opportunity to integrate the oral chemotherapy adherence screening electronically; thus, streamlining how adherence is assessed as part of our medication reconciliation during the rooming process. For patients using the online portal, the adherence questionnaire was sent before their office visit if the provider used a treatment plan to order their medication. For others, the questionnaire would be reviewed with the patient during the rooming process with every office visit or a minimum of every thirty days. Use of the adherence questionnaire facilitates easily viewable results by the healthcare team and allows identification of trends over time. Oral Chemotherapy adherence was audited during June, July, and August of 2023 showing the presence of documentation in 68%, 65%, and 67% of oral chemotherapy patients respectively. Due to provider concerns with the feasibility of using the treatment plans for oral medications, there was no significant use of the online portal functionality. Providers opted to order oral chemotherapy directly via order entry to streamline their process, and the trigger to send the questionnaire was bypassed. Team members have found the process user-friendly and appreciate the ability to trend responses. With a variety of staffing models and workflows used across our network, education and communication were essential to effectively implement the tool at each location. Incorporation into the rooming process established a reliable cadence of completion and provided the physician with screening information before talking with the patient. There is an opportunity to work on improved use of the patient portal. This would be beneficial for those on maintenance therapy, who may be seen in the clinic less frequently yet could be screened more often.
Continuum of Treatment: From Hospital to Home

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Cooperation of Care

Blinatumomab is a bi-specific T-cell engager (BiTE) monoclonal antibody that binds to CD19 on B-cells and CD3 on T-cells to cause production of cytolytic proteins, release of inflammatory cytokines, and T-cell proliferation and subsequent cytotoxicity. It is approved for CD19(+) B-cell Acute Lymphoblastic Leukemia patients with minimal residual disease (MRD) or relapsed/refractory (R/R) disease. Blinatumomab is administered as a continuous IV infusion for 4 weeks straight, with a 2-week break in between cycles. Hospitalization is recommended for the first few days of Cycles 1 and 2 to ensure the patient does not have any signs or symptoms of cytokine release syndrome or neurotoxicity. As of September 2022, the remainder of Cycles 1 and 2, along with subsequent cycles, are able to be given outpatient. Upon discharge, patients are connected to a Continuous Ambulatory Delivery Device (CADD) pump and complete the remaining treatment at home, with follow ups in the infusion center. A relationship was built to bridge the inpatient treatment team with the outpatient infusion area. A multidisciplinary team, including the inpatient oncology program coordinator, inpatient clinical pharmacist, infusion center clinical manager, and outpatient clinical pharmacist, coordinated the effort to implement a discharge education plan in order for patients to complete Blinatumomab treatment as an outpatient. Over 80% of the Oncology inpatient nurses have been trained on the set up and use of the CADD pumps. Prior to admission, the multidisciplinary team is notified in order to prepare for the patient’s discharge upon admission. In order to facilitate a safe discharge while on continuous cytotoxic therapy, the program coordinator and inpatient clinical pharmacist provide the patient with education regarding how to monitor for side effects while at home, along with the use and maintenance of the CADD pump for the duration of treatment. Through the development of the discharge process for patients on Blinatumomab, it is estimated that our hospital saved $2.6 million on inpatient stay days from September 2022 through July 2023. Patients have also reported improved quality of life and improved recovery with being able to rest and recover at home for the duration of their treatment course. Over the course of 10 months, the Blinatumomab bridge program has enhanced care and satisfaction for the patient, while improving outcomes and patient throughput for the hospital.

Chemotherapy Education: Advanced Practice Providers Role in Improving Patient Outcomes During the Initiation of Chemotherapy for New Diagnosis

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Patient Education and Safety

Chemotherapy education for patients is one of the key components of high quality cancer care. A search of the literature revealed that a designated chemotherapy education visit can help to reduce side effects, anxiety, and ensure proper follow up after treatment. Advanced Practice Providers (APPs) have increasingly become an integral part of the oncology care delivery team. The literature has shown that APPs are predominantly involved in direct patient care including counseling, management and follow up. Infusion center nursing staff at NYU Langone Long Island identified knowledge gaps in patient’s at their initial chemotherapy infusion appointments. This often required additional teaching and longer infusion center visits. An interprofessional team including nurse practitioners, office nursing staff and infusion center nursing staff was formed to standardize the chemotherapy education process and to assist in decreasing the knowledge gap in patients. APPs would conduct a chemotherapy designated education visit to discuss adverse side effects, follow up, management of symptoms and to ensure all requirements to start treatment were fulfilled. A smart phrase was utilized to complete a visit note. Office nursing staff created folders to ensure all patients received the same standardized information. A survey was provided to breast cancer and genitourinary oncology patients to assess whether they were offered a designated chemotherapy visit and if it was found to be beneficial. Patients were able to report back understanding of their treatment schedule and potential adverse effects. Nursing found that patients who did not receive chemotherapy education visits had more questions and felt less prepared for treatment. This often times lengthened treatment time. Chemotherapy education visits were found to prevent the delay in treatment times due to making sure all necessary follow ups were completed to start.
The current study showed that there was a benefit to having patients scheduled for a designated chemotherapy education visit. Patients were able to manage symptoms at home, and overall felt prepared for their first infusion visit. This project was a pilot to show the benefit of designated chemotherapy education visits for our patient. We would like to use the data from this study to determine whether a designated chemotherapy education visit conducted by an APP helped to reduce treatment anxiety and delays in treatment.

P524
YOU CAN’T DO A GOOD JOB IF YOUR JOB IS ALL YOU DO
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Professional Development
Onconcology nursing experiences a high burnout rate compared to other specialties. Outpatient infusion staff report poor work life balance and dissatisfaction related to their schedule. There needs to be a method that enables employees to self-manage their life and work schedules aligning with departmental functions in a safe and equitable manner. The project aims to develop a self-scheduling system at a large academic institution to increase employee satisfaction and reduce turnover. Partnering with staff to develop guidelines that meet clinic needs and staff requests can positively impact staff sense of autonomy and satisfaction leading to improved staff retention. Formation of a staff-led scheduling committee including one unit leader representative. Through the committee, scheduling guidelines for the infusion department were created. Before each schedule is published, the committee balances clinic needs accounting for staff requests. If staff requests are not able to be met, the staff member is sent an email with resources available to assist them in finding coverage. The staff have an active voice in selecting their schedule. They have a sense of empowerment to determine their shifts which in turn has led to positive outcomes. The scheduling committee has been able to do the following:

- Reduce moving staff’s day off requests to once per six-week schedule block
- Create a winter holiday sign up and time off requests that are completed 4 months in advance giving staff time to coordinate declined requests with PRN staff
- Help staff navigate the scheduling platform
- Empower staff to escalate issues they are facing

- Encourage staff to approach the committee with their scheduling challenges

Staff can feel empowered to use self-scheduling by utilizing the department self-scheduling guidelines. A partnership between staff and leadership to accommodate requests can improve staff satisfaction and work-life balance. Additional data needs to be collected to see how improving self-scheduling correlates to increased retention. This is an ongoing project.

P525
ESTABLISHING AN INFRASTRUCTURE TO ADDRESS CRITICAL CANCER DRUG SHORTAGES THROUGH MULTIDISCIPLINARY COORDINATION OF CARE
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Coordination of Care
Drug shortages are a national recurring problem. Congress has passed legislation requiring manufacturers to provide the FDA with notification of drug shortages, but has not mandated specific steps to alleviate the problem. As a community cancer care delivery system, there was a need to establish how we communicate and address critical cancer drug shortages. The Senior Oversight Drug Shortage Committee was developed utilizing guidance from American Society of Health System Pharmacists (ASHP). This multidisciplinary team met monthly to identify, address and monitor critical drug shortages. The need to standardize communication and action guidelines across the system, the establishment of regional oncology pharmacy buyers and the creation of a centralized inventory data source were identified. Criteria for communicating drug shortages to clinicians were established (Figure 1). The SODPST was notified of the Carboplatin shortage April 2023 and data was collected on which patients are on Carboplatin (two-week time period). The list identified 218 patients on Carboplatin across the infusion sites. Physician leaders then identified 51 patients as curative intent or adjuvant. Drug was prioritized for these patients. Therapeutic alternatives with Cisplatin were considered for remaining patients and 3-5 new starts were delayed by 1-2 weeks. Additionally, alternative dosing schedules and decreasing AUC assisted in managing the drug inventory. Inventory on
hand was closely monitored. This allowed for adaptive and quick shift of supply as needed to priority sites and patients. With these measures, our drug supply never reached zero and these countermeasures were in place for 4-6 weeks until drug supply improved. Additional opportunities were identified to establish regional oncology pharmacy buyers, and centralize the inventory monitoring system given the manual process of tracking inventory. A centralized inventory monitoring system is being established for Spring 2024 with the goal of streamlining the monitoring process. Establishing a multidisciplinary system infrastructure can streamline how community sites address this critical issue. Measures to reduce waste, ensure continuity of treatment and communicate information regarding drug shortages in this shifting environment requires multidisciplinary coordination. Through this work on drug shortages, gaps have been identified on how we approach and monitor drug shortages through communication and action guidelines and the addition of oncology pharmacy buyers. The centralized inventory software will hopefully automate an otherwise manual process.

**P526**

**IMPLEMENTATION OF CYCLE 1 DAY 1 FOLLOW-UP CALL BY RN FOR PATIENTS WHO RECEIVED INITIAL CHEMOTHERAPY AND/OR IMMUNOTHERAPY INFUSION**

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Oncology Nursing Practice

The American Cancer Society (2023) estimates a little over 1.9 million new cancer cases will be diagnosed in the United States in 2023. Chemotherapy and cancer care have significantly changed over the years, allowing patients to receive cancer treatment in ambulatory settings. Many newly diagnosed cancer patients receive their initial chemotherapy in the outpatient clinic and are discharged home immediately after completion. This can be intimidating for patients who may not feel adequately informed about how to differentiate between expected side effects and possible adverse reactions to treatment while at home. Many of these side effects are self-manageable, however, some patients end up in the emergency department (ED) due to a lack of education. The purpose of this quality improvement project was to implement a standardized follow-up nurse call after patients’ initial chemotherapy treatment to assess patients for side effects and educate patients on symptom management to prevent or limit their use of the ED. The authors created a script and flowchart for nurse-initiated follow-up calls to triage whether patient symptoms were mild, moderate, or severe. Five chemotherapy/biotherapy nurses participated in this quality improvement project from October 2022 to June 2023. During this period, 45 out of 54 first-time chemotherapy patients received telephone follow-up. Appropriate documentation of follow-up calls was recorded in Microsoft Excel and the EMR. Results demonstrated that nurses were 83% compliant in calling first-time chemotherapy patients. 91% of first-time chemotherapy patients who were called did not go to the ED. 22% of the patients who were not called went to the ED. Since the implementation of follow-up calls, nurses have been compliant in calling patients after their initial chemotherapy treatment. These calls have been an effective means of reinforcing patient education and connecting patients to doctors for further treatment. Of the 45 patients called, two with moderate to severe symptoms were evaluated in our clinic and escorted to the ED for a higher level of care. Five of the six patients who were not called were treated on a Friday. Nurses reinforced the on-call provider extension during off-site hours after patients completed treatment. Based on these results, nurses will call ten days later to educate patients further and to more accurately project patients’ symptoms.

**P527**

**NURSING TURBULENCE: HOW DECREASING WORKLOAD DECREASES PATIENT SAFETY EVENTS ON A MEDICAL ONCOLOGY UNIT**

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Oncology Nursing Practice

Nursing turbulence is the degree to which a nurse’s attention is diluted or redirected by thought diversions, resource inadequacy, communication breakdowns, or interpersonal relationships. An increase in nursing turbulence increases nursing workload and increases the occurrence of patient safety events. Nurses working on a medical oncology unit expressed a sense of frustration with increased workload caused by supply and equipment issues, and communication barriers. The purpose was to decrease nursing turbulence and workload; thereby increasing oncology nurses’ ability to provide safe and quality patient care. Nursing turbulence was measured with a 15-item survey, pretest and three posttests. Measuring thought diversion items,
inadequate resource items, communication breakdowns, interpersonal relationship items, and technology items. The top 4 factors identified were distractions, interruptions, equipment/supply issues, and delayed response time (WiFi and technology). The results guided ongoing interventions such as using a visibility board to inform staff of broken equipment, missing supplies and the status of resolution. The supplies were reviewed weekly, and an equipment room was renovated and given to staff for ease of access to equipment. A survey was administered to nursing staff prior to the beginning of the interventions, two months in, four months and a final test at six months. Interruptions and equipment/supply issues improved over the six months of implementation. Delayed response time improved slightly, while distractions did not improve and increased. Falls and medication scanning were evaluated over the period to capture patient safety events. The number of falls in 2022 was 43, and in August 2023 the number of falls for the year was 23, which is a 60% reduction in falls. Most of the recorded falls for 2023 were in the beginning of 2023 as the nursing turbulence project was starting to be initiated. Medication barcode scanning increased steadily from 65% Jan 2023 to 87% in Aug 2023, which is shown to decrease chances of medication errors. Through improving factors that lead to nursing turbulence, nursing workload will be decreased, leading to better patient outcomes. Although some factors of nursing turbulence improved, the results show that it is a continuous process of improvement.

**P528**

**Utilizing the Five A’s Model for Radiation Oncology Patient’s Tobacco Cessation**

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Oncology Nursing Practice

Research shows that continued tobacco use during cancer therapy can influence clinical response and result in subsequent cancers. First-line cancer therapy failure costs due to continued tobacco use during treatment are thousands of additional dollars. Analysis of the implementation site revealed an absence of evidence-based protocols during tobacco assessment and low referrals to the state’s quit line. This Doctorate of Nursing Practice (DNP) project used comparative data analysis to determine whether the verbiage of the Five A’s would influence the states’ referral rates for tobacco cessation. Imogene King’s Theory of Goal Attainment and Prochaska & DiClemente’s Transtheoretical Model (TTM) served as the project’s theoretical foundation.

Intervention: To appraise referral rates to the state’s quit line, forty-five radiation oncology patients who use tobacco were compared sixty days before and sixty days after implementing the Five A’s verbiage during tobacco history assessment. According to a chi-square analysis, cessation referral prevalence increased, although no statistical significance emerged (p<0.05).

This DNP project’s findings indicated that the referral rate rise is not statistically significant; however, provider documentation in the EMR increased significantly.

**P529**

**Preventing Central Line Bloodstream Infections: An Interdisciplinary Virtual Model for Central Line Rounding and Consultation**

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Oncology Nursing Practice

Central line-associated bloodstream infections (CLABSI) account for many harms suffered in healthcare and are associated with increased costs and disease burden. CLABSI are associated with an increase in length of stay, increase in cost, could delay anti-cancer treatment, and is associated with an increase in mortality in cancer patients. Oncology patients frequently require central venous access for cancer related treatment, such as prolonged course of intravenous (IV) antibiotics, chemotherapy, frequent lab collection, and parenteral nutrition. Central line rounds, like medical rounds, are a multidisciplinary bedside assessment strategy for all active central lines on a unit. In-person line rounds in this 144-bed oncology acute care setting are challenging due to a variety of unchangeable factors. The aim was to develop a process for addressing concerning central lines in this to create individualized plans to prevent infections. Additionally, our aim was to reduce the CLABSI standardized infection ratio (SIR). The project team designed a HIPAA-protected, text-based process for assessing central lines for risk factors contributing to infection. Staff initiated a consultation via a virtual platform with an
interdisciplinary team composed of oncology and infectious disease experts. The virtual discussion included recommendations for a line-related plan of care. The number of consultations averaged about five per month, with 27.4% resulting in the central line being removed, which is believed to have contributed to an overall reduction in infection rates. The CLABSI standardized infection ratio, a risk-adjusted measure which accounts for patient acuity and volumes, improved from 0.85 prior to the intervention (November 2020–October 2021) to 0.57 after the intervention (November 2021–August 2022), a 33% reduction. Our intervention led to a reduction in our CLABSI SIR, staff utilization of the consultation service, and an increase in the removal of central lines, which could have potentially contributed to infection. The Consultation service allowed to clinicians to have a clear individualized plan in place for each patient. Advocating for central line removal can be overwhelming for staff members, and staff verbalized that they felt supported by the CL Hotline in this regard. The CL Hotline also expedited the removal of central lines, which is believed to have contributed to an overall reduction in infection rates. The CLABSI SIR, a risk-adjusted measure which accounts for patient acuity and volumes, improved from 0.85 prior to the intervention (November 2020–October 2021) to 0.57 after the intervention (November 2021–August 2022), a 33% reduction. Our intervention led to a reduction in our CLABSI SIR, staff utilization of the consultation service, and an increase in the removal of central lines, which could have potentially contributed to infection. The Consultation service allowed to clinicians to have a clear individualized plan in place for each patient. 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provider productivity. This has led to a lack of understanding of the nursing role as well as nurses performing below their professional scope of practice. The purpose of this quality improvement project was to create an acuity tool utilizing objective data to determine optimal nurse staffing and to identify a standard team model with proper task alignment for each role in the ambulatory oncology setting. Utilizing nursing surveys, data from the electronic medical record, overtime, and FTE turnover reports; an acuity tool was created and implemented. Three domains were identified as contributing to the nursing workload; provider, clinic, and patient. Each domain had specific drivers for the work that needed to be completed by the nurse. The drivers were standardized for oncology in this acuity work and were applicable and implemented for all ambulatory oncology clinics, including CAR-T and BMT clinics. Acuity thresholds were created to be used to demonstrate the workload and guide addition FTE needs. The standard tool was implemented and successful at setting thresholds for team acuity using objective assessment and data, as demonstrated by a 14% reduction in nursing overtime hours and a 9% reduction in turnover rates. The tool was presented to leadership and adopted for ambulatory oncology as a standard staffing acuity tool. The tool provided a standard way to measure nursing acuity by looking at key drivers in the oncology population and allowed for proactive staffing model in teams that had consistent and anticipated growth.

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Peripheral neuropathy can be painful and disabling which may result in loss of functional abilities and decreased quality of life. Evidence-based studies have shown that localized cryotherapy may reduce peripheral neuropathy in patients receiving Paclitaxel treatments. The purpose of the Chemo-Induced Peripheral Neuropathy (CIPN) project was to determine the effectiveness of using cryotherapy in preventing CIPN for breast cancer patients receiving Paclitaxel. While the mechanism on how topical cooling is unknown, it is hypothesized that cryotherapy decreases blood flow to the affected areas, reducing the flow of chemotherapy agents and decreasing toxicity. By offering cryotherapy as standard practice to patients receiving Paclitaxel therapy the expectation is neuropathy symptoms would be reduced. The intervention utilized was for identified patients to wear frozen gloves and socks during treatment with Paclitaxel. Patients were provided icepacks for their hands and feet during the length of their treatment. The intervention was offered to new breast cancer patients in a single infusion center who were scheduled to receive their initial dose of Paclitaxel. Various exclusion criteria were in place and were reviewed with the medical team prior to offering cryotherapy. Throughout the course of treatment, neuropathy data was collected using the Peripheral Neuropathy Grading Scale (PNGS) which is a validated toxicity assessment that provides grading on a scale of 1-5. Data was collected after each cycle of treatment and then compiled to evaluate incidences of neuropathy throughout the course of therapy. Data was analyzed by comparing participant’s PNGS results from their first cycle (baseline) to their last cycle (a total of 12 Paclitaxel infusions) of treatment. After evaluation of PNGS over the course of 12 weeks scheduled Paclitaxel therapy, patients utilizing cryotherapy reported little to no symptoms (see Table 1). Based on prior studies and the results of the CIPN quality improvement project, there appears to be a correlation between the use of cryotherapy and reduction in peripheral neuropathy symptoms. The offering of cryotherapy for this patient population should be studied further as a possible standard of care.

P534
STOP OR GO: HOW AN INTERPROFESSIONAL TEAM DEVELOPED AN INNOVATIVE PROTOCOL TO REDUCE CATHETER ASSOCIATED URINARY TRACT INFECTIONS (CAUTIS)
Sandra Wetherbee, MSN RN OCN, Fox Chase Cancer Center, Philadelphia, PA; Pamela Jakubek, MSN RN CWOCN, Fox Chase Cancer Center, Langhorne, PA

Coordination of Care
An increase in catheter associated urinary tract infections led to the formation of an interdisciplinary team consisting of a surgeon, infection disease specialist, clinical nurse specialists, OR nurses, and bedside nurses. The purpose was to re-energize existing practice, empower nurses to remove catheters, and develop an innovative strategy to reduce catheter infections. Catheter-associated urinary tract infections (CAUTIs) are a common healthcare associated problem. CAUTIs increase hospital length of stay, patient discomfort, health care costs, and, rarely, can lead to mortality. A significant portion of CAUTIs are preventable. Poor communication between physicians and nurses on indwelling bladder catheter removal plans can delay timely removal thereby increasing the potential for infection. Collaboration for catheter management is essential to prevent patient harm and reduce health care costs. An internal institutional survey revealed that nurses did not feel empowered to remove catheters despite an existing protocol. The interprofessional team set innovative guidelines for insertion, maintenance and removal of foley catheters through a surgery protocol using a red (do not remove)/green (remove) sticker order system in the EMR. A physician champion created an educational video for physicians and nurses, posters were placed on nursing units, and the team filmed an indwelling bladder catheter insertion video as required viewing for incoming surgical staff in the OR. Nurses formed a CAUTI subgroup for RN and CNA champions to provide unit education focusing on bundle and protocol maintenance and other activities to support CAUTI reduction. Implementation of the innovative red/green sticker system and interprofessional teamwork resulted in a downward trend for catheter utilization and dwell time, and a downward trend in the rates of catheter-associated urinary tract infections over two years. There was a 57% decrease in urinary tract infections from FY20 to FY21. The number of CAUTI infections continued to decline in FY22 with a 50% decrease as compared to FY22. The new
protocol has proven to be an effective strategy in CAUTI reduction. Interprofessional collaboration demonstrated innovation in practice by effectively reducing CAUTIs. A new protocol held physicians accountable for indwelling bladder catheter insertion and management, empowered nurses to remove catheters promptly and promoted improved interdisciplinary communication.

P535
CREATING A WORKFLOW TO SUPPORT COLLABORATIVE CHEMOTHERAPY ADMINISTRATION IN NON-ONCOLOGY SETTINGS
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Oncology Nursing Practice
Chemotherapy, targeted therapies, and immunotherapies have seen expanded use for non-oncologic diagnoses. Current ASCO/ONS guidelines state chemotherapy should be administered by a qualified medical professional, however, the decision for who is permitted to administer these medications is based on institutional policy. The hematology & stem cell transplant (HSCT) unit is the only inpatient oncology unit at our academic medical center whose staff are trained to administer chemotherapy. In 2021, internal data revealed HSCT nurses were responsible for coordinating an average of 200 “off-unit” administrations per month. The majority of administrations were for oral targeted agents that required chemotherapy nurses to administer per institutional policy. The purpose of this project was to reduce the burden of “off-unit” chemotherapy administrations by utilizing evidence-based process improvement strategies. A survey was created to assess the ongoing volume of chemotherapy and identify associated trends. Service specialties and inpatient units with the highest volumes were targeted. A multidisciplinary approach between HSCT leadership, inpatient oncology provider consult service, patient placement and pharmacy was developed to proactively manage “off-unit” administrations. Multidisciplinary communication enhancements were implemented to streamline ordering, scheduling, and resource allocation. Additional enhancements included proactive transfer of patients to the HSCT unit if they required oversight by a trained chemotherapy nurse for complex, multi-drug regimens. If a patient was unable to transfer, a checklist was utilized to reinforce nursing expectations prior to the HCST nurse’s arrival to the “off-unit” area. Institutional USP<800> training was assigned to all clinical staff, and administration requirements for antineoplastic agents were reclassified as appropriate. This allowed oral agents or agents for non-oncologic diagnoses to be given by any staff nurse using safe handling principles, as opposed to the traditional chemotherapy-training requirement. “Off-unit” administrations decreased to an average of 12 per month. Length of time spent “off-unit” equated to an average 56 minutes per administration. Most of these administrations were for hematology/oncology patients with critical care needs who were unable to transfer to the HSCT unit. These “off-unit” administrations were unavoidable due to disease severity and treatment urgency, and relied heavily upon multidisciplinary coordination of care for safe delivery.

Discussion: Antineoplastic administration in non-oncology areas is a high-risk intervention that requires an evidence-based, multidisciplinary approach. Utilizing a continual quality improvement process can identify opportunities for sustainable care delivery and coordination.

P536
RN APPROACH FOR ONCOLOGY CARE COORDINATION DISRUPTION FOLLOWING ELECTRONIC HEALTH RECORD UPDATES
Rachel White, RN, UT Southwestern Medical Center, Dallas, TX

Coordination of Care
Oncology patients fall into a wide spectrum of laboratory monitoring needs based on where they currently fall within their oncology care plan. Depending on the oncology diagnosis, this could be as often as twice weekly to even just annual testing. Our Transplant and Cellular Therapies clinic identified an IT error that was resulting in electronic laboratory orders being hidden from laboratory check-in and phlebotomy team members after an electronic health record (EHR) update. The clinic nurse consulted the ambulatory clinical workflow analyst assigned to the oncology center regarding the increase in missed laboratory orders. The clinic RN reviewed how this increased number of patient care fallouts was resulting in care coordination disruptions that were causing decreased patient satisfaction, increased nurse call burnout, and increased clinical treatment delays. The clinic nurse worked with both the laboratory check-in team and assigned ambulatory clinical workflow analyst to identify all EHR discrepancies that could potential be causing the laboratory team members to not locate active orders within patients’ EHR. After several post-incident and real-time reviews, the cause was found to be IT issues with both EHR access and order review restrictions that limited...
the laboratory team members from viewing active orders in the oncology patients’ EHRs. As this had not been a historical issue, these new restrictions were further investigated and found to have stemmed directly from a recent EHR update that allowed non-laboratory team members to incidentally change the laboratory team members’ order views while updating their personal view preferences. This investigation provided data that has allowed our institution to improve our EHR, increase patient satisfaction by minimizing care delays, and decrease employee burnout by minimizing calls to other disciplinary teams requesting order assistance.

P537 USING TECHNOLOGY TO DOCUMENT PRESSURE INJURIES ON AN INPATIENT ONCOLOGY UNIT
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Oncology Nursing Practice

Oncology patients who develop pressure injuries are at increased risk of negative outcomes including increased length of stay, infection, and mortality. The National Pressure Injury Advisory Panel (NPIAP) released guidelines that recommend assessment of pressure injuries (PI) weekly and if changes are noted. PI require complex documentation, and are frequently overlooked when assessing the competing priorities of acutely ill oncology patients. Inconsistent charting of PI was noted on an inpatient oncology unit, indicating a need for an intervention to provide timely, accurate documentation of PI. The purpose was to implement a process for assessing and photographing PI to improve interdisciplinary team communication, prompt intervention, and potentially improve patient outcomes. After completing unit-wide education, a handheld device (Rover) was utilized to photograph pressure injuries weekly. A practice change was instituted in which wounds were assessed and photographed upon admission/transfer, and/or when any change in characteristics were noted. This process was coined “Measurement Monday” and streamlined how nurses were able to both chart and communicate skin concerns and the need for consults to the interdisciplinary team. Patient confidentiality was protected via patient barcode scanning and subsequent linkage to the electronic medical record (EMR). Communication was maintained with the interdisciplinary team via daily meetings that discussed the progress of each patient. Nurses were surveyed thirty days after implementation of the device to gain feedback on the effectiveness of the Rover and the feasibility of ‘Measurement Monday’. Random chart audits were performed to ensure compliance with practice change. Nursing staff had positive feedback about the use of the device and process of weekly photographing. Image quality, linkage to the EMR, and the ability to view wounds in a timeline style format were highly ranked by the nurses. Chart audits revealed an increase in charting wound assessments at time points recommended per the NPIAP standards of care for PI. Based on these findings, Rover will be instituted hospital-wide to increase documentation of PI assessments. An incidental finding of the study was that the technology could be utilized to document skin impairment near central line insertion, which has also been initiated at the recommendation of the oncology nurses involved in this project. This represents a potential extended benefit of picture-based documentation in the EMR and area for future research.

P538 REVAMPING ROUTINES: ENHANCING ENVIRONMENTAL ROUNDS
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Patient Education and Safety

In our large, academic hospital, maintaining the environment of care is very comprehensive and requires constant rounding. Historically, nurse leaders and oncology quality team members were rounding on the units and then sending endless emails to different departments for follow up. This was leading to consistent issues carried over from week to week or falling through the cracks. Ideally, environmental rounds involve all disciplines and the ability to address issues in real-time. The significance of this project stemmed from the amount of work that followed our weekly environmental rounds on the inpatient oncology units. The purpose of this project was to revamp and revitalize environmental rounds for the inpatient oncology units to ensure that our patients’ environment of care has optimal quality and safety. We first identified all of the key stakeholders and departments needed for
comprehensive rounds. We reached out to all of our ancillary departments and got buy-in from their leadership to have weekly rounds on the inpatient oncology units. Our rounds include representation from oncology quality, leadership, housekeeping, engineering, nutrition, linen, materials, clinical engineering, transport services, and infection prevention. We also began sending a comprehensive recap of the rounds with pictures to identify immediate needs and assigned responsibility that is updated weekly. We evaluate this project on a weekly basis and make adjustments as needed. We have added departments to round weekly, as well as decrease the frequency of rounds for others. We have received recognition from our infection prevention and environmental health and safety colleagues for maintaining quality and safety within the environment to enhance the care provided to patients. The number of email communications and follow up items that carry over week to week has decreased by over 50% since implementing these interdisciplinary rounds. Maintaining the quality and safety of patient care environments is a responsibility that all nurse leaders have a role in. Environmental rounds are only one component of this responsibility and can be very challenging to chase issues and proper follow up while balancing all other expectations and duties. Enhancing environmental rounds on the inpatient oncology units in our hospital has aided in maintaining the highest level of quality and safety to best serve our patients.

P539
STANDARDIZING LEURLOCK CAP CHANGES TO INCREASE CLABSI PREVENTION IN INPATIENT ONCOLOGY UNITS
Samantha Wray, MSN, RN, OCN, BMT-CN, University of Kentucky Healthcare, Lexington, KY
Oncology Nursing Practice
Oncology patients have a high rate of central line placement for treatment purposes. The presence of central line and the potential for immunosuppression contribute to increased risk of infections and CLABSIs in this patient population. CLABSIs are associated with significant increase in length of stay, increased unreimbursed costs to hospitals, and increased mortality rates. As part of the organization’s CLABSI prevention bundle, leurlock caps should be changed every 96 hours while patient is admitted to our oncology units; however, cap change dates vary between patients, leading to staff confusion and frequently missed care. Additionally, the EHR prevents easy access to last cap change date and often requires staff to search in a chart review for the last date of cap change compliance. In FY23, missed cap changes were identified in 6 of 11 (55%) CLABSIs in oncology units during root cause analyses, and cap changes remain one of the top 2 missed CLABSI prevention measures on the oncology service line found during prevention audits (Wildcards). Previous standardization of central line dressing changes by the organization led to increased CLABSI prevention compliance and stands as a model for this intervention. The purpose of this project was to standardize cap changes to a Wednesday/Saturday schedule in oncology inpatient units to increase compliance with the CLABSI prevention bundle while maintaining cap change frequency per organizational policy. The intervention was implemented from September 2023-October 2023. The Clinical Nurse Specialist developed staff education for end-of-week notes, staff meetings, unit flyers, and daily rounds to notify staff of determined cap change days. CNS performed daily audits on all oncology inpatients with central lines to determine cap change compliance before and after intervention using EHR reports. Prevention audits (Wildcards) on oncology units were compiled from 3 months prior to intervention and 3 months following intervention to compare rates of missed cap changes. Evaluation: Intervention in place, final results pending/to be compared and compiled (complete at end of Oct). These study findings will influence the adoption of standard cap change days into inpatient oncology practice, which could prevent harm and impact CLABSI rates. This intervention also underscores the need to coordinate care within frontline staff workflow to reduce the risk of missed care.

P540
STANDARDIZING CARE OF MULTIPLE MYELOMA PATIENTS RECEIVING INVESTIGATIONAL CAR-T
Ashlee You, RN, BSN, OCN, BMTCN, Mount Sinai, New York, NY; Donna Catamero, ANP-BC, OCN, CCRC, The Mount Sinai Health System, New York, NY
Oncology Nursing Practice
Clinical Trials offer patients novel therapies that may not have a commercially available equivalent. While investigational protocols dictate a schedule of assessments to be performed, there are other components of patient monitoring and management that are left to investigator discretion and standard of care practices. CAR-T cell therapy particularly has many potential adverse events, precautions, and monitoring to consider. The objective was to create universal clinical guidelines to manage the investigational CAR-T patient population that would supplement the requirements of their respective clinical trials. A particular challenge being
to ensure that the guidelines would be comprehensive without having to be altered too drastically for individual clinical trials. A literature review was conducted to verify the current standard practices of monitoring CAR-T patients. Subsequently, a review of the institution’s CAR-T clinical trials was performed to identify interventions that were typically cautioned, restricted, or prohibited. The sourced standard of care practices were then outlined in order of where in the process of the CAR-T journey they occur. During this process, interventions that were likely to be restricted by a clinical trial were noted as requiring verification prior to proceeding. When trial requirements differed from institutional practices the more stringent guidance was advised to be followed. The guideline was distributed to 3 research RNs and 6 Research NPs who care for the investigational CAR-T population. A period of thirty days was allotted for initial implementation and feedback from the team. During this time, there were 3 patients screened for investigational CAR-T protocols and 24 follow up visits. After the thirty day period a survey was distributed to evaluate utilization, effectiveness, and open comments for suggestions. Eight responses were received with an 87.5% utilization rate during the trial period and of those 100% reported benefit while utilizing. The feedback mechanism will remain open to allow for adjustments as updates in practice occur. Creating a management plan for the research CAR-T population that is mindful of clinical trial processes allows for patients to be treated while abiding by a common standard. This prevents omitting monitoring or interventions due to concern of conflicting with clinical trial restrictions. Clinical trials and CAR-T therapy are constantly evolving, therefore, it is imperative to ensure guidelines are re-visited regularly for any recommended updates in practice.

P541
USING HUMOR TO IMPROVE NURSING WELLNESS
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Oncology Nursing Practice
Malignant hematology and hematopoietic stem cell transplantation are a challenging, yet fulfilling career choice that frequently causes some emotional distress to its nurses as a result of the typical day-to-day happenings. Witnessing and causing many forms of patient suffering, end of life discussions, moral distress, ethical dilemmas, disease progression, relapses, failed transplants, having difficult conversations with patients and/or their loved ones, and death commonly occur; and nurses are in the middle of all of these situations. Nursing well-being or wellness has been a central focus ever since the covid-19 pandemic when many nurses left the profession. Wellness can mean a lot of different things to a lot of people; and there are no clear interventions to address this completely in today’s complex and fast-paced health care environment. Many different things have been studied or are under current investigation. This author believes that laughter remains the best medicine to combat stress and emotional distress. The purpose of this quality improvement project is to assess if humor positively impacts nursing wellness. This author applied for an internal grant opportunity and was selected to receive $11,000 to support this proposed project. It began in July 2023 and must be completed by June 2024. However, this project will be completed before the 2024 ONS Congress conference. This author has compiled several common distressing patient care scenarios and has developed exaggerated situations that depict nursing humor. IRB approval has been sought, and this author will be directing and recording these mock patient scenarios using our in-patient unit’s nurses as actors who will be performing the dialogue and specific actions on our oncology unit, which has also been approved. An approved outside vendor will be editing the video to ensure a quality final product. The humor video will be approximately 10-15 minutes long. A basic nursing video (e.g., CVC dressing change) with the same length of time will be watched in the control group. Statistical analysis will include a survey monkey questionnaire using a 10-point Likert scale comparing a control group with the intervention group. Relieving emotional distress, promoting well-being (wellness), and strengthening our peer and team connections thru laughter seems to be a very important strategy that can help develop resilience in all of the different generations of nurses who work together each day to provide excellent care to our patients.

P542
THE PROCESS OF INITIATING WIPE SAMPLING ON AN INPATIENT HEMATOLOGY/Oncology Unit: What bedside nurses need to know
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Oncology Nursing Practice
It is well known that nurses who administer chemotherapy are exposed to hazardous drugs and, subsequently, are at an increased risk for potential health complications. It is imperative that nurses are equipped with the tools to detect trace chemotherapy in their
environment and the knowledge that leads to the implementation of corrective actions aimed to minimize environmental contamination of hazardous drugs. Not only should hematology oncology nurses prioritize and advocate for their personal safety, but they should also strive to comply with USP 800 and ONS recommendations regarding routine wipe sampling. The purpose of this project is to assist hematology oncology nurses as they begin the process of proposing the implementation of wipe sampling on their units where chemotherapy is routinely administered. Wipe sampling is widely recommended and strongly encouraged, yet there is an absence of readily available guidelines that consolidate applicable resources that would allow nurses to efficiently propose an organized implementation. A simple guideline that includes different components of the process of implementation will prove to be a valuable resource that aids nurses as they navigate an important topic that can be overwhelming. Research and collaboration with an interdisciplinary team were critical components of implementing wipe sampling on the inpatient unit. Bedside nurses and nursing leadership were in communication with the president of hospital operations, supply chain management, procurement services, product representatives, pharmacy, and the clinical product evaluation council. By acting as a facilitator and creating organized, factual documentation, key stakeholders were able to make informed decisions. A guideline was created that reflects how wipe sampling was implemented on an inpatient unit as a nurse-driven initiative. Wipe sample results and outcomes will be specific for each unit. Results indicating positive hazardous drug exposure will justify changes to processes regarding chemotherapy delivery, administration, or disposal, and will likely warrant continued collaboration with other departments such as pharmacy and environmental services. It is vital that bedside nurses advocate for their safety and provide education to others within their hospital system, justifying the need to implement the process of wipe sampling. The process of implementation will be more streamlined when nurses have a guideline to follow, are prepared with research, form a core group of other bedside nurses for support, and involve the appropriate departments.

P543
EVALUATING PROVIDER ADHERENCE TO EVIDENCE-BASED GUIDELINES FOR PATIENTS DIAGNOSED WITH GASTRO-ESOPHAGEAL CANCER: A QUALITY IMPROVEMENT PROJECT
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Treatment Modalities
The National Comprehensive Cancer Network (NCCN) developed clinical guidelines based on the best available evidence and expert consensus for cancer treatment to reduce practice variation and improve patient care quality. This study evaluated the provider’s adherence to the National Comprehensive Cancer Network (NCCN) guidelines for initial diagnostic evaluation and first course of treatment for gastro-esophageal cancer at Lee Health Cancer Institute. Oncology nurse navigators conducted a retrospective chart review of 30 patients diagnosed with gastro-esophageal cancer and treated at Lee Health Cancer Institute from 2020 to 2022 to determine whether the initial diagnostic evaluation and first course of treatment were in concordance with NCCN guidelines based on the stage of the disease. 5 of the 30 patients were excluded due to an immediate referral to hospice or refused treatment. An audit tool was created to capture pertinent information, including the patient’s pathology, diagnostic imaging, laboratory tests, and consultations. For the initial diagnostic evaluation, oncologists (n=6) adherence to NCCN guidelines for initial pretreatment diagnostic assessment was 4% (non-adherence 96%) and adherence for first course of treatment was 100%. Non-adherence to the guidelines initial pretreatment diagnostic assessment was because 24/25 patients did not have the American Joint Committee on Cancer (AJCC) TNM staging documented, and 1/25 patients did not have smoking cessation counseling or were referred to a smoking cessation class. For the first course of treatment, 25/25 patients were ordered the first course of treatment as recommended by NCCN guidelines for gastro-esophageal cancer. Based on the retrospective study, it was recommended that AJCC TNM staging module with template and smart phrase to be built in electronic medical records (EMR) EPIC to assist providers with staging documentation. Implement automated reminders through EMR and manual reminders. Determining the cancer stage is a critical initial step in patient care. Knowing patient’s stage of the disease helps providers determine optimal therapy and helps oncology nurse navigators to individualize
patient care. A post-chart review will be conducted six months after implementing the recommended changes to evaluate compliance.

RADIATION

P544
IMPLEMENTING A PEER-TO-PEER PATIENT MENTORING PROGRAM IN A RADIATION ONCOLOGY CLINIC SETTING
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Survivorship
One of the most notable discoveries coming out of the pandemic is the importance of connection with others. Research into social connections indicates a positive impact upon health when individuals are connected with one another. For patients struggling with cancer feeling supported may improve overall health outcomes. For example, research indicates that women with breast cancer who have social supports have a lower risk of dying as compared to women without supports. Numerous studies indicate a high level of satisfaction with peer support programs. This large academic hospital radiation oncology department lacked a formal peer-to-peer patient mentoring program, so we sought ways to incorporate peer support into overall patient care. The purpose of the Radiation Oncology Peer-to-Peer Program is to provide increased emotional support to patients struggling with cancer and their families/caregivers. The Oncology Patient and Family Advisory Committee (PFAC) recommended implementing a program to support patients newly diagnosed with cancer. The program was coordinated by nurse and physician champions, a child life specialist, a volunteer manager, a project coordinator, and the clinical teams. The clinical teams identified potential patient participants as mentors who were then onboarded and trained in peer support. Onboarding included a background check, confidentiality agreement, peer mentor sign-up/matching form, and training session. Once completed, mentors were matched with newly-diagnosed patients through email, text, or via phone. The program was initiated in December of 2022. Eight mentors (8) have been trained and six (6) encounters between Mentor and the patient have occurred. Through the mentor relationship, patients have discussed their worries regarding their cancer journey. Strategies for coping and thriving have been explored, and non-medical advice and tips have been offered, and knowledge of information and resources have been shared. While each cancer and life situation is unique, the goal of the Peer-to-Peer Program is to match patients and their families/caregivers with mentors who have faced similar experiences. Whether a patient, survivor, family member, or caregiver, individuals have the opportunity to connect with someone to give and receive support. Through this program, we have noted an increase in interest from mentors and mentees in the opportunity to support and help one another. Future work will include data collection of the mentor and mentee experience.

P545
EXTERNAL BEAM RADIATION THERAPY VS BRACHYTHERAPY FOR SOFT TISSUE SARCOMA: IS ONE TREATMENT MODALITY SUPERIOR?
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Symptom Management and Palliative Care
Soft tissue sarcomas (STS) of the extremities represent an oncologic challenge due to the many anatomical sites of origin, the close proximity of sarcoma’s location to other organs at risk, and its relative rarity among other cancer types. According to the National Cancer Institute’s Surveillance, Epidemiology and End Results (SEER) database, an estimated 13,400 new cases of sarcoma will be diagnosed in 2023; representing approximately 0.7% of all new cancer cases. Sarcoma involving the extremities account for approximately 45% of all sarcoma cases and treatment includes surgery and radiation therapy (either given preoperatively or in the adjuvant setting). Radiation modalities include external beam radiation (EBRT) and brachytherapy. According to Pisters et al. brachytherapy was equivocal to EBRT in terms of local control. The data, however, has implied that brachytherapy has been shown to be superior in reducing long-term toxicity due to limited field volume. We sought to answer the question whether brachytherapy reduces long-term toxicity and retains functional capabilities when compared to EBRT. While surgical excision has traditionally been the gold-standard for sarcoma treatment; brachytherapy has been shown to provide patients with the convenience of less hospital visits and diminished radiation to the normal surrounding tissue thereby reducing radiation related side effects. A comprehensive review of the literature was conducted and included the search engines of PubMed & Google Scholar. Keywords included soft
tissue sarcoma of the extremity, brachytherapy, external beam radiation therapy, efficacy, morbidity, and toxicity. The search was limited to last 15 years. The NCCN guidelines in the management of soft tissue sarcoma of the extremity was also extensively reviewed. The review of the literature yielded 21 studies that we then appraised for appropriateness. Of the 21 initial studies, we determined 15 articles provided the foundation for our recommendations. Based on the review of the literature, brachytherapy has been shown to be superior to EBRT in reducing long term sequela. Oncology nurses are in a prime position to effectively screen patients who have received brachytherapy in the management of their STS of the extremity for long-term side effects. Therefore, the oncology nurse should initiate prompt implementation of strategies geared towards minimizing side effects and improving functional ability.

P546
AN INTERDISCIPLINARY QUALITY IMPROVEMENT INITIATIVE TO REDUCE LATE INPATIENT RADIATION TREATMENT TIMES

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Coordination of Care

Oncology patients receiving radiation treatment can be met with various obstacles, such as hospital admissions, in the midst of treatment potentially leading to unplanned breaks in their radiation therapy. These unplanned breaks may negatively impact tumor response to therapy. The radiation oncology department serves both inpatient and outpatient with the goal of preventing these breaks. Inpatients from 3 different sites, all within NYC, are treated in one ambulatory unit located in the main hospital. Radiation oncology patients, when admitted to the hospital, require care that is coordinated by multiple disciplines/departments; inpatient unit nurses, respiratory therapy, advanced practice providers (APPs), medical residents, patient escort, and ambulance dispatchers for those inpatients not in the main hospital. The radiation oncology nursing team noted an increase in the number of appointments late afternoon for inpatients requiring therapy which raised concerns for patient safety. As radiation oncology is predominantly an outpatient treatment they are staffed based on ambulatory hours; no patient care technician after 5pm, fewer radiation treatment therapists, and fewer nurses on the unit managing patients waiting on escort, either hospital escort or ambulance, back to their hospital bed. The purpose was to reduce the number of late afternoon inpatient appointments with the ambulatory radiation department. Nursing leadership and the medical director of radiation oncology discussed how to best address inpatient appointments. In December 2021, an electronic log was initiated to document the number of late afternoon inpatient appointments along with the reason for the late appointment. The nursing team along with treatment therapists and operations manager met daily to determine a strategic plan for management of these patients and ways to reduce the number of late afternoon appointments. In June 2022, a benchmark was instituted of < 15 inpatients as the maximum number of appointments after 4pm. December 2021 showed there had been 30 patients scheduled late afternoon, with 83% of these scheduled after 5pm. December 2021 to July 2023 there have been only 2 months which exceeded the benchmark. There are some unavoidable late treatments, which may include patients requiring twice daily treatment, brachytherapy cases, and emergency add-on cases. These cases instigated the need to adjust the reason for the late appointment into 2 categories: planned or unplanned.

P547
COMPARING RADIATION INDUCED SKIN REACTIONS AND WEIGHT LOSS IN HEAD AND NECK PATIENTS RECEIVING DIFFERENT TREATMENT TECHNIQUES

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Treatment Modalities

Radiation therapy can cause skin reactions for any patient receiving treatment, and dysphagia or weight loss can occur, particularly in those with a head/neck cancer. Determining risk factors for skin reactions and weight loss will help patients tolerate treatment better, decrease risk of infections due to skin impairment, and complete fractions without requiring a break. Two separate radiation techniques are currently used: volumetric modulated arc therapy (VMAT), and Helical. The purpose was to improve symptom management and patient satisfaction in patients undergoing radiation therapy for head/neck cancers based on technique used. An excel spreadsheet was developed to capture patient data including: technique used, site radiated, dosage of radiation, concurrent chemotherapy, skin issues, and > 10% weight loss. Weekly office visits with care team occurred to assess skin, and to measure weight which was compared to the previous week’s weight. Nutrition consults were obtained for those experiencing weight...
loss. Patients received education prior to initiating therapy regarding skin care, and product suggestions were given for use as daily moisturizers in an effort to prevent/decrease any skin irritation. Patients with grade 1 skin reactions would be instructed to use aquaphor or calendula. Grade 2 & 3 skin reactions would be prescribed silvadene at the MD’s discretion. September 2022 through July 2023 identified 37 patients treated and these patients were monitored for weight loss and skin reactions. It was determined that patients receiving VMAT technique had more skin complications and >10% weight loss. Many patients receiving radiation therapy have difficulty getting through 5-7 weeks of treatment due to skin complications and/or weight loss. These side effects may lead to treatment being put on hold for a short period of time by the MD. The data shows that head and neck patients receiving the helical technique have decreased skin reactions and decreased weight loss. Therefore, if we increase capacity of this machine it is possible we will have less patients taking treatment breaks and have higher patient satisfaction. Based on these findings, a meeting was convened with the multidisciplinary team to discuss increasing usage of the helical technique going forward, especially within the head/neck cancer population.

P548  PREVENTING PATIENT SCHEDULING DELAYS FOR PLACEMENT OF PROSTATE FIDUCIALS AND HYDROGEL
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Coordination of Care
National Comprehensive Cancer Network guidelines for prostate cancer state the accuracy of daily radiation treatments should be verified by daily prostate localization with image-guided radiation therapy (IGRT) utilizing CT, and implanted fiducials. Biodegradable rectal spacer materials may be implanted between the prostate and rectum in patients with organ-confined disease undergoing external beam radiation therapy (EBRT). This displaces the rectum minimizing exposure to high doses of radiation. Due to the high volume of patients requiring fiducial and spacer placement in the radiation oncology setting, and a low number of qualified personnel from urology to perform the procedure, a scheduling back log developed. Patients waited up to 2 months before being scheduled. This created safety concerns as treatments were delayed and patients could be lost to follow up. Additionally, patients were frustrated and anxious about delays in beginning cancer treatment. A brachytherapy certified radiation oncologist acquired training in the placement of perirectal spacer hydrogel. Training and certification were implemented with virtual and in-person sessions provided by instructors from the manufacturer. Radiation oncology nurses were instrumental in the success of this interprofessional project. Nurses developed algorithms for the procedure, procured and maintained necessary supplies, defined nursing responsibilities prior to and during the procedure, and initiated a scheduling workflow via the EMR for patients. Pre and post procedure patient education tools were also developed by nurses to ensure patient understanding and compliance. This quality improvement project reduced the wait time for patients significantly, eliminated scheduling back logs, and reduced patient anxiety as evidenced by a reduction in patient calls. Interprofessional collaboration combined with a solution driven strategy to a chronic problem in this radiation oncology department demonstrated how patient care could be improved. Staff displayed flexibility in learning, cross training and collaboration, ensuring success of this program.

P549  A CULTURE OF CARING IN RADIATION ONCOLOGY
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Psychosocial Dimensions of Care
The purpose of the project was to learn how radiation oncology creates a culture of caring in the everyday life of patients. Many patients may have non-medical factors that could affect their care like lack of education, economic status, and access to health care. A culture of caring is a flux process that includes the ways the healthcare team addresses non-medical factors that can affect individualized patient care. The purpose of this project was to investigate the lack of a clear definition of what makes a culture of caring and what it looks like in radiation oncology centers. The project used a qualitative approach with an ethnographic point of view to observe the radiation oncology center. This included in-depth observational notes and conducting semi-structured interviews with healthcare professionals in various roles involved with radiation treatment. Evaluation: The results concluded there were aspects of treatment-related care and many non-treatment-related care interventions included in a culture of caring.
Some treatment-related care examples shared by participants were about the distress survey, individualized care plans, continuity of care, and assuring it was the right treatment and right patient. Non-treatment-related care examples were learning about the patient and their family, acknowledging how the patient was feeling, and taking time to answer all patient questions.

Discussion: Treatment-related care and non-treatment-related care work together to treat patients with a holistic culture of caring. There is a clear understanding that a culture of caring is both an art and a science. Science is all done the same; art is done differently. This means many healthcare systems have similar treatment practices, but the healthcare team’s individualistic care can affect patients in many ways that contribute to a culture of caring. This could be in how the healthcare team approaches patients and takes the time to acknowledge their feelings and show acts of caring. Oncology practices should use a culture of caring to teach new staff the need to observe the roles and patient interactions of all members of the team to create a positive culture in the workplace. A culture of caring does not just benefit patients but also benefits staff, as they can find joy and purpose in their roles by using a holistic approach. “This work was conducted by a student in the Flynn Fellowship program.

P550
I GOT YOUR BACK: NURSE TO NURSE EDUCATION, PROVIDING KNOWLEDGE TO HOSPITAL NURSES CARING FOR RADIATION ONCOLOGY PATIENTS REQUIRING INPATIENT INTERSTITIAL BRACHYTHERAPY

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Patient Education and Safety

Radiation Oncology has a very specialized treatment called Interstitial Brachytherapy. The patient is required to have a device placed in the vaginal canal/ perineum area. The device delivers radiation directly to the tumor over three days with a total of five treatments. During the three days patients are admitted to the hospital while the device remains in place. Since the device remains in place the patient must remain in a supine position. The Radiation Oncology team noted there was an education need regarding proper positioning to help alleviate discomfort, prevent skin breakdown and general understanding and awareness. Due to the rarity of this patient population, it was found that there are opportunities to provide specific skin care and positioning education for those unfamiliar with Interstitial Brachytherapy. The goal of the education was to ensure the device will stay in the proper position for radiation delivery, prevention of skin breakdown, decrease infection risk and for the patient to remain comfortable. The creation of this nurse educational presentation took place in person on the oncology unit as well as virtually with Teams allowing multiple disciplines to attend. The Radiation Oncology Team (which included a Registered Nurse and Radiation Therapist) provided the information on Interstitial Brachytherapy, logistics and nursing interventions. There was a favorable response from the nursing staff and the Nurse Managers on the oncology units where the patients are admitted. Teams reported feeling more confident in working with this Gynecological Oncology patient population. Radiation Oncology team and Nursing Managers have discussed making this an annual or semi-annual educational series to ensure all disciplines feel supported and knowledgeable regarding the device, treatment and interventions. Periodic revisions of this education is beneficial for changes to device/board or standards of care.

P551
KEEPING ON PACE: COORDINATION FOR PATIENTS WITH CARDIAC IMPLANTABLE ELECTRONIC DEVICES WHEN CARDIOLOGY IS NOT EASILY ACCESSIBLE

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Coordination of Care

Patients with cardiovascular implantable electronic devices (CIED’s) undergoing Radiation Therapy face safety concerns due to the potential threat of interference with their device functionality. Care and monitoring for these patients require a collaborative, multidisciplinary approach with their Radiation Oncologist, Electrocardiologist, Physics, device manufacturers, and Nursing. Cardiology is not a service line available at Fox Chase Cancer Center, which makes the complexity of providing care greater and causes more work for the patients as well as the staff to ensure quality and safety are achieved for patients. Reviewing literature from professional Therapeutic Radiation & Oncology organizations, national standards for best practice are not clear on methods for and frequency with which this monitoring should occur, only recommendations.
Nursing should play a primary role in creating a highly reliable process to provide care to CIED patients who will undergo radiation therapy treatment. Nurses, administration, and a physician champion partnered to develop a policy and procedure to assure all patients with CIED’s are captured for monitoring before, during and after treatment at specific intervals. This required additional support from IT to identify a location in the EHR for documentation transparency, and partnering with device representatives from 4 companies to acquire devices for CIED functionality assessment as well as a cadence of communication during care of the patient. Consent forms were altered to include identifying implanted device status, to share a level of accountability with all clinical staff for identification of patients, and a quality checklist completion was also implemented. Device champions were identified and educated to be the point people for ensuring all device patients are monitored per policy. Device check compliance results are reported out monthly at interdisciplinary Quality Assurance Council. The team went from an 88% overall compliance in FY21, to a 97% compliance in FY22. These results demonstrate the dedication of the clinical staff to prioritize safety and optimal patient care, and the effectiveness of the department’s protocols and communication efforts. Although damage to CIED’s in patients undergoing radiation therapy is infrequent, a best practice standard should be followed using a multidisciplinary approach to ensure patient safety in this population. As medicine continues to modernize CIED’s, more research needs to be done to identify their sensitivity to radiation and further policies need to be developed to guide safe clinical care.

P552
BRIDGING THE GAP IN MANAGING RADIATION DERMATITIS IN HEAD & NECK: IMPROVING PRACTICE AND PATIENT CARE

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Symptom Management and Palliative Care

Since skin management of radiation dermatitis varies per physician and practice location, the practice is unstandardized which causes inconsistencies in patient education and adherence to plan of care. The purpose was to improve patient care by using a skin algorithm that incorporates evidence-based practice to manage H&N radiation dermatitis. Fishbone Analysis was used to identify the inconsistencies in patient education and adherence to plan of care. Furthermore, there were 2 identified wastes that contributed to the problem: (1) extra processing to rectify incorrect pt education and dressing used, and (2) defects were the incorrect/incomplete pt education/skin dressing and negative patient experience. H&N skin algorithm was created to guide clinicians on how to manage radiation dermatitis based on assessment, risk factors, and symptom grading. Guidance on skin care products, pharmacological treatment, and pt education were also included to make this a comprehensive multidisciplinary approach to management of H&N radiation dermatitis. The H&N skin algorithm has been a valuable clinical tool and resource to clinical staff caring for a patient with H&N radiation dermatitis in the ambulatory and inpatient setting. Knowledge of clinical staff has increased due to various recommendations in skin care, skin dressings, and pharmacological management. Since managing radiation dermatitis from different body sites is also not standardized, this algorithm will be used as the gold standard template when expanded.

P553
DEVELOPMENT OF AN ILLUSTRATED SCALE FOR RADIATION DERMATITIS IN BREAST CANCER PATIENTS

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Symptom Management and Palliative Care

Acute dermatitis is a very common side effect of radiation treatment occurring in up to 95% of patients. Often patients present with erythema, desquamation and pain. This skin reaction negatively affects the quality of life of patients with cancer. Specifically related to breast cancer, standards of care regarding prevention and management of dermatitis were needed. The purpose of this project was to develop radiation dermatitis prevention and treatment guidelines in breast cancer patients at a National Cancer Institute- designated comprehensive cancer center along with a visual
reference tool to assist with the grading and severity. Led by a Clinical Nurse Specialist, a multidisciplinary group was formed. A systematic review of the literature was conducted looking at both topical treatments and dressings for both prevention and treatment. Databases included PubMed and CINAHL, limiting for articles in English and published within the last 10 years. After duplicates were removed, each article was critically appraised, and the members met regularly to synthesize the evidence. Based on the evidence, dermatitis guidelines for prevention and treatment were updated to include specific suggestions. Topical steroids were found to have the highest efficacy when compared with other topical agents based on severity and grading. Dressings were standardized across clinical settings within the breast oncology service. A one-page tool with visual representations of Common Terminology Criteria for Adverse Events v5.0 grading served as a reference for the standardization of nursing care throughout the department. Radiation oncology nurses were educated about the new tool and associated resources. These guidelines serve as a reference tool across disciplines and clearly outline the evidence-based interventions that clinicians can employ in the prevention and treatment of breast cancer radiation dermatitis. Within the shared governance structure, feedback was gathered across disciplines and clinical settings. This tool has broad implications for cultural awareness as the illustrated scale serves as a visual aid inclusive of a variety of skin tones. The development of this tool served as an opportunity to creatively engage nurses in the evidence-based practice process and in clinical decision-making, thus empowering them to have influence over their practice.

P554
IMPROVING THE WORKFLOW OF PATIENTS UNDERGOING RADIATION TREATMENT TO THE CENTRAL NERVOUS SYSTEM WITH A VENTRICULOOPERITONEAL (VP) SHUNT
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Coordination of Care

Ventriculoperitoneal (VP) shunt is a narrow plastic catheter placed within the ventricle of the brain acting as a drainage system allowing the excess of cerebral spinal fluid (CSF) to drain into the abdomen. This is used to treat hydrocephalus by preventing increased cranial pressure (ICP). In this drainage system, a valve is placed to control the flow and pressure rate. The valve may be adjusted manually without surgery. VP shunts are generally safe and compatible for Magnetic Resonance Imaging (MRI) scans. Occasionally the strong magnetic force from the MRI scan may interfere, causing an unintentional change in the valve settings of the programmable VP shunt. This change may potentially lead to malfunctions causing complications such as hydrocephalus, ICP, or death. Most patients who require radiation to the brain and spinal cord undergo MRI scans for radiation treatment planning. MRI safety policy requires all patients with a programmable VP shunt to be evaluated by Neurosurgery after MRI scans. Patients unable to undergo MRI scans due to lack of coordination with Neurosurgery may experience delays with radiation treatment planning and the initiation of radiation treatment. Purposes were to:

- Ensure patient safety by avoiding VP shunt malfunctions and complications
- Prevent patient delays with radiation treatment planning and initiation of radiation treatment
- Improve the process of patients with VP shunt who require MRI scans for radiation treatment planning
- Establish a collaborative workflow with Radiology, Radiation Oncology, and Neurosurgery maximizing both patient outcomes and satisfaction

Method: Developed a workflow incorporating coordination of care involving Nursing, Access Center, Physicians, Advanced Practice Providers (APP) from Radiology, Radiation Oncology, and Neurosurgery.

Results were as follows:

- Patients with programmable VP shunt safely underwent MRI scans during radiation treatment planning and had evaluations completed after MRI scans
- Delays were avoided by scheduling appointments for VP shunt evaluation with Neurosurgery after MRI scans which improved patient safety and satisfaction

Coordination of this workflow required the participation of all department members in order to ensure success. Patients with programmable VP shunt were able to get MRI scans safely by creating a process for VP shunt evaluation. Nurses and APP’s play an important role in successfully managing patients with VP shunt as well as improving patient safety and outcomes.

P555
CHEATING IN THE WORKPLACE: CHEAT SHEETS AS TOOLS TO IMPROVE WORKPLACE FLOW IN RADIATION ONCOLOGY
Katherine Wintz, RN, UT Southwestern Radiation
“Cheat Sheets,” Quick Reference Tools is nurse created and directed plan to optimize workflow through knowledge sharing for Radiation Oncology Computed Tomography (CT)/Triage patient care areas. Multiple registered nurses float to the CT/Triage procedure area education is crucial to ensure quality patient care and completion of timely documentation for both inpatient and outpatients. The complex CT/Triage procedural area is multifaceted using multiple software programs: Mosaic, EPIC, Beamweb, Transport, AMS Connect, Outlook, etc. requiring different login locations for the three distinct CT/Triage areas. When nurses float to CT/Triage area of Radiation Oncology, they become frustrated or overwhelmed when managing numerous tasks. This area requires concurrent management of various computer programs, fast-pace work environment, prepping patients for treatment, phone communication to radiation therapists and hospital nurses for report, and attentive monitoring of inpatients and outpatients simultaneously. Collaboration with multidisciplinary leadership for inpatient and outpatient care, education was created by radiation nurses via Quick Reference Tools: “Cheat Sheets” to enhance patient care, simplify documentation, and optimize workflow. The “Cheat Sheets” were printed and emailed to all Radiation Oncology nurses with RN to RN training as needed. Two Quick Reference tools were designed, one providing a step-by-step guideline. Another condense “Cheat Sheet” was created on one page managing the five programs that frequent review for patient updates, care and documentation to ensure patient safety. The “Cheat Sheet”: Quick Reference Tools proved to be a valuable resource to floating and newly hired nurses. The staff surveyed expressed increased confidence in providing patient care and completing required patient documentation. It is important for nurses to be knowledgeable of their policy and procedures for each work area. This exclusively nurse driven transformation has enhanced nurses’ knowledge and confidence, enriched multidisciplinary communication, improved patient care and safety, and required patient documentation. The “Cheat Sheet” Quick Reference Tool innovations empowers the unfamiliar nurse when caring for Radiation Oncology inpatients and outpatients. “Cheat Sheet”: Quick Reference Tool require periodic revisions as EPIC, Mosaic, and as policy updates occur. Assigning a knowledgeable nurse in each CT/Triage location to update “Cheat Sheets” will ensure continued success.
optimal utilization of human resources. Telemedicine is an innovative approach can meet the needs of cancer patients who frequently find it difficult to travel to clinics due to physical burden, long travel times, lack of health insurance, lack of available resources, and other factors.

RS2
TOBACCO USE STATUS, STIGMA AND LUNG CANCER SCREENING INTENTIONS
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Health Equity
Lung cancer is the leading cause of cancer death globally. Although the uptake of lung cancer screening (LCS) with low dose CT has positively impacted the incidence and mortality rates of lung cancer, further investigation is needed to understand the barriers to LCS among high-risk individuals who are eligible for LCS. Both tobacco use and lung cancer are stigmatized, creating significant obstacles for those diagnosed with lung cancer. Social support, while important in reducing stigma’s impact, may inadvertently normalize tobacco use in families and lessen associated stigma. Our study addresses a gap in research by assessing the intention for LCS based on their tobacco use behavior and LCS eligibility. Additionally, we explore the impact of stigma on LCS intentions. Method: Secondary data analysis (N= 73) participants in a community-based LCS education intervention. We obtained data regarding demographics, Cancer Stigma Scale (CASS), and LCS intention. Analysis and Findings: Of the 73 participants, most were female (n=51), white (n=35) or black (n=25), and non-Hispanic (n=52) or Hispanic (n=15). Nearly 51% (n= 37) had used tobacco at some point; 37% (n=27) were current users; 14.0% (n=10) were former users, 18.9% were heavy tobacco users,18.9% were poly tobacco users, and 27.4% were eligible for LCS. Twenty participants were eligible for LCS, with five indicating no intention to undergo LCS. Two were current tobacco users, and three were former users. Chi-square and Mann-Whitney U-test analyses found no significant difference in the intention to be screened for lung cancer based on tobacco use behaviors or stigma. Logistic regression revealed that stigma explained only 1.0% of LCS intention variance across all participants, and 3.4% among those eligible for LCS. This indicates no significant differences in stigma scores between ever tobacco users and other non-tobacco users with family members using tobacco. The study underscores a high prevalence of tobacco use within this community sample. Moreover, approximately one-fourth of eligible participants expressed no intent to undergo LCS. While tobacco use did not substantially influence screening intentions, stigma played a limited role. This emphasizes the need for further efforts in early lung cancer detection among eligible community members and suggests additional factors influencing screening decisions beyond tobacco use and stigma.

RS3
EFFECT OF A NURSE-LED MHEALTH PSYCHOEDUCATIONAL INTERVENTION ON SELF-EFFICACY, COPING AND PSYCHOLOGICAL DISTRESS OF NIGERIAN WOMEN WITH BREAST CANCER RECEIVING CHEMOTHERAPY: A RANDOMIZED CONTROLLED TRIAL
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Survivorship and Palliative and Psychosocial Oncology Care
Breast cancer (BC) is the most common malignancy worldwide. Chemotherapy, a prominent therapeutic approach extensively employed for BC, is accompanied by psycho-educational needs. mHealth, health-related interventions delivered through mobile communication devices, has been proposed as a viable strategy to support this group. This study aimed to test the effect of the ChEmo Nurse Breast cancer Application (CENBA) program, a newly developed mHealth psychoeducational intervention (mPEI), on self-efficacy, coping and psychological distress of Nigerian women with BC receiving chemotherapy. An assessor-blind multi-centre randomized controlled trial (RCT) was conducted among 126 women from two tertiary hospitals in Nigeria using the CENBA program. The CENBA program, underpinned by Bandura’s self-efficacy theory, has four major components: BC education,
coping skills training, discussion forum, and nurse-led consultation. The research team obtained evidence for the program design from a systematic review and qualitative study. Participants in the intervention group received the CENBA program over six weeks, while those in the control group received usual care. Study outcomes included self-efficacy, coping, symptom severity and interference, anxiety, depression, and quality of life. Sixty women in the intervention group completed the CENBA program. The results suggested that the CENBA program effectively improved self-efficacy, problem-focused coping, and emotion-focused coping in the intervention group after six weeks (all \( p < .001 \)). Similarly, there was a significant improvement in the total quality of life score (\( p < .001 \)) and all the quality-of-life domains, except the physical well-being domain (\( p = .058 \)), in the intervention group after six weeks. Moreover, symptom interference in the intervention group was significantly reduced (\( p < .001 \)). However, avoidant coping was significantly reduced (\( p = .001 \)) in the control group after six weeks. No significant intervention effect was found in symptom severity, anxiety, and depression. Although psychological issues have been reported among Nigerian women with BC receiving chemotherapy, this study has shown that an mPEI could address these issues. Similarly, this study showed that nurses could be effective providers of these interventions. As mHealth interventions are a relatively new idea in the oncology care of Nigerian patients, this study has provided evidence for the incorporation of mHealth into the care of this population.

**RS4**

**PSYCHOLOGICAL WELL-BEING AND QUALITY OF LIFE ASSESSMENT IN OMANI CANCER SURVIVORS: A STUDY ON ANXIETY AND DEPRESSION**

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Survivorship and Palliative and Psychosocial Oncology Care

Cancer survivors face a spectrum of physical and psychological health challenges in the aftermath of their treatment. Notably, they frequently exhibit elevated rates of anxiety, depression, and cognitive impairment compared to the general population. These struggles with anxiety, depression, and compromised cognitive function can significantly impede their overall quality of life following cancer treatment. The primary objective of this research is to investigate the prevalence of anxiety and depression among cancer survivors in Oman and explore their correlation with overall quality of life. A cross-sectional survey design was employed. The Hospital anxiety and depression scale and Quality of life index- Cancer version were used for data collection from the participants. The study encompassed a sample of 240 cancer survivors with mean age of 48.5 (SD 13.4) years, with 78.8% being females and married. A majority (62.5%) had completed secondary school or less, and 53.3% had battled breast cancer, while 19.2% faced colorectal cancer and they survived for an average of 2.5 (SD 3.3) years. Findings revealed that 13.1% of participants were categorized as anxiety cases, with an additional 12.1% classified as borderline cases. Moreover, 7.7% exhibited signs of depression, while 13.8% were borderline cases. Importantly, a significant negative correlation was observed between anxiety (\( r=-0.497, \ p<0.001 \)), depression (\( r=-0.413, \ p<0.001 \)), and quality of life. Omani cancer survivors persistently grapple with psychological distress even after completing their treatment, profoundly affecting their overall quality of life. Implementing ongoing assessment and monitoring protocols is imperative to promptly identify affected individuals. The provision of essential resources, including psychiatric care, supportive online groups, and the facilitation of open communication channels, can play a pivotal role in mitigating the enduring impacts of cancer and ultimately enhancing the quality of life for survivors.

**RS5**

**DETERMINANTS OF INITIATING CANCER TREATMENT OF BREAST CANCER SURVIVORS: A DESCRIPTIVE QUALITATIVE STUDY**

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The timing of initiating cancer treatment is a critical factor impacting the risk of cancer metastasis and recurrence, morbidity, mortality, and overall survival rates. Based on the Health Belief Model, health beliefs and cues to action are the main determinants that in-
fluence women diagnosed with breast cancer to initiate treatment. This qualitative study aimed to explore the health beliefs regarding initiating treatment, cues to initiate treatment, and strategies to influence women diagnosed with breast cancer to initiate cancer treatments. Methods: A convenient purposeful sample of 25 breast cancer survivors undergoing cancer treatment was recruited from a Midwestern medical center. A descriptive qualitative design was employed. Semi-structured interviews were conducted by telephone or video conference, digitally recorded, and transcribed verbatim. A content analysis was used to define the subthemes of priori themes derived from the Health Belief Model. Findings: Breast cancer survivors had a mean age of 51.5 years (range 31-75 years), were primarily Caucasian (n=17), had an average duration since the diagnosis of 31 months, and the time between being diagnosed and initiating the first treatment ranged between 2 weeks to 2 years. The first treatments received were chemotherapy (n=16), surgery (n=7), and hormonal therapy (n=2). Health belief subthemes that emerged: 1) perceived benefits including personal, physical, and social benefits, having long life expectancy, and fighting cancer; 2) perceived barriers including personal, physical related, financial and health insurance related, facility related, treatment-related, and community related barriers; 3) perceived threats involving death, cancer spreading and recurrence, and the need for more aggressive treatments, and 4) self-efficacy influenced by having social support system, having knowledgeable trusted health care professionals, trusting the treatment plan and effectiveness, and having life responsibilities. The primary reported cues to initiate treatment were social support services, cancer organization support services, education and communication with the healthcare providers, individual intrinsic resources, and availability of online cancer-related information. The participants suggested strategies to enhance early treatment initiation, such as increasing public awareness using social media and online resources, early screening, patient educational programs, support services, and financial security. Discussion: Health beliefs related to initiating cancer treatments are essential factors that oncology nurses should assess in women diagnosed with breast cancer. Continuous working on strategies influencing early treatment initiation with the involvement of stakeholders and cancer-specialized organizations is crucial.

RS6
DEFINITION AND MEASUREMENT OF OPI-O-PHOBIA AMONG ADULT PATIENTS AND THEIR FAMILY CAREGIVERS
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Survivorship and Palliative and Psychosocial Oncology Care
The ongoing opioid crisis and public media attention surrounding opioids and those who employ them potentially results in opioid underutilization in cancer pain management. Fear of opioids may significantly contribute to this underutilization. Appreciating the impact of opiophobia on pain management is complicated because its conceptual definitions vary, and no gold standard to measure this complex problem exists. Thus, there is a critical need to understand the definition and measurement of opiophobia across the pain spectrum. This information is required to determine the prevalence of opiophobia and the impact of interventions to mitigate it. The purpose of this scoping review was to identify the definition and measurement of opiophobia among quantitative research articles published between 1982 and 2023. We conducted a literature search using the terms “opiophobia,” “opiophobia,” and “opioid” or “opiate” combined with stigma, phobia, fear, paranoia, or “judg*.” Searches were conducted in the CINAHL, Embase, Medline, and Scopus databases. Papers were included in the review if they met the following criteria: 1) quantitative studies involving adults; 2) published in English; 3) measured opiophobia as a variable. Study selection and screening were conducted using Rayyan software. The search yielded 862 articles. After removing duplicates, 449 articles remained of which 409 were excluded following title and abstract review for inclusion criteria. The remaining 40 articles underwent full-text review, and 10 were included in the final analysis. 7 of the 10 articles specifically defined opiophobia. Common components of the definition included prejudice against opioids; fear of opioids and their side effects; exaggerated concerns regarding opioids; and reluctance to utilize opioid analgesia. Most studies (8 out of 10) employed investigator-developed instruments to assess opiophobia. Opiophobia-related items were included in the overall data collection, but not as part of a defined opiophobia score or results. The results of the review revealed inconsistencies among the definition and measurement of opiophobia in quantitative research. Fear of opioids was a common factor found among the definitions of opiophobia in the qualifying studies. To our knowledge, a standardized measure of opiophobia has not been developed. Future studies are needed to
design a framework for and an optimal measure of opioids among patients with cancer and their family caregivers to guide the development of interventions to mitigate opioidophobia and its detrimental effects on optimal cancer pain management.

RS7
ENHANCING QUALITY OF LIFE IN AML PATIENTS UNDERGOING AZA/VEN TREATMENT: AN INTERDISCIPLINARY APPROACH
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Healthcare Delivery
Patients with Acute Myeloid Leukemia (AML) undergoing Azacitidine (Aza) and Venetoclax (Ven) treatment often experience fatigue, weakness, and shortness of breath, impacting their physical function and quality of life. However, limited research exists on physical function assessments and interventions in this population. This study aims to improve the quality of life of AML patients undergoing Aza/Ven treatment by addressing physical capacity and activity. An interdisciplinary team, including Registered Nurses (RNs), Occupational Therapists (OTs), and Physical Therapists (PTs), administers assessments, educates patients, and collaborates to create individualized interventions. The PT’s role is crucial in this collaborative intervention. Key interventions include administering outcome assessments, creating patient-centered SMART goals, developing home exercise programs, providing patient-specific education, monitoring treatment response, and offering caregiver-specific education. In the control phase, assessments such as the Timed Up and Go (TUG), Berg Balance Scale (BERG), and AMPAC were used. However, these did not adequately assess strength and endurance, leading to the addition of the 30-Second Sit to Stand and 6-Minute Walk tests. The interdisciplinary approach addresses the multifaceted needs of AML patients, focusing on endurance, strength, and patient preferences. Challenges include limited time due to busy clinic schedules, impacting assessment scheduling and adherence to intervention prescriptions. In the future, we aim to establish regular follow-up appointments, remove the AMPAC assessment due to limited usefulness, and create protocols for use in community cancer centers. This study highlights the importance of an interdisciplinary approach in improving the quality of life for AML patients undergoing Aza/Ven treatment. While challenges exist, flexibility and regular team communication are key to addressing patient needs effectively. Future research should explore additional outcome measures and broader applications of this approach in various healthcare settings and consider the inclusion of other disciplines. In the realm of cancer treatment, the collaborative efforts of healthcare professionals play a pivotal role in enhancing the quality of life for patients undergoing challenging therapies. The PACT study explores the role of Occupational Therapy (OT) and Physical Therapy (PT) in the context of patients with Acute Myeloid Leukemia (AML) undergoing Azacitidine (Aza) and Venetoclax (Ven) treatment, focusing on optimizing patients’ physical and emotional well-being.

RS8
WHO NEEDS MORE SUPPORT? - AN EVALUATION OF BREAST CANCER SURVIVORSHIP PROGRAMS AND SURVIVORS’ WELLBEING
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Survivorship and Palliative and Psychosocial Oncology Care
Cancer affects people’s life not only physically but also psychosocially. The National Accreditation Program for Breast Centers (NAPBC) established standards to assure high-quality care and improve survivorship support by oncology navigators as one of the NAPBC’s focus. In order to improve support for cancer survivors, a study to evaluate current practice and patients’ perceptions is needed. The purpose of this study was to evaluate the breast cancer patients’ perception of the survivorship-care-plan and the newly-developed cancer survivorship program. Also, this study aimed to understand how demographics impact health-related quality-of-life (QOL). The research team, consisting of nurse navigators, oncology CNS and nurse scientist, created an e-survey to ask questions on survivorship programs, navigator support, and patients’ QOL. Validated tools, FACT-G and FACT-B are used to measure QOL. After IRB approval, the voluntary survey was sent to cancer survivors from the health system in Western US with 20 acute care centers from August to September 2022. The data were analyzed using SPSS v.28.
177 (27% of valid email addresses) survivors started and 149 (22%) completed the survey. Mean age was 61-year-old and 74% was married. 43% had chemotherapy and 73% had stage 0/I/II. 86% talked to nurse navigator and found it helpful, but only 28.2% answered they received survivorship care plan. 30% answered they received survivorship program information, but only 13.8% participated in the program. When age groups were compared, the results revealed that survivors younger than 40-year-old had statistically significantly lower Social WB (p=0.043), Emotional WB (p=0.013), Breast Cancer Subscale (p=0.007), FACT-B Trial Outcome Index (p=0.016), FACT-G total (p=0.01) and FACT-B total (p=0.006) than all older age groups. Survivors are not aware of support/integrative/survivorship programs. There is a need for making the programs visible and a part of Survivorship-Care-Plan. Currently some programs let survivors choose to be on the email-list, and the recommendation based on the findings is to change the recommendation to home can be stressful for both the patient and

RS9
CHARACTERISTICS OF INDIVIDUALS WITH EARLY-ONSET CANCER IN THE SOUTHEASTERN US
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Health Equity
There has been a significant increase in early-onset cancers, defined as cancer in adults under 50 years of age, especially gastrointestinal cancers. Furthermore, cancer diagnosis and treatment disparities continue to rise, especially in South Carolina (S.C.); however, risk factors contributing to early-onset cancer diagnoses are mainly unknown. To address this gap, we first examined the characteristics of patients with early-onset gastrointestinal cancers in S.C. Purposes were to determine 1) prevalence of patients with early-onset gastrointestinal cancers in S.C. and 2) characteristics and social determinants of health of patients with early-onset gastrointestinal cancers in S.C. We conducted a retrospective review of electronic medical records (EMR) (1/1/2020-8/30/2023) to identify patients with newly diagnosed early-onset colorectal or appendix cancer at a community oncology clinic in S.C. We determined potential cases using an electronic report (i.e., age, new patients, diagnosis). Eligibility criteria were confirmed by EMR review, and data were entered into a REDCap database, including socio-demographics (e.g., age, gender, race, insurance type), and cancer-related information (e.g., stage, smoking status, and BMI). Using SAS (v9.4), we computed descriptive statistics, including frequencies and percentages, to characterize the patient sample and chi-square of independence for potential associations among variables of interest. The total number of colorectal and appendix cancer cases (all ages) seen during the three years was N=562. Seventy-two cases met study entry criteria (N=63 colorectal; N=9 appendix). Early onset prevalence was 13%. Most patients had stage III (39%) or stage IV (35%) cancer. The average BMI was 30.21 (SD=6.85). Sixty-four percent were nonsmokers, and 24% had a history of anxiety. Most were female (60%) and 40% were African American. Other sociodemographic characteristics included 50% married/partnered, 32% unemployed, and 53% lived in a rural area. About 48% had commercial insurance, 29% had Medicare/Medicaid, and 23% had no insurance, department of corrections, or veteran’s insurance. There was a statistically significant association between insurance and race (p=0.0010), employment (p=0.0002), and marital status (p=0.0067). Findings suggest disparities in healthcare access remain in S.C. and potentially for individuals with early-onset gastrointestinal cancers. Future research is needed to examine health disparities concerning race, geography (e.g., rural/urban), gender, and socioeconomic status (e.g., insurance coverage) to elucidate risk factors for early-onset cancer and provide a basis for creating multilevel screening and intervention strategies to improve patient mortality and survival.

RS10
CAREGIVER SATISFACTION DURING THE TRANSITION FROM INPATIENT CANCER CARE TO HOME-BASED END OF LIFE CARE
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Survivorship and Palliative and Psychosocial Oncology Care
A preponderance of cancer deaths occurs in hospitals despite many patients citing home as their preferred place of death. Hospice care can improve outcomes at end of life but the transition from inpatient hospitalization to home can be stressful for both the patient and
Caregivers are co-recipients and co-providers of care at EOL; their experience with this transition is a gap in literature. The purpose of this descriptive study was to explore informal caregiver perceptions of the transition experience from an inpatient admission at a large, urban comprehensive cancer center to home-based EOL care. A cross-sectional design using the FAMCARE-2 survey, a reliable, validated tool that measures caregiver satisfaction with advanced cancer and palliative care, was undertaken. Through a 17-item, 5-point Likert scale questionnaire, the FAMCARE-2 yields a composite score from 17 (very dissatisfied) to 85 (very satisfied). Caregivers were identified from a case-management report highlighting planned discharges to home hospice. Caregivers over age 18 who spoke English were approached at bedside or via telephone immediately after discharge for a 6-month period. The survey included non-identifying demographic information, and completion conveyed consent to participate. An open-ended text field allowed for additional feedback. Results: One hundred ninety-eight caregivers agreed to receive the survey with 53 (27%) responding. Overall, the responses on the FAMCARE-2 were very positive. Those who reported receiving all or most of the support they need at home had statistically significant higher FAMCARE-2 scores than those who reported some or no support. A number of factors were found not to be significant including the caregiver’s relationship to the patient, their age, gender, race and ethnicity, employment status and financial security. For patients who wish to die at home, the greatest predictor of this occurring is the presence of a willing and able caregiver. Literature has shown informal caregivers are essential for successful home hospice transitions and care but there is limited data on how to identify caregivers that may need additional support. The results of this study encourage early identification of and support for these caregivers. Improvements in these areas may not only increase caregiver satisfaction, but also enhance the likelihood of patients getting and remaining at home for death. This benefits hospital metrics around patient discharges and flow efficiencies, but most importantly improves patient outcomes at end of life.

RS11
EXPERIENCES OF ONCOLOGY CLINICAL TRIAL NURSES AND STAFF IN NAVIGATING FAMILY CAREGIVER INVOLVEMENT IN INFORMED CONSENT
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Healthcare Delivery
Family caregivers are a vital component of the cancer care team, providing daily physical, emotional, and logistical support to patients. Caregivers also assist with important medical decisions, including participation in clinical trials. Clinical trial staff play a key role in the informed consent process and serve as a primary contact point for patients and caregivers throughout trial participation. Although caregivers are regularly involved in decision-making informally, there is little consensus regarding how they should be included in the informed consent process for clinical trials. This qualitative study sought to identify attitudes, beliefs, and approaches used by clinical trial nurses and research staff to navigate family caregiver involvement in oncology clinical trial consent. Clinical trial staff at a cancer center were invited via email survey to join a focus group. Purposive sampling was employed to capture various disease teams and types of clinical trials. Staff members were separated into two focus groups: one for clinical research nurses, and one for research specialists (non-licensed). Five nurses participated in the first focus group, and 5 research specialists participated in the second. Participants were asked about their attitudes towards caregiver involvement, their strategies for including them in the consent process, and caregiver roles in decision-making. Thematic analysis identified the following themes related to family caregivers: influencing the decision, supporting patient understanding, and family burden. A theme specific to clinical trial staff was a lack of training in communication strategies. In most cases, staff found caregivers to be helpful and encouraged their involvement in the consent process. Certain disease teams, such as neuro-oncology and urology, reported unique issues that necessitated caregiver involvement during and beyond consent. Some challenging situations arose in which family members disagreed, which prompted staff to talk with the patient alone. Clinical trial staff perceive family caregivers to play an active role in decision-making and supporting patients throughout clinical trial participation. Caregivers should be involved early on in the consent process, both to facilitate patient understanding and to be aware of implications of clinical trial participation for their own lives. Additional training may be warranted for clinical trial staff to formalize...
caregiver involvement in consent and navigate family disagreement when needed. Relational autonomy may be a useful framework for the ethical inclusion of family caregivers in clinical trial decision-making.

RS12
PILOT TESTING OF VIRTUALLY-DELIVERED VIDEO-RECORDED SIMULATION-BASED EXPERIENCES IN AN ONCOLOGY NURSING SEMINAR
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Healthcare Delivery
The COVID-19 pandemic forced nurse educators to rapidly switch to online instruction. Literature suggests video-recorded simulation-based experiences (SBEs) are positively received by nursing students, and increase knowledge and clinical judgement. No studies have explored the use of virtually-delivered, video-recorded (VDVR) simulation-based experiences to enhance learning of oncologic emergency management in nursing education. The primary aim of this pilot study was to determine the effect of VDVR SBEs including patient and family member standardized participants on prelicensure nursing students’ self-perceived confidence and competence, and anxiety and self-confidence with clinical decision-making, related to oncologic emergency management. A secondary aim was to explore nursing students’ perceptions, satisfaction and self-confidence in learning using VDVR SBEs in a seminar course. A pre-test/posttest, one-group, convergent mixed-methods design with questionnaire variant was used. Nineteen senior, baccalaureate nursing students enrolled in a virtual oncologic emergency management seminar participated in this study. Students watched a Needs Improvement version of a video-recorded oncologic emergency simulation using Debriefing for Meaningful Learning as an observation guide, engaged in a faculty-facilitated debriefing, then watched an Exemplar version of the same oncologic emergency simulation. Self-perceived confidence and competence, and anxiety and self-confidence with clinical decision-making were measured before and after the SBE. Data about perceptions, satisfaction, and self-confidence in learning were collected after the SBE. Quantitative data were analyzed using descriptive statistics and paired-sample t-tests; qualitative data were analyzed using thematic analysis. Overall, students expressed positive perceptions of VDVR to learn oncologic emergency management. Paired-sample t-tests demonstrated a significant increase in mean competence scores from pre-SBE to post-SBE (t(18)=−3.71; p<0.001; d=−0.86) with a large effect size. There were non-significant increases in confidence and self-confidence with clinical decision-making, and a non-significant decrease in anxiety related to clinical decision-making. Thematic analysis revealed 3 themes: Realism, Critical Analysis, and Preference for Hands-on Learning. This pilot study was the first to explore the use of VDVR SBEs for prelicensure nursing students to learn how to manage clinical emergencies in patients and families affected by cancer. Given the benefits of the directed observer role in simulation, and the current findings that support increased self-perceived competence and positive perceptions toward this teaching strategy, VDVR SBEs hold promise to enhance student learning. More research is needed to determine the effect of VDVR SBEs on learning outcomes to establish best practice recommendations.

RS13
FECAL INCONTINENCE QUALITY OF LIFE AND ASSOCIATED FACTORS IN PATIENTS WITH NEWLY DIAGNOSED RECTAL CANCER: A PILOT STUDY
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Symptom Science
Approximately 80% of patients with rectal cancer (RC) experience low anterior resection syndrome (LARS), which leads to psychological distress and poor quality of life (QOL). Therefore, the aim of this study was to explore the associated factors with fecal incontinence quality of life (FIQL) in patients with newly diagnosed rectal cancer. A longitudinal study was conducted in a surgery clinic at a medical center in Northern Taiwan. Patients who were newly diagnosed with stage to RC and scheduled for treatments were recruited. A structured questionnaire was used to assess patients’ demographic and clinical characteristics, LARS, depression, anxiety, and FIQL at four assessments (i.e., before treatments (T0), one month (T1), two months (T2), and three months (T3) after treatments). Generalized estimating equations were used to explore associated factors with FIQL. Among patients, the mean age was 58.7 (SD=10.8). Patients showed higher levels of anxiety (M=3.8; SD=5.8) and depression (M=10.4; SD=11.5) at T0. In addition, patients experienced higher levels of LARS (M=24.2; SD=14.6) and poor FIQL.
(M=106.8; SD=16.5) at T2. Overall, the LARS ( □ = -.160; p < .001) showed a negative impact on FIQL, especially in the lifestyle ( □ = -.160; p < .001), coping ( □ = -.155; p < .001), and embarrassment ( □ = -.034; p = .004) aspects of FIQL. Moreover, the distance of the tumor from the anal verge ( □=.260; p = .011) was positively associated with FIQL. Healthcare providers should pay more attention to psychological distress before treatment, and assist patients in managing LARS to improve FIQL after receiving treatments in patients with newly diagnosed RC. FIQL is a specific measurement to assess patients’ faecal incontinence-related QOL. In addition, this is the first study to connect LARS and FIQL.

**RS14 HISTORIES, PERSPECTIVES, AND VALUES OF WOMEN CONSIDERING CONTRALATERAL PROPHYLACTIC MASTECTOMY (CPM)**

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Survivorship and Palliative and Psychosocial Oncology Care

Contralateral prophylactic mastectomy (CPM) is a risk-reducing surgical removal of a healthy breast to reduce the risk of developing breast cancer. Although most women diagnosed with breast cancer will never develop a contralateral breast cancer, it continues to be an area of discussion at surgical consultation. Further, in 2016, the American Society of Breast Surgeons (ASBrS) consensus statement reported that CPM does not increase overall survival benefit in patients without a genetic mutation and should be discouraged in average-risk women with unilateral breast cancer. The purpose of this study was to explore patient reported histories, perspectives, and values at the time of surgical consultation when considering unilateral mastectomy versus CPM. Histories, perspectives, and values were identified through single, semi-structured interviews with patients considering unilateral mastectomy versus CPM. Through convenience sampling, patients were enrolled from two breast specialty clinics located in Central Virginia. Inclusion criteria for interviews were 1) women age 25 or older, (2) patients with a diagnosis of breast cancer, (3) breast cancer stage 0, I, II or III, (4) women that have received a breast consultation within the last 12 months, and (5) women that are considering CPM, have had a CPM, and those that decided unilateral mastectomy alone. Ineligible patients included those with known BRCA or advanced stage cancer. A total of 15 patients diagnosed with early breast cancer participated in this study. Four themes were identified from the qualitative data: 1) fear of cancer recurrence or a cancer diagnosis in the opposite breast, 2) empowerment and self-trust, 3) previous experiences, histories, and influences related to cancer, and 4) expressed need for increased psychosocial support at the time of initial diagnosis. The interview results build upon previous research exploring the patient reported factors for choosing CPM versus unilateral mastectomy. Participants endorsed that the DA intervention in conjunction with the trained nurse delivering the DA to be most helpful. A trained nurse interventionist to deliver a guided conversation to assist patients in balancing breast oncology surgical choices is well-received and acceptable by breast surgery patients according to the findings of this study.

**RS15 DECISION AID INTERVENTIONS FOR CONTRALATERAL PROPHYLACTIC MASTECTOMY: AN INTEGRATIVE REVIEW**

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Survivorship and Palliative and Psychosocial Oncology Care

The use of a decision aid (DA) for women facing the decision of contralateral prophylactic mastectomy (CPM) is limited. Multiple systematic reviews from 2016-2020 demonstrate that most surgical decision aids for the breast cancer population focus on the lumpectomy, axillary surgery, unilateral mastectomy, and/or reconstruction. However, despite being recognized as a preference-sensitive decision, the systematic reviews did not include specific DAs for CPM. The purpose was to build on previous literature regarding the use of patient DAs in the breast oncology setting, the purpose of this integrative literature review is to identify current research testing the use of a DA intervention for CPM versus unilateral mastectomy. A recent search was conducted in CINHAL, OVID Medline, PubMed, Web of Science, PsyCINFO, and Cochrane databases using search terms contralateral prophylactic mastectomy and decision aid. The studies were assessed for relevance in testing a patient DA for CPM and
measurements used for the decision process and decision quality. Five studies met the inclusion criteria. These studies included a pre-post cohort pilot study, one randomized controlled trial, two mixed-method studies, and a qualitative study. Findings among the included literature indicate that a DA for CPM is acceptable and feasible in clinical practice when balanced information is presented. In breast oncology surgery settings, further testing of a DA for women considering CPM should be considered. From this review of the literature, it is recognized that decisional support is beneficial in the oncology setting, especially when the treatment options can be driven by patient preference. Further, it is important in oncology care to ensure that patients are provided the best instruments to help make shared, informed decisions surrounding treatment next steps.

RS16
SYSTEMATIC REVIEWS OF VITAMINS B, C, E, AND SELENIUM REGARDING SAFETY AND EFFICACY IN THE ONCOLOGY SETTING AND THE IMPORTANT ROLE OF THE ONCOLOGY NURSE
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Survivorship and Palliative and Psychosocial Oncology Care

In 2009, Miller et al found 73% of adult cancer survivors used dietary supplements. In 2020 Du et al, reported people with cancer were more likely to use multivitamin/vitamin supplements than those without a cancer diagnosis (70.4% vs 51.2%). The American Cancer Society when educating regarding dietary supplements, informs the reader dietary supplements can have risk, especially for those undergoing cancer treatments. Oncology nurses are interested in patient safety and outcomes, as well as, in an important position to assess risks and empower patients with evidence based information to make patient centered choices regarding their care. Two systematic reviews were performed in 2022 regarding the efficacy and safety of dietary supplementation for Vitamins B, C, E and Selenium by patients in the oncology setting. An interdiscipli- nary oncology team reviewed the results and nursing & pharmacy members provided information to inform the point of care. Systematic reviews were conducted following The Preferred Reporting Items for Systematic Reviews and Meta-Analyses—Scoping Reviews guidelines, using pre-specified search terms in PubMed to include randomized control trials, clinical trials, and case studies. Two reviewers independently reviewed titles, abstracts, and full-text articles for inclusion, with a third reviewer resolving conflicts, before the included articles underwent data extraction and quality appraisal. Data extraction was conducted through COV- IDENCE, which managed and tracked the data during the search process. Data Bases searched used were PubMed. CINAHL also for Vitamin C, E, and Selenium. Findings were as follows:

- Inclusion criteria found studies on Vitamin B1, 3, 6, 9, 12
- Across the 25 included studies for Vitamin B and 24 for Vitamin C, E and Selenium, reports of efficacy and safety varied greatly
- ACS, ASCO, and more are apprehensive to recommend the use of Vitamin Bs due to lack of consensus
- ACS, ASCO and more do not recommend the use of antioxidant supplements, and some advance caution towards their use due to reports of harmful effects.

Further study is warranted. However, there is need for oncology nurses and cancer center leaders to have consistent processes assessing for patient dietary supplement use. Oncology nurses often are trusted colleagues and can encourage open dialogue between patients and cancer healthcare providers. Consistent evidence based messaging from cancer care team members to patients could increase this trust and lead to greater patient satisfaction.

RS17
CANCER TREATMENT DELAYS IN ADULTS WHO ARE VULNERABLY HOUSED – A SCOPING REVIEW
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Health Equity

Homelessness amplifies health risks which may affect health-seeking behaviors. Understanding the intersectionality of homelessness and time-sensitive illnesses, e.g., cancer, is essential for clinical decision-making. To date, there is no synthesis of how homelessness may impact time-to-treatment initiation and completion in adults with cancer. The purpose was to conduct a scoping review examining how homelessness typologies (chronic, episodic, transitional) relate to (1) time-to-
treatment initiation, 2) treatment completion, 3) facilitators and barriers to treatment, and 4) implications for future studies. Following an a priori protocol, JBI and PRISMA guidelines, 5 databases were searched with reference lists of included studies hand-searched for additional relevant studies not captured by the search. The search was re-run prior to submission to identify newly published articles for inclusion. Two authors assessed 914 titles and abstracts, then 32 full texts. Sixteen studies involving 251 adults across five countries were analyzed in this review. This study found that 56% of individuals in the sample had regional or advanced cancer, with lung, breast, and head and neck cancers being the most observed types. Time-to-treatment varied from 30 to 365 days, with significantly greater delays for chronically homeless individuals (up to 365 days) compared to episodic or transitional homeless. Missed appointments and treatment abandonment were prevalent among those with regional or advanced disease. In studies reporting typology, missed appointments were noted in both chronically and episodically homeless people, with fragmented care underscored for episodic experiences. There were no observations in transitionally homeless people. Treatment abandonment was observed in 19%-58% of the sample and occurred in those with regional or advanced disease using various cancer treatment modalities. In studies reporting typology, hospital elopement and complete loss to follow-up after diagnosis were noted for chronically homeless and multiple treatment abandonments in the episodically homeless. There were no observations in transitionally homeless people. Barriers to treatment included geographic obstacles, disease progression, mental health disorders, miscommunication, financial toxicity, and diagnostic errors. Facilitators included early interdisciplinary partnerships and patient assistance programs. The existing literature, though limited, suggests differences in how homelessness intersects with the cancer care continuum based on typology. Tailoring interventions by typology with a focus on follow-up for people experiencing chronic homelessness and continuity of care for people experiencing episodic homelessness, may enhance public and hospital-based programs. Further studies are essential to understand this area.

RS18
ADDRESSING FINANCIAL TOXICITY AND COST-RELATED HEALTH LITERACY TO SUPPORT HEALTHCARE TRANSITIONS OF ADOLESCENT AND YOUNG ADULT (AYA) CANCER SURVIVORS: A CASE STUDY
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Survivorship and Palliative and Psychosocial Oncology Care
Adolescent and young adult (AYA) cancer survivors (diagnosed between 15 and 39 years of age) are vulnerable to financial toxicity (FT) due to developmental life stages, healthcare transitions (HCTs) from pediatric oncology care to adult and/or primary follow up care, and the long-term effects of cancer on AYAs. However, limited research has been conducted to investigate the impact of financial toxicity (FT) and cost-related health literacy on the quality of HCTs especially among AYA’s residing in rural areas. Financial toxicity (FT), defined as financial distress related to the costs of cancer care, is linked to increased symptom burden, as well as decreased treatment compliance and cancer survival. In addition, low levels of cost-related health literacy are correlated with poor HCT outcomes such as greater use of emergency services and less utilization of preventative care. The purpose of this study was to examine the impact FT and cost-related HL have on HCTs amongst AYAs residing in rural areas. Two key informant interviews were conducted using a semi-structured interview guide with AYA survivors from a pediatric oncology clinic. Guided by the Social-ecological Model of AYA Readiness for Transition a qualitative case study analysis approach was used to understand experiences of FT and HCT to help identify potential targets for future interventions. Case 1: 33-year-old male currently in remission from leukemia; diagnosed in 2013; experienced FT due to loss of assets and subsequent lack of access to proper financial aid. Case 2: 22-year-old non-binary who currently has relapsed with rhabdomyosarcoma; experienced FT due to costs of cancer care and side effects. Major themes that arose were related to experiencing FT, mistrust in the healthcare system and providers, cost-related HL, and financial navigation. Barriers to successful HCTs resulted in noncompliance with medications and healthcare follow-up after completing cancer treatments. Furthermore, treatment plans were impacted due to barriers to access, FT, and lack of patient advocacy. In conclusion, potential interventions include improving primary care provider’s knowledge of survivorship care, facilitating patient-provider costs of care conversations, providing support for caregivers,
and enhancing insurance navigation services. Further implementation of these interventions could lead to improved financial and health outcomes amongst AYA cancer survivors.

**RS19**

**EXAMINING THE IMPACT OF FINANCIAL TOXICITY ON HEALTHCARE TRANSITIONS OF ADOLESCENT AND YOUNG ADULT CANCER SURVIVORS: KENTUCKY CANCER REGISTRY**

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Survivorship and Palliative and Psychosocial Oncology Care

Adolescent and young adult (AYA) cancer survivors (diagnosed between 15 and 39 years of age) are vulnerable to financial toxicity (FT) due to developmental life stages, healthcare transitions (HCTs) from pediatric oncology care to adult and/or primary care, and the long-term effects of cancer. However, limited research on the impact of financial toxicity (FT) on AYA HCTs has been conducted. The purpose of this study was to examine the impact FT on HCTs and health-related QOL among AYA cancer survivors in Kentucky. A cross-sectional survey design was used to recruit AYA cancer survivors from the Kentucky Cancer Registry. 260 survivors completed surveys measuring FT (COST-FACIT), HCT outcomes (transition readiness, healthcare utilization, and late/long-term health impact), and health-related QOL (PROMIS Global health, anxiety and depression). Data were summarized using descriptive statistics and bivariate analysis to examine associations. Our sample was predominantly white (73.5%), female (74.3%), employed (75%), married/domestic partnership (53%), insured via employer health plan (59%), with a college degree or higher (56%) and living above the Federal Poverty Level (85.4%). The mean age at diagnosis was 31.7 years (SD= 5.95). Overall, our sample had moderate COST-FACIT scores (M=25.2; SD=7.6), however 22% reported finding it difficult/very difficult to live on current income, 8% had to borrow money/debt, and 8 filed for bankruptcy. 3% indicated having to delay or forego care because of costs. On average, participants reported high transition readiness (M=60.2; SD=12.89) and health-related QOL (Global [M=27.3; SD=8.73]; Anxiety [M=56.3; SD=9.38], Depression [M=53.1; SD=10.07]). The majority indicated seeing a health provider since their cancer diagnosis (86.5%), fewer within the past 2 years (79.2%), however most relied on their oncologists as their main healthcare provider. Many experienced symptoms related to their cancer/treatment (57%) and had an average of 1.8 (SD=2.26; 0-13) medical conditions since diagnosis. There were no significant associations between COST-FACIT and any of the HCT or health-related QOL outcomes. Findings are inconsistent with existing literature indicating high FT rates among AYA’s and negative impact on QOL. Additional research is needed to better understand the impact of FT on HCT among sub age groups within AYA population.

**RS20**

**ELECTRONIC HEALTH RECORD CLINICAL AND RESEARCH DATABASE FOR COMMUNITY-BASED CLINICAL TRIAL RECRUITMENT**

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Survivorship and Palliative and Psychosocial Oncology Care

Community-based interventions in geriatric oncology are underdeveloped in Northern California, despite the growing prevalence of older cancer survivors and the rising incidence of geriatric syndromes. This research aims to address this critical gap by identifying and engaging eligible patients within our catchment area for a pilot study on geriatric oncology survivorship. However, effective strategies to recruit these patients are limited due to the lack of existing methods in our community. The purpose was to create an Electronic Health Record (Epic) embedded database with detailed patient-level, treatment, and functional information allowing clinical and research application for a pilot survivorship clinical trial. This research involved aggregating data from eligible patients into a de-identified database for a pilot clinical trial in geriatric oncology. The eligibility criteria for participants included having breast, prostate, or colorectal cancer, being between the ages of 65-90, having a PHQ-9 score less than 20, and resided in the health system’s catchment area. The study protocol was approved by the Institutional Review Board (IRB #1943526). Epic’s SlicerDicer feature was utilized to identify patients who met the eligibility criteria for the study, using data from September 2022-September 2023. Descriptive statistics summarized the distribution of the eligible participants. Findings from Epic’s SlicerDicer feature showed 4,995 participants eligible for the study, with a diverse sample in terms of ethnicity and gender. Among eligible
participants, age distribution was 50.0% between 65-74, 40.4% between 75-84, and 9.6% between 85-90. Most patients’ records did not have a PHQ-9 score in the last 12 months. Based on analysis, recruiting 49 participants over 12 months is feasible, with recruitment scheduled to begin in February 2024. Before starting recruitment, a review of the EHR data determined study feasibility. To enhance participant engagement, each participant will be paired with a community health worker for 6 months. Physical functioning is the primary outcome, and secondary outcomes include anxiety, self-efficacy, fatigue, and social support. A mixed mode of recruitment, including Epic MyChart messages, direct calling, and community-based recruitment, will be implemented. Analyzing clinical data before recruitment has enhanced the study design and participant-centric approach. By leveraging clinical data and IT resources, this research efficiently identified potential participants for the clinical trial. This innovative approach streamlined recruitment and ensured data reliability and accuracy.

RS21
ENGAGING OLDER LGBTIQI INDIVIDUALS IN CANCER QUALITATIVE RESEARCH USING A PROPRIETARY SOCIAL MEDIA PLATFORM (MAYO CLINIC CONNECT)
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Health Equity
LGBTIQI populations are at elevated risk of several types of cancer (Quinn et al., 2015) and older LGBTIQI individuals are more vulnerable to poor health outcomes and less likely to seek healthcare due to fear of discrimination (Caceres, 2019). Furthermore, there is a dearth of research regarding LGBTIQI and cancer healthcare experiences. This paucity of research contributes to lack of clarity on best methods for how to engage this population in qualitative research (Rosser & Capistrant, 2016). This IRB-approved, exempt qualitative study focused on engaging with older LGBTIQI individuals using a large proprietary social media platform (Mayo Clinic Connect) dedicated to health and illness. Individuals were screened and recruited anonymously to learn about the experiences and challenges faced by older LGBTIQI individuals diagnosed with cancer or other serious illnesses offering either a self-initiated, telephone interview or an online, comment-style, written survey. Over an initial four-week period, 11 of 16 individuals were deemed eligible and 5 (45%) expressed an interest in doing an anonymous interview, however, no individual initiated telephone contact. During a subsequent four-week period, 24 of 26 individuals were deemed eligible with 14 (58%) people providing anonymous written responses to four open-ended questions. When seeking anonymous qualitative data from older LGBTIQI individuals via a social media platform, offering anonymous written comments were more successful than offering self-initiated telephone interviews. Convenience and immediacy may explain the preference for written responses versus initiating a telephone interview during specific time periods. The written option provided time to reflect on the questions before responding and was possibly viewed as an extension of their existing online engagement. Furthermore, speaking with an interviewer by phone may also have opened the possibility of divulging personal demographic information triggering fears for risk of discrimination. This presentation will share lessons learned and insights gained when comparing two methods of engagement for obtaining anonymized qualitative data from older LGBTIQI adults using a proprietary social media platform. Recruiting and engaging stigmatized populations to participate in research through social media platforms poses many challenges including ensuring participant privacy and investigator transparency. This study contributes insights to the field of conducting qualitative research using a proprietary social-media platform and lays a foundation for further research.

RS22
THE MENTAL HEALTH OF ANAL AND COLORECTAL LGBTIQI+ CANCER SURVIVORS
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Health Equity
Lesbian, gay, bisexual, transgender, queer, intersex, and other sexual and gender diverse (LGBTQI+) individuals are more likely to experience disparities in health outcomes. In particular, sexual minority men report poorer self-esteem and sexual minority women experience higher rates of anxiety, depression, and stress than their heterosexual cisgender peers. However, most research has focused on people with breast and prostate cancer, and it is unknown to what extent other types of cancer, such as gastrointestinal cancers, influence the mental health of LGBTQI+ individuals. The purpose was to explore how anal and colorectal cancer influence the mental health of LGBTQI+ people. Secondary analysis of “OUT: The National Cancer Survey,” a web-based survey conducted between 2020 and 2021 in the US. Mental health was examined by asking the participants how many days in the past month...
they have had poor mental health (e.g., problems with stress, depression, and emotions). Social well-being included Likert-type questions about primary support, number of close friends, and strength of support before and after cancer diagnosis. We run descriptive statistics to characterize the sample and a hierarchical linear regression with number of poor mental health days as the outcome variable to assess predictors of mental health. Analyses were run in RStudio. Alpha was set at .05. The final sample included 295 LGBTQI+ individuals with a median age of 60 years (IQR: 54-80 years). Most were white (83.7%), non-Hispanic (90.8%), gay (73.6%), cisgender men (80.3%), without disabilities (60.7%), diagnosed with colorectal cancer (54.6%), and with at least a college/vocational degree (71.5%). The median number of days with poor mental health was 5 (IQR: 1-15 days). Most reported having a support person (87.1%), three or more close friends (64.4%), a strong social support before cancer (76.6%), and either no change (45.4%) or stronger support after cancer diagnosis (43.1%). The final model (R2= 10.41%, F [3, 289]= 11.19, p<.001) showed that having a disability (□= 5.09, p<.001) and two or less close friends (□= 5.16, p<.001) were significant contributors of poor mental health. People with a disability and with fewer close friends might be at higher risk of worse mental health outcomes. Further studies that confirm our exploratory findings are needed. Finally, practice frameworks to engage underrepresented AYAs in the conceptualization and conduct of social science research. Study findings will provide important insights to guide oncology care providers and program administrators in the design of inclusive and equitable cancer care delivery programs for SGM AYAs.

RS24
SAFETY AND EFFICACY OF LONCASTUXIMAB TESIRINE WITH RITUXIMAB IN FOLLICULAR LYMPHOMA
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Data Science
There is no standard-of-care for treatment of relapsed/refractory (rel/ref) follicular lymphoma (FL). Loncastuximab tesirine (loncastuximab) is an antibody-drug conjugate directed against CD19. Here we report initial results of a single-institution study evaluating this combination in rel/ref FL (NCT04998669). Adult
ONCOLOGY NURSES’ EXPERIENCES CARING FOR DYING TRANSGENDER PATIENTS: A PILOT STUDY
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Health Equity

There are approximately 1.4 million transgender adults in the United States, and this number is expected to grow. As transgender youth continue to age and older, previously closeted transgender adults socially transition, oncology nurses will have increased exposure to this population. This descriptive phenomenological pilot study sought to understand nurses’ (N=3) experiences when caring for transgender oncology patients at the end of their life. All three nurses held bachelor’s degrees, had at least 3 years of oncology nursing experience, and were cisgender, white women. Data was collected and analyzed using Colaizzi’s (1978) descriptive phenomenological methodology. Unstructured interviews were thus performed and audio-recorded, then transcribed, and themes were developed. Prevalent themes include 1) Unprepared, 2) Gossiping, 3) Unmet Needs, and 4) Sense of Duty. Unanimously, participants felt Unprepared and reported a lack of education about transgender and gender-diverse people resulting in poorer quality of care than dying cisgender oncology patients. They found other nurses were Gossiping about the patient, and treating the patient as a spectacle rather than a patient deserving of care. The patient had Unmet Needs that were primarily rooted in the nurses’ discomfort with gendered language in the presence of transgender patients and fear of offending transgender patients. Lastly, nurses reported a Sense of Duty to the patient by wanting to improve for future transgender patients. The results of this pilot study show that nurses have serious concerns about their ability to apply their knowledge about oncology-related palliative and hospice care to dying transgender patients. These results suggest that more, larger qualitative research is warranted to better understand nurses’ experiences caring for transgender oncology patients receiving hospice care, as well as preferred routes of educational intervention. Oncology nurses must focus on developing culturally appropriate, gender-affirming care for their patients, especially at the end of life, when patients are at their most vulnerable.
To advance oncology nursing science and clinical practice, researchers and clinicians must understand the important problems facing nurses who provide direct care to people with cancer or manage processes that support patient care. Identification of critical oncology nursing problems frequently stems from workplace experiences. Capturing and communicating this information in a rigorous and standardized format is often lacking and delays our ability to address high-priority, real-world concerns through scientific inquiry. Cancer care advances and recent historic events, such as the COVID pandemic, likely influence current research priorities among oncology nurses. The purpose of this study was to develop a comprehensive compendium of real-world concerns among oncology nurses and build consensus regarding their importance to reinvigorate an oncology nursing research program. Using Delphi survey methodology, this study was conducted in three phases: 1) Identification of experts, defined as RNs employed within our academic cancer center; 2) Qualitative content analysis of 353 responses from 267 RNs who responded to the question, “What do you see as a nursing research concern, problem, and/or issue on your unit or in your work environment that needs to be studied?”; and, 3) Survey completion (n = 248 RNs) rating the importance of 62 research themes identified from the qualitative content analysis. The top ten nursing research priorities included patient safety, patient education, oncologic emergencies, patient expectations and compliance with care, team communication, patient psychosocial needs, patient reported outcomes and quality of life, health-care team burnout, workload, and nurse burnout. The research themes were categorized according to nursing’s metaconcepts of person, nursing, health/illness, and environment. Six of the top ten research priorities were person-related research themes. Across all job titles, person-related research themes were most consistently identified, followed by environment (where care is delivered), health/illness, and nursing (nursing role and professional practice). These findings support the nursing discipline’s fundamental focus on patient safety. The delivery of oncology nursing care is often complex and complicated, thus supporting the need to focus on person-related research themes, such as patient education, expectations and compliance with care, psychosocial needs, and patient reported outcomes and quality of life. Understanding how burnout, team communication, and workload influence patient outcomes is a fertile field for inquiry as a new normal for the delivery of care emerges following the pandemic.

**RS27 ASSOCIATIONS BETWEEN CHRONIC FATIGUE IN BREAST CANCER SURVIVORS AND CYTOKINE GENE POLYMORPHISMS**

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Symptom Science

Cancer-related fatigue (CRF) occurs in 25% to 33% of cancer survivors. CRF impairs quality of life (QOL) and interferes with reintegration into daily activities. While inflammatory mechanisms are implicated in the development of CRF, less is known about their role in chronic fatigue during and following treatment for breast cancer. Using an extreme phenotype approach, the purpose of this study was to evaluate for associations between chronic CRF and polymorphisms for cytokine genes among breast cancer survivors. This candidate gene analysis is part of a larger, longitudinal study that evaluated multiple symptoms in patients prior to, during, and following breast cancer surgery. Patients completed the Lee Fatigue Scale a total of ten times. Growth mixture modeling was used to identify subgroups of patients with distinct CRF profiles from prior to through 12 months after surgery. Genotyping of single nucleotide polymorphisms (SNPs) in cytokine genes was performed using a custom array. Multiple logistic regression analyses were done to identify associations between CRF and SNPs in 16 candidate genes. Compared to patients in the Low chronic CRF class (n=216; 66.9%), patients in the Moderate-increasing chronic CRF class (n=107; 33.1%) were younger; had a higher comorbidity burden and a poorer functional status; and were more likely to have received neoadjuvant and adjuvant chemotherapy within the 12 months following surgery. In the logistic regression analysis, one haplotype for IL1B and one SNP for TNF SF (i.e., rs1799964) were associated with membership in the Moderate-Increasing chronic CRF class. The percentage of patients with chronic CRF is consistent with previous reports. The findings regarding the polymorphisms in IL1-B and TNF SF, that code for inflammatory cytokines, are consistent with previous studies of the underlying mechanisms for fatigue. However, this study is the first to suggest that polymorphisms in...
cytokine genes may play a role in the development of chronic CRF in survivors of breast cancer. If confirmed, these genes may become targets for interventions that decrease fatigue, assist with individuals’ reintegration into routine activities; and improve survivors’ overall QOL.

RS28
CANCER DISPARITIES IN PAIN AND HEALTH-RELATED QUALITY OF LIFE AMONG GASTROINTESTINAL CANCER SURVIVORS IN THE U.S.: WITH A FOCUS ON SOCIAL DETERMINANTS OF HEALTH (SDOH)
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Survivorship and Palliative and Psychosocial Oncology Care

There are health disparities in cancer pain and health-related quality of life (HRQoL) among gastrointestinal (GI) cancer survivors. However, the factors contributing to these disparities are unknown. The purpose of this study is to examine the associations of pain and HRQoL with individual levels (e.g., age, race) and contextual levels (e.g., income, education, home ownership, health care access) of social determinants of health (SDOH). An increasing number of long-term GI cancer survivors often experience chronic pain, including abdominal/pelvic pain, neuropathy pain, and bodily pain, caused by cancer or cancer treatments. Chronic pain in GI cancer survivors has emerged as one of the most prevalent issues, reducing HRQoL. Understanding the social determinants of pain and HRQoL among GI cancer survivors is a vital aspect of cancer survivorship to identify their needs and optimize their care. Adult GI cancer survivors (n = 3,201) in the Behavioral Risk Factor Surveillance System (BRFSS) surveys from 2014-2021 were analyzed. Logistic regression was used to estimate the odds ratios (ORs), 95% confidence intervals (CIs) for the association of SDOH with pain and HRQoL in both unadjusted/adjusted models. We only included SDOH factors in the regression models if they were significantly associated with pain or HRQoL. Stepwise eliminations were performed in multivariate regression models to select a parsimonious model. In the adjusted models, non-Hispanic Blacks, health risk behaviors (sedentary lifestyles, smoking, and alcohol consumption), younger age < 65 years old, being diagnosed with liver or pancreatic cancers among GI cancer types, poor health care access, and more morbidities were associated with higher pain and poor HRQoL. Healthy diet habit was not associated with pain or HRQoL. Among SDOH risk factors, lack of physical activity was the most significant risk factor for cancer pain (OR = 2.01, 95% CI: 1.81 to 2.41) and poor HRQoL (OR = 1.98, 95% CI: 1.71, 2.32). SDOH plays a critical role in cancer pain and HRQoL. Future studies are warranted to develop tailored community-based survivorship interventions such as physical rehabilitation, behavioral interventions, and social support, and to test a machine learning/artificial intelligence-based predictive model to identify GI cancer survivors at high risk of pain and poor HRQoL. Identifying risk factors of pain and HRQoL with a focus on SDOH is the first time research among GI cancer survivors.

RS29
HIGHER MULTIMORBIDITY IN ONCOLOGY OUTPATIENTS RECEIVING CHEMOTHERAPY IS ASSOCIATED WITH A HIGHER SYMPTOM BURDEN
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Symptom Science

While the presence of multiple chronic conditions in the same person (i.e., multimorbidity) is associated with lower functional status and quality of life, patient characteristics and the symptom burden associated with multimorbidity remains poorly characterized in oncology patients. Study purposes were to identify groups of patients with Low (≤2) and High (≥3) multimorbidity and evaluate for differences in demographic and clinical characteristics, the occurrence, severity, and distress of 38 symptoms, and the stability and consistency of symptom clusters in a heterogeneous sample of oncology outpatients (n=1329) undergoing chemotherapy. Using the Self-Administered Comorbidity Questionnaire, patients were classified into Low and High Multimorbidity Groups based on their number of chronic conditions. Memorial Symptom Assessment Scale was used to assess the occurrence, severity, and distress ratings of 38 symptoms for each
multimorbidity group prior to their next cycle of chemotherapy. Symptom clusters for each multimorbidity group were identified through exploratory factor analysis (EFA) using occurrence ratings. Clusters were determined to be stable if they appeared across both multimorbidity groups. Clusters were consistent if the same two or three symptoms with the highest factor loadings were identified across multimorbidity groups. Compared to the Low Group (n=824, 61.4%), patients in the High Group (n=519, 38.6%) were older, had fewer years of education, were less likely to be married or partnered, less likely to be employed, and had a lower annual income. In addition, they had a higher body mass index, poorer functional status, were a longer time since their cancer diagnosis, and were more likely to have received previous cancer treatments and have metastatic disease. Patients in the Low Group reported 12.7 (±6.7) concurrent symptoms while patients in the High Group reported 15.9 (±7.5). For the majority of symptoms, patients in the High Group had significantly higher occurrence (68.4%), severity (65.8%), and distress (50%) ratings. Using EFA, an eight-factor solution was selected for the Low Group and a seven-factor solution was selected for the High Group. While psychological, gastrointestinal, weight gain, hormonal, and respiratory clusters were stable across multimorbidity groups, only weight gain and respiratory clusters were consistent. Findings suggest that higher multimorbidity is associated with various social determinants of health and a higher symptom burden. Assessment of multimorbidity will assist clinicians to identify patients who are at increased risk for a higher symptom burden.

RS30
“OTHER KIDS MY AGE didn’t HAVE TO DO IT”: A MIXED-METHODS EXPLORATION OF CAREGIVING YOUTH IN ONCOLOGY

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Survivorship and Palliative and Psychosocial Oncology Care

Of the estimated 1.9 million new cancer cases diagnosed each year in the U.S., 25% occur among individuals raising children. When a parent receives a cancer diagnosis, the whole family system is affected causing reorganization of functioning, roles, and responsibilities where children may adopt a caregiving role. In the U.S., ~5.4 million caregiving youth provide multifaceted, extended care for ill family members. This experience results in both positive and negative outcomes for youth—spanning multiple domains of health and well-being. The degree to which youth experience consequences of the role is dependent on the complex interplay of individual, relationship, community, and societal factors. Despite evidence of youth providing support when a parent has cancer and the myriad of potential consequences, to date no studies specifically investigate caregiving youth in oncology. The purpose of this study was to explore the caregiving experience, outcomes, and unmet needs of caregiving youth (aged 12-24) who have a parent with cancer. An explanatory sequential mixed methods study design was employed. Fifty-two adults who, as children, lived with a parent with cancer were recruited via social media and asked to complete an online survey (questions pertained to caregiving activity, unmet needs, positive and negative outcomes, and parentification). A subsample of 18 individuals reporting high to very high amounts of caregiving were subsequently interviewed. The mean reported caregiving youth age was 16.13 (±4.86). They provided care approximately 22.43 hours/week, with most (71.2%) reporting high to very high amounts of caregiving activity. Higher unmet needs and higher caregiving activity were found to be significantly associated with both higher reported negative outcomes and higher parentification scores. Qualitative findings included four themes: stepping into the role, family communication, dealing with feelings, and a new separateness. Identified needs included a desire for better communication within the family, help processing emotions, information to aid in uncertainty, and peer-to-peer support. Caregiving youth cannot mitigate the challenges surrounding their role independently. It is important for oncology nurses to be aware of and acknowledge the unique needs of caregiving youth and aid in the development and implementation of tailored interventions to meet those needs.

RS31
THE IMPORTANCE OF ASSESSING THE PATIENT EXPERIENCE OF HYPERSENSITIVITY REACTION

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Healthcare Delivery

The goal of this research was to describe the patient experience of chemotherapy induced hypersensitivity reaction (HSR) at a major comprehensive cancer institution. The patient experience of HSR is often
accompanied by intense emotional responses. Current guidelines for the management of HSR do not universally address the impact on quality-of-life that a patient may experience during or after the event. What is not known, or captured, is the patients’ emotional experience of the event. Thirty patients who had experienced HSR to chemotherapy and had been referred to the allergy clinic for assessment were invited to participate. Methodologic Approach: This quantitative descriptive mixed method study was conducted using a patient self-assessment tool, along with one open-ended question that allowed participants to share their experience. Findings: The qualitative data uncovered three themes that were identified in the group. These include fear of future treatment reactions, confidence in the care team and their own self-confidence. The collected raw data revealed that there was no significant relationship between total scores and age nor grade. Assessment of the experience of HSR provides nurses with information that allows better care of the patient who may be experiencing distress. Nurse-led research should continue to explore the experience and best assessment of quality of life in patients who have had HSR.

RS32
SLEEP HYGIENE EDUCATION, READIWATCHTM ACTIGRAPHY, AND TELEHEALTH COGNITIVE BEHAVIORAL TRAINING FOR INSOMNIA EFFECT, ON SYMPTOM RELIEF DURING ANDROGEN DEPRIVATION THERAPY (SHERE-RELIEF): AN INTERIM ANALYSIS
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Survivorship and Palliative and Psychosocial Oncology Care
Around half of people diagnosed with prostate cancer (PC) receive androgen deprivation therapy (ADT). Subjective self-report measures indicate sleep disturbances are associated with ADT and can negatively affect mood, cognitive function, and pain perception. Feasible, effective interventions are needed for this population. An objective actigraphy device, the ReadiWatchTM, collects sleep metrics (quantity+timing+efficiency=ReadiScore) which are communicated to the wearer along with sleep hygiene education via an interactive application(app). Patients may modify their sleep behavior in response to that information. Telehealth-delivered Cognitive Behavioral Therapy for Insomnia (tele-CBT-I) addresses the behaviors and negative thoughts that perpetuate insomnia and provides additional sleep improvement strategies. The purpose of this two-arm randomized pilot study is to test feasibility of two months of ReadiWatchTM wear and sleep hygiene education alone compared to ReadiWatchTM wear, sleep hygiene education and 4 weekly tele-CBT-I sessions. This interim data analysis was conducted to evaluate feasibility and is a midpoint data check comparing study outcomes in PC patients receiving ADT. PC patients receiving ADT without confounding diagnoses are eligible. Study measures include feasibility (percent recruitment and retention), patient-reported outcomes (PROs) for insomnia, sleep quality, cognition, anxiety, and pain, and pre/post intervention ReadiScores. PROs are collected at baseline, one-month, and two-months. The sample size of the interim analysis plus non-parametric data distribution necessitated using Wilcoxon Signed Rank and Spearman correlation tests (alpha=0.05) and effect sizes. Feasibility: Enrollment is on target (20/40, overall attrition 20%). Tele-CBT-I adherence is 100%. Average ReadiWatchTM wear time is 93.02%. Analytics: No significant between-group changes were seen for ReadiWatchTM scores or PROs. Mean ReadiScores showed weak but significant correlation to Insomnia Sleep Index (ISI) [r=-0.740; p=0.003] and Pittsburgh Sleep Quality Index (PSQI) [r=-0.35; p=0.062]. The tele-CBT-I within-group change improved on ISI [p=0.018; ES 0.740]. No other within-group changes were significant; however, the tele-CBT-I PRO improvement was consistently closer to significance than the ReadiWatchTM alone group. ISI scores across timepoints showed statistically significant correlation of moderate strength to PRO measures. See Tables 1-3. Feasibility was demonstrated and full data collection and analyses are warranted. ReadiWatchTM wear and sleep hygiene education alone did not improve sleep quality. The addition of Tele-CBT-I improved insomnia severity. Interim analyses indicated that ReadiWatch wear combined with tele-CBT-I have potential to relieve sleep disturbance in PC patients receiving ADT.

RS33
QUALITY OF LIFE AMONG PARENTS OF CHILDREN WITH CANCER
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The low Health Related Quality of Life (HRQoL) among the parents of children with cancer as the main caregiver can have negative consequence on their child’s HRQoL. Assessment of HRQoL measure contains overall health and physical well-being. This includes presenting symptoms, emotional, cognitive, role, social, and sexual functioning. As healthcare providers, we should understand the implications of HRQoL of parents caring for a child with cancer in order to assess and implement targeted interventions. The purpose was to evaluate the HRQoL among parents of children with cancer. A cross-sectional study conducted at King Fahad National Children Cancer Center, Riyadh Saudi Arabia. Random sampling technique was used to enroll 250 parents. A 36-item short-form survey (SF-36) constructed for self-administration. SF-36 was developed with two main domains, the physical component (PC) and the mental component (MC) each domain containing four subscales. Descriptive analysis was performed on the data to determine the HRQoL of the parents. The parents reported low to medium levels of HRQoL varying from 39.1 MC score and 57.1 PC score. MC domain indicated low level of HRQoL, three out of four subscales for MC domain scored low HRQoL (Role Limitation Due to Physical Health, Energy/Fatigue, and Social Function) with 20.6, 39.8, 42.6 respectively, while the last subscale (Emotional well-being) reported medium level of HRQoL score. The PC domain reported medium level, and the most affected subscale was the Role Limitation Due to Physical Health with 32 total score that indicated low level of HRQoL. This, followed by the Pain and General Health subscale scored as 43.4 and 57.7 respectively, which reported as medium HRQoL while the physical function reported good HRQoL with 68.3 score. Number of factors were detected that have a significant impact on the HRQoL; age and gender of the child, the treatment modality, and the distance from the treatment center. All of the above-mentioned factors impact HRQoL. The main factors that negatively influence the score for different domains are female children and children of younger ages. The parents are crucial caregivers, offering mental, physical and emotional support to their family. Our study helps us to emphasize the importance of mental support for parents, including implementing number of coping strategies; support groups, therapy for the family or individual, and online resources to enhance their HRQoL.

RS34
CANCER SURVIVOR EMPOWERMENT THROUGH PATIENT-REPORTED OUTCOMES
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Survivorship and Palliative and Psychosocial Oncology Care
The purpose was to assess if the use of patient-reported outcomes (PROs) is associated with patient empowerment (PE) of adult cancer survivors following primary cancer treatment. Aims were to: (1) describe the relationship between PE and PROs in cancer survivors; (2) demonstrate the associations between PE and PROs; and (3) explore whether the associations between PE and PROs change over time, comparing immediately post-treatment and three months post-treatment. Conventional approaches for assessing and managing symptoms in cancer survivors are unlikely to be effective in survivorship. Clinician-driven assessment limits the voice of the cancer survivor while the burden and complexity of cancer care increases. No studies describe how PE may facilitate the cancer survivor’s ability to assume responsibilities for symptom self-monitoring and -reporting in early survivorship. Patient-reported assessment of symptoms, utilizing PROs instruments, may be a mechanism to empower cancer survivors; however, the relationship and associations are unknown. A convenience sample of 83 adult breast, colorectal, gynecologic, and lung cancer survivors immediately following chemotherapy in any phase of primary cancer treatment were enrolled in the study from a Midwestern community-based cancer center. Potential participants were identified from clinic schedules. Thirty-three participants, who finished chemotherapy as the last modality, completed the questionnaire again three months post-treatment. Cancer-related Patient Empowerment Scale, PROMIS® Self-Efficacy Managing Chronic Diseases, and PROMIS®-29 Profile v2.1 instruments were utilized. Sociodemographic and clinical characteristics were collected. Pearson’s correlation coefficient found a significant relationship between PE and self-efficacy and a significant negative correlation between self-efficacy and symptoms. Hierarchical
multiple regression analysis demonstrated that PROs self-efficacy predicts PE immediately following chemotherapy treatment; however, this was not observed three months post-treatment. A decline in PE from immediately following the last dose of chemotherapy to three months post-treatment was found using ANCOVA repeated measures. Homogeneity of sample limits generalizability. Cancer survivor empowerment must be assessed in clinical practice to engage survivors in their new responsibilities. PROs self-efficacy was a predictor of PE immediately following the last dose of chemotherapy; however, it is seldom assessed. With a decline in PE and no statistically significant change in PROs self-efficacy and symptoms three months post-treatment, a qualitative study for conceptual clarification of cancer survivor empowerment is needed. Oncology nurses are critical for envisioning how to transition to cancer survivor-reported assessment and implementing research-based interventions that build empowerment in cancer survivors.

RS35
THE MEANING OF PATIENTHOOD FOR BREAST CANCER SURVIVORS PARTICIPATING IN CLINICAL TRIALS
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Survivorship and Palliative and Psychosocial Oncology Care
The diagnosis of breast cancer (BC) is a life altering event with far-reaching implications in many aspects of a patient’s lived experience, including their understanding of self. This study explored the lived experiences of BC survivors who had participated in a clinical trial (CT) and the meaning of their respective patienthood. The concept of patienthood is derived from the work “Regimes of Patienthood: Developing an Intersectional Concept to Theorize Illness Experiences” (Joyce et al., 2020). This work contextualizes the patient as a construction of social location, describing the social process of assuming identity through one’s response to illness. Although a plethora of research has examined the role of patient, less research exists focused on elucidating the patient’s conceptualization of the meaning of their experience and its contributions to an internalized sense of self. Thus, research is needed to elucidate this meaning of patienthood, to allow the voices of patients to be shared, and to acknowledge them for their often-invisible work needed for the patient role.

This qualitative study used interviews conducted by the principal investigator using a semi-structured interview guide. Hospital-based strategies were used to recruit eligible participants: a) females 18 years or older of age; b) diagnosed with BC; c) currently participating or had previously participated in a BC clinical trial. The sample size was N=10. Data were analyzed using the Colaizzi Method of Phenomenological Analysis. Six themes that emerged from phenomenological analysis were synthesized into a statement of structural phenomena, validated by all participants. The fundamental structure of meaning of patienthood for BC survivors participating in a CT is the integration of BC and treatment into an evolving self-identity that requires work inclusive of coping with chronic uncertainty that is sustained over time by social supports, the CT team care, and personal altruism. Participants were given the opportunity to share their meaning of patienthood. Their rich descriptions of experiences and resulting themes may inform clinicians and palliative care specialists on acknowledging patienthood and integrating it into their care. The provision of comprehensive patient care requires situating the meaning of patienthood within the context of a patient’s illness experience. Future research should explore the significance of this concept to the BC patient’s psychological adjustment to treatment and disease.

RS36
DIFFERENCES IN MITOCHONDRIA FUNCTION AND FATIGUE AMONG PATIENTS WHO RECEIVED DIFFERENT CANCER TREATMENT TYPES
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Symptom Science
Approximately 30% of cancer survivors report persistent fatigue after cancer treatment. Evidence suggests that cancer treatments, especially chemotherapy and radiotherapy can disrupt mitochondrial function, leading to increased fatigue. However, the interactions of cancer therapies, oxidative stress, and mitochondrial dysfunction with objective measures of physi-
cal function and self-reported cancer-related fatigue (CRF), are not fully elucidated. This study aimed to explore the relationships of self-reported CRF and objective measures of physical function with mitochondrial function in cancer survivors who received different primary cancer treatments. This is a secondary analysis of data from a cross-sectional study that examined the relationships between mitochondria oxidative capacity and cancer-related symptoms in solid-tumor cancer survivors who completed primary cancer treatment (e.g., chemotherapy, surgery, and radiation) >3 months or those receiving adjuvant hormone and/or immunotherapy >3 months. For this report, participants were grouped based on primary cancer treatment type received. CRF was measured by the Patient Reported Outcomes Measurement Information System-fatigue (PROMIS-F). Muscle strength and physical activity were measured by handgrip dynamometer and average daily steps from a physical activity tracker. Mitochondrial function was assessed by Magnetic Resonance Spectroscopy (MRS), measuring rate of phosphocreatine (PCR) recovery in skeletal muscle (PCr). Prolonged PCr indicated poor mitochondrial function. Descriptive statistics (mean, standard deviation) characterized CRF, muscle strengths, and mitochondrial functions of the study population by primary cancer treatment types. Eleven participants, age ranged from 34 to 70 (mean 53.3 ± 12.1), were included in this analysis. Majority were diagnosed with breast cancer (n=4). Participants who received multiple cancer treatments had lower handgrip strength (Left = 47.49 ± 14.18 lbs., Right = 49.17 ± 14.65 lbs.) and longer PCr (50.78 ± 14.54) but similar self-reported CRF (51.46 ± 9.20) compared to participants who received single treatments. Participants who received immunotherapy reported higher CRF, longer PCr, weaker handgrip strength, and longer daily average steps than participants who did not receive immunotherapy. Although our findings are limited due to the small sample size and cross-sectional nature of the study, this preliminary evidence suggested the impact of different cancer treatments on CRF, muscle strength, physical activity, and mitochondrial function. Moreover, we offer additional evidence to support the use of non-invasive means to assess musculoskeletal bioenergetics. Future research that can explore the impact of different cancer treatment types on CRF and mitochondrial function is needed.

**SCORE AND OUTCOMES FOR OLDER ADULTS WITH HEAD AND NECK CANCER (HNC)**

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**Aging**

Older adults with head & neck cancer (HNC) who receive chemoradiation are at risk for experiencing negative outcomes. Electronic frailty indices (eFIs), such as the Veterans Affairs-Frailty Index (VA-FI-10), provide estimates of frailty using readily available data from electronic health records. However, few researchers have investigated whether eFI scores are related to negative outcomes for head and neck cancer patients (HNC). The purpose of this study is to use the VA-FI-10 to determine the impact of frailty scores on treatment related adverse events among older adults undergoing chemoradiation for HNC. In this study, treatment related adverse events include 1) ED visit 2) unplanned hospitalization 3) insertion of a feeding tube and 4) weight loss greater than 20% of body weight during treatment. Data were obtained from Saint Louis University-SSM (SLU-SSM) health care System’s Virtual Data Warehouse (VDW). We selected patients age 65 or older diagnosed with HNC in the past 10 years and initiated treatment within 6 months of diagnosis (n=323). We examined the frailty score using a categorized version and a continuous version of the VA-FI-10. Cox proportional hazards models were computed to estimate the association between frailty score and hazard of each outcome of interest. Patients were on average 73.1 (SD: 6.6) years of age at diagnosis. Most of the cohort was non-frail (35.3%), and pre-frail (33.1%). The most common outcomes were inpatient hospitalizations (51.1%) and ED visits (47.1%) followed by feeding tube placement (36.5%), and weight loss >20% (13.9%). Survival analysis indicate that the frailty categories were significantly associated with time to ED visit. Pre-frail patients had almost twice the hazard of ED visit compared to non-frail patients (HR 1.99; 95% CI: 1.32-3.00). The continuous frailty index was significantly associated with inpatient admission (HR 1.07; 95% CI: 1.03-1.10) in addition to time to ED visit (HR 1.04; 95% CI: 1.01-1.08). We found that as patients’ with HNC frailty scores increased, there risk for a visit to the ED and risk for hospitalization also increased. In the future, utilization of eFIs in determining patient risk for poor outcomes may prove valuable in making data informed treatment decisions for older adults with HNC bearing in mind their quality of life and

**RS37**

**THE RELATIONSHIP BETWEEN THE VETERANS AFFAIRS-FRAILTY INDEX (VA-FA-10)**

**Kristin Keller, PhD, RN, CNS, Saint Louis University, Saint Louis, MO; Tim Chrusciel, MPH, Saint Louis University, Saint Louis, MO; Zach Pudlowski, MA, CIP, Saint Louis University, Saint Louis, MO**

**Aging**

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assessing their risk for negative outcomes during their treatment trajectory.

RS38
EFFECTS OF EXERCISE ON NEUROPATHIC PAIN IN CANCER SURVIVORS: A SYSTEMATIC REVIEW AND META-ANALYSIS
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Survivorship and Palliative and Psychosocial Oncology Care
Neuropathic pain is often found in cancer survivors who underwent neurotoxic chemotherapy. Severe pain can cause dose reduction, treatment delays, or treatment discontinuation. Only duloxetine shows adequate evidence for pain management for cancer survivors who had completed chemotherapy. Several primary studies suggested that exercises can reduce neuropathic pain but the effects vary. The purpose of this meta-analysis was to evaluate the effects of exercise on neuropathic pain in cancer survivors. We searched 12 electronic databases and five websites without date restriction through July 2022, for primary studies examining the effect of exercise on neuropathic pain in cancer survivors reported in English. We coded, computed effect sizes across studies, and examined moderator effects of source, participants, methods (study quality indicators), and intervention characteristics. Ten primary studies (N=437) were included in this meta-analysis. Eight studies were randomized control trials. Only two teams blinded data collectors and assessed intervention fidelity. Five research teams used combined exercise. Resistance training combined with aerobic or balance training was often used. Three research teams used a single exercise; two teams used yoga. Seven research teams described exercise intensity in their exercise protocol, but only two teams used a scale to determine exercise intensity (e.g., determining exercise intensity level based on 55-70% of heart rate reserve, or using the Borg Rating of Perceived Exertion to measure physical activity intensity level). Using the random-effects model, exercise moderately reduced neuropathic pain with a summary effect of 0.45 (Knapp-Hartung adjusted 95% CI, 0.22 to 0.66, p=.001). Subgroup analysis revealed that combined exercise (ES=0.54; 95% CI, 0.31 to 0.78) had a greater effect than a single exercise (ES=0.27; 95% CI, -0.05 to 0.59), but the difference was not significant (Fmodel=1.84, p=.21). Future researchers might consider using combined exercise when developing exercise intervention of decreasing neuropathic pain in cancer survivors. Resistance, aerobic, and balance training were likely beneficial for reducing neuropathic pain in cancer survivors. Clinical staff should encourage survivors to engage in exercise and assess their functional status, disease status, and barriers to exercise before performing exercise. Exercise should be tailored based on individual performance. Future researchers might consider reporting quality indicators for their studies.

RS39
NAVIGATION OF PATIENTS WITH SUSPECTED pancreatic CANCER TO IMPROVE CARE QUALITY AND RESEARCH ENROLLMENT
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Health Equity
Patient navigation aims to overcome access barriers and optimize care delivery, but navigators cannot identify pre-diagnosed patients using traditional methods, hindering navigation efficacy. We observed care gaps among patients identified at our institution with suspected pancreatic cancer during January 2023: among 67 patients with new pancreas cancer, only 36% underwent biopsy with 22 days between radiology and biopsy; and 30% were seen by an outpatient oncologist with 32 days between radiology and visit. We sought to improve patient care outcomes through daily prospective AI-guided identification and navigation of patients with radiographic findings suspicious for pancreas cancer. In June 2023, we implemented an AI-guided daily workflow using the following steps: 1) at 24-hour intervals, an NLP model reviewed abdominal imaging reports and flagged reports containing language suspicious for pancreatic cancer; 2) a trained coordinator and GI oncologist validated reports with new masses and sent such reports to a GI navigator; and 3) the navigator facilitated appointments for proper follow-up, including GI services, the multi-disciplinary tumor board, and clinical trial coordinator. During June 2023, the model identified 69 patients with suspicion for new pancreas cancer. 19% were immediately eligible
for navigation and scheduled for follow-up within our institution with an average of 8 days between report and navigation - 77% saw an outpatient oncologist with an average of 17.5 days between report and visit, 69% underwent biopsy with an average of 4.5 days between report and biopsy, and 54% were seen at multidisciplinary pancreatic cancer tumor board with an average of 16 days between report and pcTB. We were able to enroll 4 patients to clinical trials and 5 accruals to biospecimen studies during this one-month period. 2 of these accruals were to the P-1000 study, which has been open at our institution for the last 2 years with a 0.5 per month accrual rate. We show that an AI-guided workflow can transform referral patterns of pre-diagnosed pancreatic cancer patients, creating a new access stream for navigators to intervene earlier in a patient’s cancer care with resultant improvement in healthcare delivery, evidenced by an average of 4.5 days between imaging and biopsy and 17.5 days between imaging and outpatient oncology visit, compared to our traditional cancer care approach with averages of 22 and 32 days. We have rapidly accelerated pancreas cancer clinical trial enrollment and biospecimen accrual.

RS40
CARE PARTNER PREPAREDNESS: WHAT DO AML CARE PARTNERS NEED TO SUCCEED?
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Aging
The treatment options for patients over 60 with AML have expanded to include a lower-intensity chemotherapy regimen comprised of hypomethylating agents + venetoclax (HMA + ven). HMA + ven provides complete remission rates in up to 70% of patients, similar to more intensive treatments, but is available outpatient. The care of these patients receiving outpatient treatment now falls on loved ones as they become full-time care partners. Their caregiving responsibilities include caring for the patient’s physical and emotional needs, managing medications and emergencies, and navigating the healthcare system. Caregiving responsibilities often cause AML care partners to experience intense caregiver burden and distress. Oncology nurses are often responsible for educating patients and their care partners to navigate this disease. This study encompasses the intervention of an interdisciplinary team that, in part, aims to evaluate the preparedness of care partners across seven cycles of HMA + ven treatment and determine the areas in which care partners feel least prepared throughout their caregiving. We recruited eighteen patients and seventeen care partners to participate in this study. The care partners completed surveys during each cycle. These surveys included a validated eight-item self-reporting tool, the Preparedness for Caregiving Scale (PCS), to report their perceived level of caregiving preparedness. The PCS also provides a free text area where the care partner can write in specific areas they would like to be better prepared for while caregiving. Additionally, the nurse interventionist called the care partner weekly to discuss symptom management and any care partner concerns. Evaluation: The care partners’ perceived level of preparedness varied greatly depending on the area being assessed. The perceived level of preparedness varied between cycles and often changed as the patient’s physical condition improved or worsened. Our care partners reported several areas not listed in the PCS that they would like to be better prepared for while caring for their loved ones during treatment. Oncology nurses can utilize the information gathered by this study to optimize the education provided to the care partners of AML patients receiving HMA + ven. Improving the education in the areas that care partners felt least prepared for may improve patient outcomes at home and decrease distress and burden for care partners.

RS41
FATIGUE IN PEOPLE WITH A DUAL DIAGNOSIS OF OPERABLE PANCREATIC CANCER AND DIABETES MELLITUS: A PROPENSITY SCORE ANALYSIS
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Fatigue is one of the most common symptoms reported in people with cancer and diabetes mellitus (DM). Furthermore, DM is highly prevalent in people with operable pancreatic cancer (OPC). However, research seldom explores fatigue in people who have both burdens of OPC and DM. The purposes of this study were to (1) compare the fatigue characteristics between people with comorbid OPC and DM to those with DM but not OPC and (2) examine the determinants of fatigue in people with both OPC and DM. This was a secondary analysis of 2 datasets (57 people with comorbid OPC
and DM and 150 people with DM but not OPC). Fatigue was measured by the Fatigue Symptom Inventory. The data were matched by age, sex, and diabetes duration using propensity score analysis. Generalized estimating equations (GEEs) were used to compare the fatiguing characteristics between the two groups. The determinants of fatigue in people with both OPC and DM were analyzed using multiple regression analysis. After propensity score matching, a final sample of 88 matched individuals (44 participants with both OPC and DM and 44 with DM but not OPC) was included in the GEE analysis. Compared with people with DM but not OPC, people with both OPC and DM have higher fatigue disturbances, including disturbances with general daily activities ($r = .92, p = .009$), work activities ($r = .36, p = .007$), relationships with others ($r = .72, p = .023$), and mood ($r = .11, p = .012$). The two groups showed no statistically significant differences in total fatigue score, fatigue intensity, and fatigue duration. Lower performance status ($r = .528, p < .001$) and more diabetes-related symptom distress ($r = .34, p = .009$) were statistically significant determinants of higher fatigue levels in people with both OPC and DM. Healthcare providers are advised to assess fatigue disturbances and provide interventions to improve patients’ performance status and diabetes-related symptom distress to alleviate fatigue in people with concurrent OPC and DM.

**RS42**

**SYMPTOM CLUSTERS IN CANCER PATIENT-CAREGIVER DYADS USING MULTIGROUP LATENT PROFILE ANALYSIS: LOW-INCOME AS A RISK FACTOR**

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Symptom cluster identification may provide healthcare providers with insight into the integrative tailoring of cancer patient-caregiver dyad interventions targeting multiple, co-occurring symptoms. Results also suggest that social determinants of health, such as household income, may be linked to symptom burden in patients with cancer and their caregivers. Assessment of the social determinants of health is important for both patients with cancer and their caregivers to provide guidance for needed supportive care.

**RS43**

**PHASE II TESTING OF A NATURE-BASED VIRTUAL REALITY STUDY TO SUPPORT END OF LIFE CAREGIVERS**

Rebecca H Lehto, PhD, RN, FAAN, Michigan State University, East Lansing, MI; Mohammed Alanazi, RN, Ph(c), Michigan State University, East Lansing, MI; Arienne Patano, BSN RN CHPN, Michigan State University, East Lansing, MI; Grace Caldwell, BSN student, Michigan State University, East Lansing, MI; Dawn Goldstein, PhD RN PMHNP-BC, Michigan State University College of Nursing, East Lansing, MI; Gwen ever, little research has focused on symptom clusters in cancer patient-family caregiver dyads. The purpose of the study was to identify dyadic profiles of symptom clusters in individuals with colorectal cancer and their caregivers and to determine factors influencing symptom cluster membership. This is cross-sectional secondary data obtained from patients with colorectal cancer and stomas and their caregivers from a tertiary hospital in South Korea. Five symptoms (pain, fatigue, sleep disturbance, depression, and anxiety) were measured by the Patient-Reported Outcomes Measurement Information System (PROMIS) 29 Profile. Symptom clusters were explored by a multigroup latent profile analysis. A total of 206 (103 dyads) colorectal cancer patients and their caregivers were included in the study. Patients were 62.3 (SD, 11.6) years old and 66% were male. Caregivers were 51.9 (SD, 14.3) years old and 78% were female. For patients with cancer, two symptom cluster groups were identified: (1) Symptoms with Normal Limits (Class 1a, 62%) and (2) All Symptoms (Class 2a, 38%). For family caregivers, two symptom cluster groups were identified: (1) Symptoms with Normal Limits (Class 1b, 71%) and (2) All Symptoms (Class 2b, 29%). Patients with low household income were more likely to be in the symptomatic group ($p < .001$). This study provides evidence that five symptoms commonly found in both patients with colorectal cancer and their caregivers tend to occur in clusters. Symptom cluster identification may provide healthcare providers with insight into the integrative tailoring of cancer patient-caregiver dyad interventions targeting multiple, co-occurring symptoms. Results also suggest that social determinants of health, such as household income, may be linked to symptom burden in patients with cancer and their caregivers. Assessment of the social determinants of health is important for both patients with cancer and their caregivers to provide guidance for needed supportive care.
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Survivorship and Palliative and Psychosocial Oncology Care

Cancers are the second leading cause of death globally. Research shows that most patients desire to be at home at end of life (EOL). However, family caregivers (CGs) may experience decrements in emotional health and lowered quality of life (QOL) outcomes stemming from burdens associated with delivering home-based care. Innovative interventions that can be flexibly implemented in the home are strongly needed to support these CGs. The natural environment (nature) provides opportunity for emotional restoration but is often not accessible to CGs given the need to remain with the patient. Thus, offering a virtual reality (VR) intervention that provides a nature encounter is a novel approach for enhancing QOL including emotional health. Following testing of an immersive nature-based VR experience in the laboratory (phase I), the current study purpose (phase II) was to evaluate feasibility, acceptability, any VR symptoms, and QOL following implementation of a 5-day home-based VR nature intervention delivered to hospice CGs. Framework: Ferris’s City of Hope EOL CG QOL framework was used. Using a pre-post design, CGs engaged in self-selected 10-minute immersive nature experiences over a 5-day period that were delivered via VR headset while seated. Nature choices included night-sky, an ocean beach, green meadows, planets, winter-scapes, sea life, fall scenes and sunsets. Pre-intervention surveys included demographics and the PROMIS-29 QOL measure (physical function; anxiety and depressive symptoms; fatigue; sleep disturbance; social roles; pain interference). Post-intervention surveys included 4-items evaluating both acceptability and feasibility, PROMIS-29, and a 9-item VR-related symptom experience checklist. Descriptive statistics and paired t-tests were used for data analysis. 15 participants (mean 61.13±12.47 years; 12 females) were included. CGs were relatives (n=13) or spouses (n=2) and 10 (66.7%) were retired. Most were well-educated (n=10; 66.7% were college graduates) and identified as white (n=10; 66.7%). Findings showed high acceptability (14.4±3.7; range 0-16); feasibility (13.9±2.4; range 0-16). Few VR adverse symptoms were found (3.2±3.8; range 0-27). Composite PROMIS-29 scores were significantly lower following the 5-day intervention (pre: 66.3±8.4; post: 61.0±7.83; p=.01). QOL significance was largely compelled by pre-post changes in anxiety (t=2.216, p<.05) and favorable trends for other QOL subscales. Promising feasibility, acceptability and QOL data for the use of VR nature immersive experiences show positive trends and are encouraging towards further testing with larger and more diverse samples. With further research and more established evidence, oncology clinicians providing can identify nature VR to support emotional wellbeing and QOL for family CGs.

RS44
ADAPTABLE AND STRATEGIES TO OVERCOME BARRIERS TO RECRUITMENT IN MULTI-SITE RESEARCH: LESSONS LEARNED
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Complex Research Designs and Advanced Methods

Many research studies encounter recruitment challenges. Challenges may be compounded in multisite studies that recruit from sites with varying levels of care, such as community cancer centers (CCC) and NCI-designated cancer centers (NCI-CC). Solutions to recruitment challenges may not be one-size-fits-all due to differences in sites and patient populations. This abstract aims to describe eligibility changes made to a multi-site randomized clinical trial that tests a serious game to help older adults receiving chemotherapy of moderate-high emetic potential learn how to self-manage nausea and vomiting at home. Screening and enrollment tracking began at the start of the study. Due to low chart review screen “passes” in the first three months of the study, the original inclusion criteria were revised to enable more potential participants to be eligible for recruitment. Top reasons for being ineligible included age, low emetic potential chemotherapy, number of chemotherapy cycles, and language barrier. Initial changes focused on potentially modifiable inclusion criteria. After retrospective chart reviews using modified criteria for age and number of chemotherapy cycles showed an increase in the number of potential participants, eligibility criteria were revised to lower the eligible age from 60 to 50 years and accept participants with four cycles of treatment. Eligibility trends were monitored weekly. Overall, the ratio of chart reviews to passes improved from 7:1 to 4:1 after modifications were made. The percentage of chart screen passes improved from 14.4% to 22.2%. The greatest impact was seen at the CCC where the chart screen passes improved from 16.3% to 40.3%. No improvement at the
NCI-CC was noted. Revising the inclusion criteria was helpful, but not at both sites. Language is the main reason for the difficulty in recruiting at the NCI-CC’s single site. Researchers should consider performing mock screening reviews with desired inclusion criteria prior to the start of a study to assess if the criteria are reasonable. Furthermore, mock reviews to determine the impact of potential changes should be considered in advance of making changes. It is important to proactively monitor and track enrollment and recruitment in advance of making changes. It is important to proactively monitor and track enrollment and recruitment.

statistical trends to determine the difficulty in advance so potential effective improvements to recruitment can be made.

RS45
TRAJECTORIES OF HEALTH-RELATED QUALITY OF LIFE IN OLDER ADULT COLORECTAL CANCER SURVIVORS
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Aging
There are 1.4 million survivors of colorectal cancer (CRC) in the US, of whom three-fourths are older than 65 years. Health-related quality of life (HRQOL) is at high risk for deterioration from the effects of cancer and its treatments, and this decline may be more pronounced in older adult survivors. This study aimed to examine factors affecting HRQOL over-time in survivors of CRC, determining specific characteristics that place survivors of CRC at highest risk for sharp decline. Methods: This secondary analysis utilized the Surveillance Epidemiology and End Results and Medical Health Outcomes Survey (SEER-MHOS) and included adults aged 65+ diagnosed with CRC who had completed at least one survey pre-diagnosis and two within ten years post-diagnosis. HRQOL was assessed using the Veterans Rand 12-item scale which provides mental and physical composite scores (MCS and PCS). Group-based trajectory modeling was employed to identify HRQOL trajectories for MCS and PCS. Multinomial logistic regression was used to predict group membership based on demographic and clinical characteristics. The cohort (n=649) was predominantly female (58%) and white (70%), with an average age at T0 of 77 years. Most were diagnosed at Stage I (56%) and underwent surgery (63%). The median time from diagnosis to survey was 1.3 years at T0, 1.17 years at T1 and 3.6 years at T2. Three groups were identified based on trajectories of MCS: low increasing, medium decreasing, and high stable. Those with more comorbidities and lower income were more likely to belong to the low-increasing MCS group. Five groups were identified based on trajectories of PCS: low decreasing, medium stable, steeply decreasing, high decreasing, and high stable. Those who were older at diagnosis and/or had a higher number of comorbidities were significantly more likely to be in the low decreasing and steeply decreasing groups versus the high stable group. Those who identified as Hispanic were also more likely to be in the steeply decreasing group versus the high stable group. Comorbidities, age at diagnosis, ethnicity, and income significantly impact the HRQOL of older adult survivors of CRC. Nurses should be alert to interactions between comorbidities and the effects of cancer and its treatments. The resources and needs of each patient should be considered in long-term survivorship plans.

RS46
CARING BEYOND CURE: PERSPECTIVES OF PEDIATRIC ONCOLOGY NURSES ON PALLiative AND END OF LIFE CARE
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Survivorship and Palliative and Psychosocial Oncology Care
Pediatric patients with cancer are faced with significant stress associated with a cancer diagnosis and treatment. Providing holistic palliative care, timely discussions of goals of care and high-quality end of life (EOL) care should be a priority. Nurses play a crucial role in palliative and EOL care as they spend the most time with patients compared to any other discipline. Limited research exists on nurses’ attitudes toward providing palliative and EOL care for pediatric oncology patients, and none that explores the role of work experience in developing comfort with providing this care. In a sample of nursing students and nurses working in pediatric oncology, this study aims to: a) Describe attitudes towards providing palliative and EOL care; b) Examine the relationship between educational preparation, work experience and attitudes towards providing palliative and EOL care; and c) Explore the experiences of providing pediatric palliative and EOL care. This descriptive mixed methods study included pediatric oncology nurses. Participants completed a Qualtrics questionnaire which included a demographic survey and the Frommelt Attitude Toward Care of the Dying (FATCOD), a five-point scale designed to measure...
attitudes toward providing EOL care, modified for the pediatric population. Following the questionnaire, 10 participants completed qualitative interviews, which were transcribed and coded. Descriptive statistics and multiple regression were used to complete the second aim, while qualitative data analysis and the integration of quantitative and qualitative themes were used for aims 1 and 3. Participants (N=38) were primarily female (87%) and white (89%). Participants on average held positive attitudes towards providing EOL care, with staff nurses holding slightly more positive attitudes than student nurses. All participants had experience in providing EOL care, yet only 2 (5.41%) responded that their education thus far prepared them. Age, education level, years of experience and burnout were associated with nurse’s attitudes towards providing EOL care. Qualitative themes included challenges of preparedness and training (gap between education and practice), the nurse’s role (advocate, teacher, bridge), and parent team barriers (miscommunication, parental misconceptions). Training in pediatric palliative and EOL care is crucial to address the gap in knowledge in this area. Further research should explore the impact of burnout, compassion fatigue and interdisciplinary conflict on EOL care.

RS47
INCORPORATING THE DISTRESS THERMOMETER INTO PREOPERATIVE VITAL SIGNS IN PATIENTS UNDERGOING ONCOLOGY SURGERY: A PILOT FEASIBILITY STUDY
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Survivorship and Palliative and Psychosocial Oncology Care
Extensive literature supports distress assessment at relevant transitions of care. However, the implementation is limited in the surgical setting because integrating psychosocial assessments into the busy preoperative time period is logistically challenging. Our Nurse Scientist-led multidisciplinary team completed a pilot study to assess the feasibility and acceptability of including a standardized psychosocial assessment, the Distress Thermometer (DT), with the collection of admission vital signs by Patient Care Technicians (PCTs) in patients undergoing oncology surgery. The Nurse Scientist-led multidisciplinary team discussed the ideal staff and point in time that would not disrupt the task-filled time frame immediately before surgery. Nurse leaders identified the PCTs as the ideal staff to include the DT with the collection of vital signs. All PCTs were provided in-person training about the screening protocol by the Nurse Scientist and then sent an e-mail with directions. One PCT volunteered to be responsible for communicating any issues. We assessed feasibility by the response rate and acceptability through discussions with the PCTs. This innovative pilot was the first opportunity for PCTs to collect additional data as a part of their routine charting in the preoperative setting. DT data was gathered between March 7 and July 5, 2023. Of the 189 men who underwent radical prostatectomy at our center, 71 were approached with the DT scale, and all patients who were approached completed the DT with no missing data. The staff reported no issues with data collection. A total of 21/71 (30%; 95% CI 19%, 42%) reported a clinically relevant distress DT ≥ 4. The multidisciplinary Nurse Scientist-led team was a crucial facilitator in the success of the pilot. Additionally, the ongoing check-ins provided opportunities to troubleshoot any unexpected issues. Our results demonstrated that incorporating the DT into vital sign collection was feasible, acceptable, and provided a valuable assessment. The multidisciplinary team with expertise in clinical workflow, technology, and psychiatry helped identify the ideal staff members at the optimal time point. Notably, 1 in 3 patients reported clinically relevant levels of distress, which emphasizes the importance of a psychosocial assessment at this time point. We encourage other institutions to incorporate a quantitative psychosocial assessment such as the DT into routine nursing and PCT charting at relevant time points, including the preoperative setting.

RS48
THE INTERPLAY AND INFLUENCE OF ANXIETY AND DEPRESSION BETWEEN MEN WITH EARLY-STAGE PROSTATE CANCER AND THEIR CLOSE ALLIES
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ASSOCIATIONS BETWEEN ANXIETY AND

CONCEPTUAL FACTORS IN FAMILY CAREGIVERS OF PATIENTS BEGINNING RADIATION THERAPY

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Survivorship and Palliative and Psychosocial Oncology Care

There is a high prevalence of anxiety in family caregivers during the early phase of cancer survivorship. The psychological status of the caregiver may impact their quality of life, ability to assume the caregiving role, and the health of the patient. Identifying factors associated with anxiety is critical to identifying caregivers who are vulnerable and in need of early intervention and support. Few studies have explored the relationship between caregiver anxiety and contextual factors, such as the social determinants of health. The purpose was to investigate the relationships between anxiety and contextual factors (demographic, economic, health literacy, neighborhood, rural/urban status) in family caregivers of patients with head and neck, esophageal, lung, rectal, and an anal cancer beginning radiation therapy. Using a cross-sectional design, baseline data from 178 family caregivers from an ongoing, two-group RCT testing a psychoeducational intervention incorporating simulation techniques during radiation therapy were used. Study variables were measured using the PROMIS Anxiety 8a, BRIEF Health Literacy, Ohio Opportunity Index (OOI), and Rural-Urban Continuum Code (RUCC). The OOI uses census tracts to generate an overall opportunity score and scores in 7 domains: environment, crime, education, employment, health, housing, and transportation. The analysis included descriptive statistics, t-tests, ANOVA, Pearson’s and Spearman’s rank correlations. Although the mean anxiety T-score was within the normal range (M=53.09, SD=7.78), 30 (17%) of caregivers scored in the moderate to severe range. Limited or marginal health literacy was reported by 56 (32%) of caregivers. Females (M=53.97, SD=6.90) reported higher levels of anxiety than males (M=49.71, SD=9.57); t(49.85)=2.59, p=.013. Caregivers who were younger (r=-.221, p=.004), had lower annual household income (rs=-.153, p=.047), and had lower health literacy (r=-.264, p<.001) reported higher anxiety scores. There was no difference in anxiety scores based on race, marital status, education, employment, neighborhood conditions, and rural-urban status.
Consistent with previous studies, caregivers who are female, of young age, and with lower household income are vulnerable for anxiety. Oncology nurses are in a key position to more fully assess and intervene with caregivers at treatment initiation. Given the large amount of new information and instructions to patients and caregivers, use of universal precautions to promote health literacy is critical. Lack of variability in OOI and RUCC scores contributed to the nonsignificant findings and additional study sites have been added to better diversify the sample.

RS50
NURSE-LED MEANING-CENTERED PSYCHOTHERAPY FOR CANCER CAREGIVERS: A PILOT TO ADDRESS EXISTENTIAL DISTRESS IN CAREGIVERS OF HEMATOPOIETIC STEM CELL TRANSPLANT PATIENTS

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Survivorship and Palliative and Psychosocial Oncology Care

Comprehensive support from family caregivers (partner, relative, friend) during hematopoietic stem cell transplantation (HCT) is critical. Yet, these essential and highly burdened caregivers receive limited to no psychosocial support. Many HCT caregivers report symptoms of anxiety, depression, and fatigue and experience existential distress, defined as loss of meaning and purpose. The burden of caregiving demands, witnessing suffering, experiencing loss, and ongoing uncertainty contribute to existential distress which leads to poor caregiver outcomes. HCT caregivers need interventions that directly address their existential distress. Meaning-Centered Psychotherapy for Cancer Caregivers (MCP-C) could meet this need, as it is a palliative-based intervention that targets existential distress by helping caregivers connect to sources of meaning in their lives. Purposes were: (1) Determine feasibility and acceptability of full dose MCP-C (7 weekly, one-hour sessions) delivered to HCT caregivers via phone/Zoom by a Registered Nurse trained in delivering MCP-C and a psychologist; (2) Qualitatively evaluate acceptability and suitability for HCT caregivers. This study was guided by the middle-range nursing theory of meaning and the conceptual underpinnings of Meaning-Centered Psychotherapy. We conducted a pre-post single group pilot study using mixed methods (quan+QUAL). HCT caregivers completed baseline assessments (T1) that included measures of distress, anxiety, depression, spiritual well-being, meaning and purpose, meaning in caregiving, and benefit finding. Caregivers completed assessments after the 7 sessions of MCP-C (T2) and 8 weeks after T2 along with exit interviews. We enrolled 36% of the caregivers approached for participation. MCP-C was delivered to 22 caregivers by a Registered Nurse interventionist and 10 caregivers by a health psychologist within 7 days of the HCT patient’s admission to the hospital (n = 32 caregivers). MCP-C was feasible with 27/32 caregivers completing all 7 sessions of the intervention. Caregivers reported the intervention was relevant, helpful, and they would recommend it to HCT caregivers. Outcome measures trended in the appropriate direction at T2, but most decreased slightly at T3 (although still higher than T1). Qualitative data revealed opportunities to enhance the intervention with HCT caregiver examples, modify intervention timing, and continue nurse-led delivery. The palliative care needs of HCT caregivers are under addressed in oncology research and practice. This project contributes to an emerging evidence base about the effects of a nurse-led palliative-based intervention and will inform tailoring of MCP-C for the HCT caregiver population.

RS51
CERVICAL CANCER HEALTH LITERACY AND CHALLENGES IN ACCESSING HEALTH CARE AMONG CERVICAL CANCER PATIENTS AT OCEAN ROAD CANCER INSTITUTE

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Cervical cancer is one among leading cancer in Tanzanian. Contributing to 39% of all cancer cases. Appropriate interventions are in the place to ensure access to prevention and control services. Health literacy is an important predictor of health outcome. This study was conducted to assess health literacy and challenges in accessing health care among patients with cervical cancer at Ocean Road Cancer Institute (ORCI). A descriptive cross-sectional study designed quantitative approach,
using structured questionnaires. Univariate analysis and multivariate logistic regression were conducted to determine the association and the potential predictors of low health literacy. P-value < 0.05 was considered statistically significant. SPPS software version 26 was used to analyze data. A total of 294 patients were enrolled, the mean age was 51.47 years (27 to 81 years of age). One hundred fifty nine (54.4%) had inadequate Health literacy. One hundred thirty four (81.3%) had heard information related to cervical cancer screening, from the health care providers. Thirty five (21%) from television and radio and thirty five (13.8%) from social media, friends and family. Two hundred and forty seven (85.2%) demonstrate that negative perception of the community and beliefs as a major challenge, financial hardship 152 (52.4%) and cultural aspects such as stigma & discrimination 145 (50.0%). It was also found that cultural issues and lack of knowledge were the contributing challenges, 34.8% and 44.1%, respectively. These results demonstrate inadequate health literacy, sources of information and challenges faced in accessing healthcare services among patients with cervical cancer. Therefore, health education and advocacy for cervical cancer prevention should be provided to women. Healthcare providers working with cervical patients should be capacitated in cervical cancer advocacy in the initiatives of cervical cancer prevention and control. Primary prevention strategies should focus on factors hindering access to care.

RS52
CLINICAL NURSES’ PERCEPTION OF NURSE MANAGERS AS AUTHENTIC NURSE LEADERS: IMPACT ON PATIENT FALLS AND OTHER QUALITY OUTCOMES
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Healthcare Delivery
Despite evidence-based fall prevention programs, primarily led by Nurse Managers, patient falls continue to be a persistent problem in hospitals. Patient falls, a nursing-sensitive quality indicator, are the most common sentinel event reported to the Joint Commission. The significance of the problem is that patient falls increase morbidity, mortality and healthcare costs. A significant difference in fall rates among five clinical units at one hospital served as the impetus for this research study. The Oncology Unit had zero patient falls year-to-date in 2023 in comparison to four other comparable units that reported 4-9 patient falls during the same time period. The purpose of the study was to identify if there was a relationship between Authentic Nurse Leadership (ANL), among Nurse Managers, as perceived by clinical nurses, and patient outcomes, specifically: patient falls, hospital-acquired infections and pressure injuries, patient satisfaction; nurse turnover and engagement scores. The study used a non-experimental, quantitative design. Instruments were: Demographic Form and the Authentic Nurse Leadership Questionnaire (ANLQ). The Authentic Nurse Leadership Conceptual Framework, developed by Giordano-Mulligan (2017) served and the theoretical foundation for the study. Two Magnet-designated hospitals were the sites for the study and included 13 clinical units. Participants were RNs assigned to the study units. Approximately 338 RNs were eligible to participate in the study. An a priori power analysis was conducted that identified that 215 nurses were needed in the study sample. Preliminary findings show higher ANLQ scores associated with the Nurse Manager of the Oncology Unit reporting zero falls and other hospital-acquired conditions, high patient satisfaction, high RN engagement and low RN turnover. New knowledge generated from this study may bridge a gap in what is currently know about the influence of nurse leadership styles, specifically ANL, on patient outcomes. In addition, new knowledge from this study may be helpful in developing educational programs that build ANL attributes among current and future Nurse Managers, attributes that promote high quality outcomes among patients and nurses.

RS53
IMMUNOSUPPRESSANT ADHERENCE IN ADULTS FOLLOWING ALLOGENEIC HEMATOPOIETIC STEM CELL TRANSPLANT
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Healthcare Delivery
Medication adherence regularly falls below the recommended 80 to 95 percent in cancer populations. In patients who have undergone hematopoietic stem cell transplant (HSCT), immunosuppressant medication adherence ranges from 33 to 95 percent. Nonadherence to oral medications in HSCT has been linked to an increased risk for infections, one of the leading causes of mortality in the first year. There is a lack of objective measurement of medication adherence in this population with most studies using self-report. In addition, there is a critical need to understand the modifiable...
and non-modifiable factors influencing self-management behaviors so meaningful interventions can be developed to improve patient outcomes and survival. The purpose of this analysis is to describe tacrolimus medication adherence rates and patterns using an electronic medication adherence monitoring device. This pilot study had a longitudinal exploratory design and recruited adults who had an allogeneic HSCT from two Midwestern hospitals and followed for 6-months post-discharge over 4 time points. Demographics were collected and electronic medication adherence monitoring devices (Argus Loc eCap) were distributed to monitor immunosuppressant taking behavior. Tacrolimus twice daily medication adherence rates were calculated for the percentage of prescribed doses taken, percentage of prescribed doses taken on time (±60 minutes), and the percentage of days with prescribed doses taken. Thirteen participants were prescribed tacrolimus for immunosuppression following HSCT for acute myelocytic leukemia (N=6), myelodysplastic syndrome (N=3), acute lymphocytic leukemia (N=1), Hodgkin’s lymphoma (N=1), T-cell lymphoma (N=1), and myelofibrosis (N=1). Participants had an average age of 58 (range 39-71 years), were primarily male (N=10), Caucasian non-Hispanic (N=13), and married (N=12) with spouses/partners as primary caregivers. The average percentage of prescribed doses taken was 75.6% (CI 66.5-84.7). Average percentage of days the correct dose prescribed was taken 51.6% (CI 33.4-69.7). The average percentage of prescribed doses that were taken on time was 45.25% (CI 34.4-56.1). Six participants had a consistently high pattern of adherence, five had a variable pattern, and two decreased over time. The evening was consistently high pattern of adherence, five had a variable pattern, and two decreased over time. The evening was consistently high pattern of adherence, five had a variable pattern, and two decreased over time. The evening was consistently high pattern of adherence, five had a variable pattern, and two decreased over time.

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RS54
EMERGING FROM THE HAZETM: RANDOMIZED, WAIT-LIST CONTROLLED PILOT COMPAREING TWO VIRTUAL DELIVERY FORMATS OF A COGNITIVE REHABILITATION INTERVENTION FOR CANCER SURVIVORS REPORTING IMPAIRED COGNITIVE FUNCTION FOLLOWING CHEMOTHERAPY

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Survivorship and Palliative and Psychosocial Oncology Care

Effective, evidence-based, disseminatable interventions for cancer-related cognitive impairment (CRCI) are urgently needed to promote cancer survivors’ quality of life. Research indicates innovative interventions targeting improvements in physical activity, sleep disturbance, mindfulness, and loneliness reduction may improve cognitive function. Virtually delivered standardized cognitive rehabilitation programs integrating these strategies may represent safe, low-cost, broadly disseminatable, efficacious treatments. Emerging from the HazeTM (HAZE) is a multi-dimensional cognitive rehabilitation intervention that includes psychoeducational and experiential content. The pilot study purpose was to gather feasibility and preliminary data comparing two virtual delivery methods for providing HAZE to cancer survivors compared to wait-list control (WLC). A 3-arm randomized design was used to determine feasibility for comparing virtual “live” group presentation of HAZE sessions, to virtual “pre-recorded” group presentation sessions, or WLC. Feasibility was measured by percent recruitment and retention for the three groups. Eligible participants reported CRCI following chemotherapy for stage I-III solid tumors, Hodgkin or Non-Hodgkin Lymphoma. Self-report pre/post data were electronically captured. Between- and within-group differences for change in perceived cognitive function were assessed (perceived cognitive function/PCF; perceived cognitive abilities/PCA). Study power was 80% for detection of large between-group effect sizes. Health behavior changes (physical activity, sleep, mindfulness), psychosocial outcomes (mood, loneliness), a determinant of behavior change (intentions), and health-related quality of life (HRQOL) were explored. Target enrollment was exceeded (n=93/90). Complete data were collected for 92.4% with 11.9% overall attrition (“Live”-19%, “Pre-recorded”-16%, WLC-0%). Mean virtual session attendance for both intervention groups was 80% (8/10). Participant satisfaction ratings were high (2 or higher on a 0-4 scale=90-100%, 3 or higher=64-90%). Significant PCF improvement was reported for the “live” group versus WLC (PCA: p=0.010, d=0.707) at week 10. PCF improvement reported for the “pre-recorded” group versus WLC was clinically meaningful with a
moderate effect size (PCI-p=0.10, d=0.443) at week 10. No significant between-group difference for PCF was seen between the two intervention groups. The “pre-recorded” group reported significant improvement in physical activity and HRQOL at week 14 (p<0.01) without control for multiple exploratory outcomes. Feasibility for two virtual group HAZE delivery methods was confirmed. “Pre-recorded” HAZE group delivery has great potential for broad dissemination and scalability. Preliminary results suggest potential efficacy for “pre-recorded” group delivery. Study results justify future multi-site research powered to detect moderate effect sizes to demonstrate efficacy for “pre-recorded” group delivery.

RS55
ANALYSIS OF TRAVEL BURDEN AND TRAVEL SUPPORT IN PATIENTS WITH CANCER TREATED AT A COMPREHENSIVE CANCER CENTER IN THE SOUTHEASTERN UNITED STATES

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Health Equity
Patients with cancer frequently cite transportation as a barrier to cancer care. Understanding the current status of travel burden and travel support and the influencing factors is critical to developing systematic programs to address travel barriers in cancer care. The purpose was to describe travel burden and types of travel support provided at a Comprehensive Cancer Center in the Southeastern US and examine the influencing factors of travel burden and the amount of travel support. We conducted a retrospective analysis with data from the electronic medical records (EMRs) of patients treated at a Comprehensive Cancer Center in the Southeastern US from 2021-2023, and identified all patients who received travel support. Travel burden was measured using travel distance (miles) and duration (minutes) to the healthcare site based on patients’ residential addresses. Travel support was evaluated using the value of total travel support (in $), type of travel support (funds, direct rides, and public transportation vouchers), and total number of travel support. Patients’ sociodemographic factors were extracted from EMRs. Neighborhood socioeconomic deprivation was coded using the area deprivation index by patient’s 9-digit ZIP codes. Descriptive statistics and univariate statistical tests were used for the research question. Our sample of patients who received travel support included 1063 patients, 64% solid tumors and 36% hematologic cancers. Most patients were 40-64 years old (31.7%), female (53.6%), and African American (63.8%). Approximately 29% were uninsured or with Medicaid insurance. On average, these patients traveled 58.1 miles with a travel time of 68.4 minutes for care, and received an average estimate of $74.5 in total for travel support. Most patients (88.3%) received travel-related funds (e.g., gas cards); 5% received direct rides (e.g., Uber); 3.8% received vouchers for public transportation; and 2.9% received combined travel support. Male (p=0.004) and White (p<0.001) patients had a higher travel distance than female and other races, respectively. Patients residing in more deprived neighborhoods had increased travel distance (r=0.27, p<0.001) and travel time (r=0.28, p<0.001). Only race was significantly associated with the total value of travel support, showing African Americans with more travel support than other races (p=0.010). Most patients received funds to offset the costs of gas or parking. Those from socioeconomic deprived neighborhoods had more travel burden. Further understanding of the impact of travel burden and travel support on cancer care outcomes is critically needed.

RS56
DISTINCT ATTENTIONAL LAPSES PROFILES ARE ASSOCIATED WITH STRESS AND RESILIENCE IN PATIENTS RECEIVING CHEMOTHERAPY: A LATENT PROFILE ANALYSIS

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Survivorship and Palliative and Psychosocial Oncology Care
Up to 50% of patients report cancer-related cognitive impairment (CRCI). However, prevention and/or mitigation strategies are limited. CRCI impacts a range of cognitive functions (e.g., attention) and can negatively impact multiple domains of quality of life. While
problems with attention are often reported, less is known about how inter-individual variability in attentional lapses contributes to overall CRCI. Given known associations between CRCI and stress, an evaluation of associations among attentional lapses and various types of stress warrants investigation. The purpose was to identify subgroups of patients with distinct attentional lapses profiles and evaluate for differences in demographic and clinical characteristics, and levels of global stress, cancer-specific stress, cumulative life stress, and resilience. Patients with a diagnosis of breast, gastrointestinal, gynecological, or lung cancer (n=1329) were assessed for self-reported CRCI using the Attentional Function Index (AFI). The AFI’s attentional lapses subscale assesses difficulties with selective attention (i.e., actively inhibiting distractions). Global, cancer-specific, cumulative life stress, and resilience were evaluated using Perceived Stress Scale, Impact of Event Scale-Revised, Life Stressor Checklist-Revised, and Connor-Davidson Resilience Scale, respectively. Latent profile analysis (LPA) was used to identify groups of patients with distinct attentional lapses profiles over two cycles of chemotherapy (six assessments). Four classes were identified (i.e., Very low level of attentional lapses (25.1%), Low level of attentional lapses (33.5%), Moderate level of attentional lapses (33.8%), Very high level of attentional lapses (7.5%). Compared to the Very low class, the Very high class was more likely to be younger, had a lower functional status, a higher number of comorbidities, and a higher chemotherapy toxicity rating score. In addition, the Very high class was less likely to be married/partnered, employed, and to exercise on a regular basis and was more likely to self-report back pain or depression. Compared to the Very low class, the Very high class reported higher scores for each of the three types of stress and lower scores for resilience.

Discussion and Innovations: Based on these findings, preliminary evidence suggests that that higher levels of attentional lapses are associated with a significant number of demographic and clinical characteristics as well as with higher levels of stress and lower levels of resilience. Increased knowledge of risk factors and sources of stress associated with higher levels of attentional lapses will assist with the development of targeted interventions.

**RS57 PREVALENCE OF METABOLIC SYNDROME IN CANCER SURVIVORS IN THE UNITED STATES.**
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Survivorship and Palliative and Psychosocial Oncology Care

Metabolic syndrome is a group of conditions that occurs together that increase risk for cardiovascular disease, stroke, and type 2 diabetes. These conditions include high blood pressure, hyperglycemia, excess abdominal body fat, and increased cholesterol and/or triglyceride levels. Metabolic syndrome and cancer have many common risk factors including unhealthy diet, lack of physical activity, and alcohol consumption, suggesting that cancer survivors have an increased risk for metabolic syndrome. However, the prevalence of metabolic syndrome in cancer survivors is unclear in the U.S. as is its impact on these survivors. The purpose of this study is to examine the prevalence of metabolic syndrome in cancer survivors in the U.S. Data from the National Health and Nutrition Examination Survey (NHANES) 2009-March 2020 collected by the National Center for Health Statistics, Centers for Disease Control and Prevention in the U.S. was used for this study. Adults who were diagnosed with at least one cancer were included in the study. Metabolic syndrome was defined as meeting three of the five following criteria: high waist circumference; high triglycerides; low high-density lipoprotein cholesterol; elevated blood pressure; and high fasting glucose level. Statistical analyses were conducted according to NHANES analytic guidelines using IBM SPSS Complex Samples software. A total of 1,158 adults were included in the analyses. They all indicated that they had been diagnosed with cancer and all had complete data on metabolic syndrome components. They include 540 men and 618 women. More than 40% of total cancer survivors had metabolic syndrome. For men, 58.4% had high waist circumference, 26% had high triglycerides, 28.8% had low HDL, 73.7% had high fasting glucose, 37.8% had high blood pressure, and 43.6% had metabolic syndrome. For women, 71.7% had high waist circumference, 26.2% had high triglycerides, 30.3% had low HDL, 55.6% had high fasting glucose, 34.2% had high blood pressure, and 41.4% had metabolic syndrome. High prevalence of metabolic syndrome in cancer survivors suggests the need for a comprehensive and holistic approach to survivorship care. As the number of cancer survivors continue to increase due to improved cancer treatments, multidisciplinary interventions including lifestyle modifications, psychosocial support, and regular monitoring are essential to reduce the risk and prevalence of metabolic syndrome.

**RS58 SUSTAINABLE INTERVENTIONS FOR FOOD**
The COVID-19 pandemic had profound global effect beyond its direct health impact. One of the significant consequences was exacerbation of food insecurity in vulnerable populations including cancer survivors. Food insecurity, defined as a lack of consistent access to enough food to live a healthy life, surged as a result. Cancer survivors faced unique challenges related to food insecurity including nutritional requirements, immune compromised status, and limited ability to work. Sustainable interventions are needed to address ongoing food insecurity in the post COVID-19 era for cancer survivors. The purpose of this study is to examine impact of the COVID-19 pandemic on food insecurity in cancer survivors and identify sustainable interventions at individual, community, and societal level. Comprehensive literature review was done using databases including PubMed, CINAHL, Web of Science, and Google Scholar. Search terms including COVID-19, food insecurity, cancer survivors, interventions, sustainability were used in various combinations. A narrative approach was used to synthesize findings and provide a comprehensive overview. The results of this study reveal strategies operating at different levels to address food insecurity in cancer survivors. At the individual level, universal screening tools were employed to identify individuals who were either experiencing or were at risk of food insecurity. Routine inquiries on household food insecurity enabled early intervention and support. At the community level, innovative cross-sector collaborations were established including partnerships with food delivery companies. Community gardens affiliated with healthcare institutions served as valuable sources of fresh produce and nutritional support. Clinical-community partnerships facilitated connection to available food resources. At the societal level, expanding federal food assistance programs, community food resources, and community gardening initiatives demonstrated a commitment to address food insecurity. The comprehensive examination of interventions to alleviate food insecurity in cancer survivors reveals a range of strategies that can be applied across different levels of care. These multilevel approaches are essential in addressing the complex interplay of factors contributing to food insecurity. In moving forward to the post COVID-19 era, a collective effort involving healthcare providers, community organizations, policymakers, and researchers is essential to address the unique challenges faced by cancer survivors in food insecurity.
levels (SMD: -0.59, 95% CI [-0.92, -0.25], p=.0007), quality of life (SMD: -0.31, 95% CI [-0.61, -0.00], p=.05) and depressive symptoms (SMD: -1.18, 95% CI [-2.08, -0.28], p=.01) immediately after the intervention. The effect of PEIs was maintained at long-term follow-up for depressive symptoms (SMD: -0.52, 95% CI [-1.54, -0.36], p=.0004). Likewise, the synthesised data showed that PEI effectively enhanced coping skills. The review provides evidence that PEIs are effective in reducing negative psychological outcomes and enhancing the coping skills among caregivers of children with cancer. Therefore, PEIs for caregivers are promising interventions that can be applied in clinical practice to promote the psychological well-being of caregivers of children with cancer. However, due to the methodological flaws and heterogeneity in evaluating interventions, more research is needed to identify the most effective PEI design and improve the quality of evidence.

RS60
ADVERSE CHILDHOOD EVENTS (ACES) AND LONG-TERM BREAST CANCER TREATMENT SEQUALAE
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Survivorship and Palliative and Psychosocial Oncology Care

ACEs are highly prevalent in the United States and may contribute to factors associated with increased risk for adult cancers. No research has been conducted to investigate a relationship between ACEs and cancer treatment outcomes, such as long-term treatment sequelae. The study purpose was to explore the incidence of ACEs in our breast cancer survivor (BCS) population and the potential association between ACEs and breast cancer (BC) treatment outcomes. A cross-sectional observational pilot study was conducted to investigate feasibility and acceptability for ACEs Questionnaire administration during female BCS’s annual survivorship clinic visits. Feasibility was measured by the percentage of eligible participants consented and questionnaire completion. The incidence, type, and quantity of ACEs were described. Correlations (Spearman coefficients) were explored between ACEs questionnaire scores and BC attributes at diagnosis, and patient-reported outcomes for severity of long-term treatment sequelae (sleep disturbance, fatigue, emotional distress, and cognitive impairment). Linear modeling was used to explore resilience as a potential moderator for ACEs’ impact on long-term treatment sequelae. 120 women were approached and consented (100%). Full data were collected for 119 (99%). Most participants had hormone receptor positive (73.6%), HER2 negative (86.8%) stage I-III disease, ranging from 1-31 years since diagnosis (mean=14.7). The sample primarily was white (92.6%), non-Hispanic (95.9%), highly educated (6-27 years, mean=15.83), retired (43.8%), and married (73.6%), with a mean age of 62.95. Seventy-seven participants reported 1 or more ACEs (64.7%). The most common ACES included: verbal or physical abuse, parental loss/abandonment, or depressed, mentally ill, or suicidal family members. No correlation was seen between ACE scores and BC attributes at diagnosis or current body mass index. Significant correlations (p<0.05) were seen between ACE scores and patient-reported severity for fatigue, anxiety, depression, impaired cognitive function without control for multiple testing. Brief Resilience Scale scores were positively associated with cognitive function and negatively associated with fatigue, anxiety, and depression. However, no evidence of a moderating effect of resilience characteristics was demonstrated for ACEs impact on long-term treatment sequelae. Feasibility/acceptability were demonstrated for ACE assessment during BCS survivorship clinic visits. Most BCS reported one or more ACEs. Significant correlation was demonstrated between ACE scores and the severity of some long-term treatment sequelae. These results warrant confirmation in a future study as well as prospective investigation of ACE scores as potential predictors long-term treatment sequelae.

RS61
EXPLORING THE RELATIONSHIP BETWEEN COGNITION, EMOTIONAL FUNCTIONING, AND CANCER TREATMENT-RELATED SIDE EFFECTS IN OLDER ADULTS NEWLY DIAGNOSED WITH CANCER UNDERGOING CHEMOTHERAPY: CHANGES OVER TIME
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Symptom Science
Chemotherapy-induced cognitive impairment (CICI) is a debilitating side effect of chemotherapy
RS62
A NURSE-LED VIDEOCONFERENCING INTERVENTION FOR FEAR OF PROGRESSION IN ADVANCED CANCER
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Survivorship and Palliative and Psychosocial Oncology Care
Up to 70% of patients with advanced cancer experience elevated levels of fear of cancer progression (FOP), characterized by intrusive thoughts, uncertainty, unhelpful coping behaviors, and difficulty planning for the future. Targeted and immunotherapies increase survival rates however extended treatment durations and frequent monitoring contribute to FOP. Psychosocial support services are scarce, especially in community settings. Most FOP interventions are resource intensive, delivered by psychologists, and focus on early-stage cancer. Increasing access to psychosocial support services is a key priority for intervention research. A previous pilot study established feasibility of a nurse-led videoconferencing intervention for FOP. The current study assessed the feasibility and preliminary effects of the revised intervention in patients with stage III or IV gynecologic or lung cancer. A single group pilot study was conducted at COH and community sites including underserved areas. Guided by a cognitive model and the Relaxation Response model, the intervention consists of five videoconferencing sessions, a follow-up call, and a supportive website. It incorporates patients’ values and teaches skills to manage worry, uncertainty, and unhelpful behaviors. Feasibility measures were enrollment rate, attendance, and attrition. Participants completed questionnaires assessing FOP, distress, and other measures at baseline, six, and 10 weeks and an exit interview. Conventional content analysis with inductive approach was used to analyze the interpretive data. A convenience sample of 39 patients enrolled over 7 months. Most were female (n=31), Caucasian (n=29), with a median age of 63. The majority had stage IV cancer; the most common diagnoses were ovarian (n=9), uterine (n=9), and NSCLC (n=15). Patients attended a mean of four sessions (SD 1.2). Eight dropped before completing any sessions and...
four dropped prior to T2 data collection. Linear mixed models analyses showed improvements across time for all outcomes \((p \leq 0.0005)\). Three themes were identified: Longing for connection; Shifting my mindset, and Internalizing skills in everyday life. Feasibility and acceptability were established, although the attrition rate was higher than anticipated. Patients reported that the skills practice refocused their thoughts and kept worries at bay. They felt empowered knowing they have tools to manage triggers and deal with daily stressors. Suggestions included adding nurse videos, patient videos, and a less cumbersome website. Oncology nurses can play a key role in educating patients about skills practices, resources, and support services for managing FOP.

**RS63**

**BREAKING BARRIERS: BRINGING VIRTUAL RESEARCH TO REMOTE ONCOLOGY CLINICS**

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Complex Research Designs and Advanced Methods

In recent years, the integration of virtual technologies into healthcare has gained momentum. This virtual research project aimed to assess the feasibility of conducting research remotely in oncology clinics, leveraging the advantages of virtual tools to facilitate data collection and analysis. The study’s primary objectives were to evaluate the efficiency and cost-effectiveness of conducting virtual research in a remote setting. Traditional research practices in healthcare often involve laborious and resource-intensive processes, particularly challenging in remote oncology clinics. Virtual research offers a promising solution to bridge this gap, providing an opportunity to streamline data collection and enhance patient engagement while maintaining high standards of research integrity. This project was conducted in collaboration with a remote oncology clinic. Five cancer patients were trialed utilizing virtual research tools. Patients and clinical staff involved were surveyed to assess the idea versus implementation of virtual research. Virtual research tools, including telemedicine platforms, and surveys were employed to collect data efficiently and securely. To ensure the validity and reliability of results, strict adherence to ethical guidelines and informed consent procedures were followed. The results of this project demonstrated successful implementation of remote data collection and analysis in oncology clinics. Virtual tools significantly reduced geographical barriers, allowing researchers to access a broader pool of participants and providing patients in remote areas with equal research opportunities. Virtual tools proved effective for data collection and analysis in studies with minimal physical contact from research team. Contextual factors played a crucial role, and caution is advised when applying virtual methods to studies requiring extensive physical assessments or specialized procedures. Further research is needed to optimize the integration of virtual research in diverse clinical settings. This project highlights the feasibility and benefits of employing virtual methodologies in remote clinics. The integration of virtual tools has potential to revolutionize the landscape of healthcare research, enabling efficient data collection, increased participant engagement, and substantial cost savings. However, it is essential to acknowledge potential limitations, such as technological barriers and training and support for both researchers and participants. Despite these challenges, virtual research offers a promising pathway for enhancing inclusivity and effectiveness of research in remote settings. Further studies and collaborations are encouraged to build upon these findings and expand application of virtual research in other healthcare domains.

**RS64**

**ONCOLOGY NURSES’ DEVELOPMENT OF COPING MECHANISMS TO AVOID BURNOUT AND FOSTER RESILIENCE**

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Complex Research Designs and Advanced Methods

Nurses working in an oncology setting are exposed to high levels of stress, which can lead to burnout. As a result, unaddressed burnout can manifest in oncology nurse workforce turnover. Fostering resilience is an effective coping mechanism associated with wellness and career longevity for nurses. Though resilience and burnout among healthcare professionals have been widely researched, only a handful of studies have addressed oncology nurses’ professional experiences with resilience and burnout. This qualitative research study explored protective factors that support oncology nurses’ resilience. The purpose of this study was to investigate the lived experience of oncology nurses to understand their development of protective
mechanisms to manage work-related stressors. The Neuman systems model informed this interpretative phenomenological study. A purposeful sample of five experienced oncology nurses participated in two semi-structured interviews. Data analysis followed a horizontal process using Smith’s six-step analysis method. Each transcribed interview was read twice to identify keywords and phrases leading to the development of themes and sub-themes to derive a deeper understanding of the participants’ experiences. The participants were five oncology nurses with an average age of 49.5 years, and an average of 15.8 years of experience, all female. The general description of resilience that developed from this study defines resilience as a dynamic, complex, and multifaceted process. Four central themes were identified: (a) processing experiences, (b) utilizing supportive resources, (c) gaining and applying knowledge, and (d) transforming relationships. The results are summarized in Table 1. All of the participants demonstrated a deep sense of commitment to the profession of oncology nursing. The participants chose the specialty through a desire and passion to care for patients with cancer, all participants expressed that oncology nursing is one of the most challenging yet rewarding nursing specialties. The results of this study described the oncology nurses’ experience with resilience and the meaning it holds for them. The four emerging themes demonstrate resilience as a strength-based capacity that helps nurses face setbacks in practice. Strengthening resilience in an oncology nurse work environment is achieved by processing experiences, utilizing supportive resources, gaining and applying knowledge, and transforming relationships. A well-developed network of relationships helps the oncology nurse rebound from setbacks and significantly improves resilience.

RS65
EVALUATION OF PERCEIVED STRESS LEVELS AND COPING STRATEGIES OF PATIENTS AND NURSES IN AN ONCOLOGY UNIT DURING THE PANDEMIC, WITHOUT A DIAGNOSIS OF CORONAVIRUS
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Complex Research Designs and Advanced Methods
The end of 2019 marked the emergence of the COVID-19 infection, which would become a pandemic in 2020 and a major global public health concern. Healthcare teams were under intense physical and psychological pressure, as were the patients. Both groups experienced fears. Attention to stress-related aspects and coping strategies is necessary to better understand needs that can be more effectively managed in the future in the context of mental health during similar situations. The purpose was to assess the perceived stress and coping strategies of nurses and oncology patients during the COVID-19 pandemic. A cross-sectional observational study was conducted at an Oncology Center of a private hospital in São Paulo from June 2020 to January 2021. The study sample was convenience-based and consisted of nurses from the Oncology Center and oncology, onco-hematology, and bone marrow transplant patients, both inpatient and outpatient, without a coronavirus diagnosis. Perceived stress was measured using the Perceived Stress Scale, and coping strategies were assessed using the Folkman and Lazarus Coping Strategies Inventory, both validated in Brazil. The project was approved by the Institutional Ethics Review Board. Results: The study included 46 participants (28 nurses and 18 oncology patients). The majority of nurses were female (88%), with an average age of 39 years. The average score on the Perceived Stress Scale was 29, ranging from 13 to 54 points (0 to 56). Considering scores greater than or equal to 30, the prevalence of perceived stress was 43% among nurses. In the same nurse population, the most commonly used coping strategies, based on the overall mean in percentiles for each coping strategy, were positive reappraisal (28%), distancing (14%), and acceptance of responsibility (14%). Among the patient population, 61% were female, with an average age of 51 years. The average score on the Perceived Stress Scale was 22, ranging from 6 to 40 points, and the prevalence of perceived stress was 22%. The most commonly used coping strategies in this patient population were positive reappraisal (27%), problem-solving (14%), distancing (12%), self-control (12%), and social support (12%). The results provide insight into the varying levels of perceived stress among nurses and patients, as well as the coping strategies most frequently used by them. The perceived stress results for nurses were nearly 50%, which is considered high.
THE IMPACT OF MYELODYSPLASTIC SYNDROMES (MDS) ON THE MENTAL HEALTH OF PATIENTS AND CAREGIVERS

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MDS has a significant impact on the mental health of patients and their caregivers. This study highlights that caregivers suffer mental health issues as a result of caring for MDS patients, in a manner similar to patients themselves and could benefit from intervention and outreach from HCPs during the care journey. This study identifies certain subgroups that have higher risk for mental health issues, allowing HCPs to focus on those MDS patients with support and educational interventions.

PATIENTS AND CAREGIVERS

Patients with myelodysplastic syndromes (MDS) have significantly worse health-related quality of life (HRQoL) than the general population. However, data about the effects of MDS on the mental health, social, and emotional well-being of patients is limited. Furthermore, little is known about how caring for MDS patients impacts the health and wellbeing of caregivers.

The purpose of this study was to better understand the mental health of MDS patients and their caregivers, and to understand the impact of MDS on HRQoL among patients and their caregivers. Patients were recruited from the patient database and social media outreach groups of the AAMDSIF and social media groups of other MDS-affiliated patients. Three validated surveys of self-reported outcomes were completed by patients and their caregivers between May 5 and October 6, 2021. Surveys consisted of the PHQ-4, the FACT-An, and the Caregivers Self-Assessment Questionnaire. Data were analyzed using means and medians, and comparison between groups was calculated using the chi-square test. Linear regression was used to adjust for potential confounders in the FACT surveys, while logistics regression was applied to the results of the PHQ-4 and CSA Questionnaires. Among the 158 complete responses, 36% of patients and caregivers had moderate or severe scores on the PHQ-4, indicating concerning levels of depression and/or anxiety. Functional impairment, high risk MDS, and transfusion dependency were associated with worse mental health as measured by elevated PHQ-4 scores, whereas good support networks and lack of financial concerns positively impacted mental health. The burden of MDS was reported to be even more severe by caregivers than patients; caregivers reported a larger impact of MDS on their lives than patients. Most caregivers (60%, n=15) reported a high degree of distress as per the Caregiver Self-Assessment Questionnaire. MDS has a significant

PATTERNS OF DIET AND PHYSICAL ACTIVITY AMONG PEOPLE OF COLOR AFFECTED BY CANCER DURING THE POST-TREATMENT SURVIVORSHIP

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Health Equity

Cancer survivors have a low rate of engagement in physical activity, a non-healthy body mass index, and a poor diet with significant disparities across sociodemographic factors. Specifically, people of color affected by cancer tend to be more overweight/obese and have a significantly lower rate of adherence to fruit and vegetable consumption guidelines compared to non-Hispanic White individuals. More information is needed to better understand these disparities. The aim of this secondary analysis was to explore levels of engagement in the physical activity and dietary patterns of people of color affected by cancer during post treatment survivorship. The parent study was conducted using a cross-sectional, mixed-method design. The sample included 72 people of color (i.e., Hispanic/Latinx, non-Hispanic Black, African American/Black, multiracial) affected by any stage of (breast, lung, or gastrointestinal cancer, aged ≥18 years old, who completed primary cancer treatments within the prior five years. Participants completed a sociodemographic survey, the International Physical Activity Questionnaire, and the Dietary Screener Questionnaire. Participants were recruited through community outreach in Western MA, the MA state cancer registry, and cancer support organizations’ social media platforms between April 2022 and August 2023. Among the 72 participants, the mean age was 58.35±13.8, 91.7% identified as female, 55.6%
were African American/Black, and 36.1% identified as Hispanic, Latino, or Spanish. Most participants (51.4%) had Federal/State health insurance (i.e., Medicare, Medicaid, MassHealth), and 13.9% reported speaking a language other than English at home. Most participants (77.8%) were diagnosed with breast cancer. The mean cancer stage was 1.8±0.8. Among the sample, 20.8% reported smoking sometimes/every day, 58.9% were overweight/obese and 36.1% had insufficient engagement in physical activity with average 8.15 hours (±5.1) sitting time per day. The average daily consumption of fruits and vegetables was 1.48±0.36 and 0.93±0.38 cup equivalents per day, respectively. Further, 88.9% of the sample consumed <2 cup equivalents of vegetables, and 88.3% consumed <1.5 cup equivalents of fruit, notably lower than the recommended daily 2-3 vegetable and 1.5-2 fruit cup equivalents. In our study, a large proportion of cancer survivors had insufficient daily vegetable and fruit consumption, and a considerable proportion were below the recommended levels of engagement in physical activity. Future studies that identify and address barriers to nutrition and engagement in physical activity among people of color who completed cancer treatment are warranted.

RS68
DECREMENTS IN MORNING ENERGY ARE ASSOCIATED WITH HIGHER LEVELS OF STRESS AND LOWER LEVELS OF RESILIENCE IN PATIENTS RECEIVING CHEMOTHERAPY
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Symptom Science

Very limited evidence suggests that lower levels of morning energy is associated with higher levels of stress and lower levels of resilience in patients receiving chemotherapy. If decrements in morning energy are associated with higher levels of stress, clinicians may provide patients with stress reduction strategies to improve their energy levels when they awake in the morning. Study purpose was to identify subgroups of patients with distinct morning energy profiles; evaluate for differences among the profiles in demographic and clinical characteristics and measures of three types of stress (i.e., global, cancer-related, and cumulative life stress) and resilience. A total of 1,343 patients receiving chemotherapy were enrolled in the study. Patients completed a demographic questionnaire and the stress (i.e., Perceived Stress Scale (global stress), Impact of Event Scale-Revised (cancer-related distress), Life Stressor Checklist-Revised (cumulative life stress (e.g., being mugged, sexual assault)) and resilience (Connor-Davidson Resilience Scale) measures at enrollment (i.e., prior to their second or third cycle of chemotherapy). Morning energy was assessed using the 18-item Lee Fatigue Scale at six time points over two chemotherapy cycles. Latent profile analysis was used to identify the subgroups of patients with distinct morning energy profiles. Three distinct morning energy profiles were identified (i.e., High (17.3%), Low (60.3%), Very Low (22.4%). Compared to the High class, patients in the two lower morning energy classes were less likely to be employed, had a lower functional status and a higher comorbidity burden, and were more likely to self-report diagnoses of depression and back pain. For all three types of stress (i.e., global, cancer-related, and cumulative life stress), significant differences were found among the three latent classes with scores that demonstrated a dose response effect (i.e., High < Low < Very Low; as decrements in morning energy increased, stress scores decreased). Compared to the High class, patients in the Very Low class reported higher rates of physical and sexual abuse. The resilience scores exhibited a dose response effect as well (i.e., High > Low > Very Low). Study findings highlight the complex relationships among morning energy, various types of stress, and resilience in patients with cancer undergoing chemotherapy. Clinicians need to assess for stress and adverse childhood experiences to develop individualized management plans to increase patients’ energy levels.

RS69
BREAST CANCER SURVIVORS’ EXPERIENCES OF BARRIERS AND FACILITATORS TO LYMPHEDEMA SELF-MANAGEMENT BEHAVIORS: A THEORY-BASED QUALITATIVE STUDY
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Symptom Science

Lifelong self-management plays a critical role in the prevention and management of lymphedema among breast cancer survivors. However, adherence to lymphedema...
self-management behaviors has remained suboptimal. Hence, we adopted a theory-informed method to elucidate the facilitators and barriers of lymphedema self-management for breast cancer survivors. In-depth semi-structured interviews were conducted between August and October 2022 in the lymphedema nursing clinic of a tertiary cancer hospital. The maximum variation sampling and purposive sampling technique was used to ensure a diverse sample. The ITHBC (Integrated Theory of Health Behavior Change) framework was used to inform the interview outline and data analysis. The transcripts were analyzed and coded using NVivo 12.0 software. Interview transcripts were coded line-by-line and mapped to domains in accordance with the ITHBC, using both deductive and inductive content analysis. A total of 16 participants were interviewed (aged 35 to 67). 8 of them were diagnosed with lymphedema. 23 themes (including 12 facilitators and 11 barriers) were mapped onto the three domains: knowledge and belief, social facilitation, and self-regulation skill and ability of ITHBC as facilitators and barriers to lymphedema self-management. Three additional themes including limited treatment resources for lymphedema, inconvenience of lymphedema management, boredom and tedium of lymphedema self-management, were categorized under the domain of other barriers. By utilizing constructs from a theory-based health behavior change framework—the ITHBC, this study offers valuable insights into the barriers, facilitators, and cues to action among breast cancer survivors for engaging in lymphedema self-management behaviors. Incorporating these findings into the ITHBC framework allows for a more systematic selection of theory-based strategies that may improve the design of effective lymphedema self-management interventions for breast cancer survivors. The findings can support future efforts towards targeted lymphedema self-management behavior change. Healthcare providers and policymakers can apply these findings to develop more effective interventions and policies to support breast cancer survivors in their efforts to manage lymphedema.

RS70
EXPLORING SENTINEL SYMPTOMS AT DIFFERENT STAGES OF BREAST CANCER-RELATED UPPER LIMB LYMPHEDEMA
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Symptom Science
One in every five breast cancer women reported breast cancer-related lymphedema (BCRL) after surgery. The BCRL is typically classified into 4 different stages (stage 0-subclinical to stage IV-severe). Although swelling is the most recognizable clinical indicator for BCRL, the precise predictive value and interplay of various sentinel symptoms for each stage of BCRL remain unclear. The purpose was to examine sentinel symptoms of patients at different stages of BCRL. This secondary data analysis analyzed the data from two cross-sectional studies conducted among post-surgery breast cancer patients by Peking University School of Nursing and Tianjin Medical University Cancer Institute & Hospital. Participants’ symptoms occurrence and distress were assessed using the Breast Cancer and Lymphedema Symptom Experience Index. Lymphedema stages were defined based on inter-arm circumference differences: 1-2cm denoting the sub-clinical stage, 2-3cm indicating the mild stage, 3-5cm signifying the moderate stage, and >5 cm representing the severe stage. Apriori algorithms combined with the time of the first occurrence of symptoms after surgery was employed to determine the sentinel symptoms of each BCRL stage using SPSS 26.0 and SPSS Modeler 18.0. A total of 894 participants aged range from 26 to 85 (mean ± SD = 54.32 ± 11.28) years old were included in the analysis. The prevalence of BCRL post-surgery (stage I-IV) was 58.50% (n=523). The top three most frequent BCRL symptoms were arm-swelling, heaviness, and fatigue. Based on inter-arm range symmetry differences, participants were classified into non-lymphedema (n=371), subclinical (n=267), mild (n=135), and moderate-to-severe (n=121) lymphedema stages. Sentinel symptoms for each stage were as follows: fatigue, heaviness, and arm-swelling for the subclinical stage; arm-swelling, limited-elbow-movement, limited-arm-movement, and firmness for the mild stage; and fibrosis, stiffness, and limited-wrist-movement for the moderate-to-severe stage (Support > 40%, Confidence > 60%, Lift >1). Discussion: This evidence supported sentinel symptoms associated with different stages of lymphedema. It underscores the critical importance of promptly identifying and addressing these sentinel symptoms, highlighting the need for healthcare providers to incorporate sentinel symptom assessment into post-surgery care for breast cancer patients. Future research should
investigate the underlying mechanisms and influential factors associated with these sentinel symptoms. Additionally, it should focus on devising and evaluating interventions tailored to address sentinel symptoms, ultimately aiming to enhance outcomes for individuals at risk of or already living with BCRL.

**RS71**

**MEMBERSHIP IN HIGHER SHORTNESS OF BREATH AND STATE ANXIETY PROFILE IS ASSOCIATED WITH HIGHER PERCEIVED STRESS AND LOWER RESILIENCE IN ONCOLOGY OUTPATIENTS RECEIVING CHEMOTHERAPY**

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**Symptom Science**

Anxiety appears to play a crucial role in increasing the occurrence of shortness of breath (SOB). Recent findings study suggest that higher rates of SOB are associated with multiple types of stress. While associations between anxiety and stress are established, little is known about inter-individual variability in the co-occurrence of SOB and state anxiety and its associations with various types of stress (i.e., global, cancer-related, cumulative life) and resilience in oncology outpatients. The purpose was to identify subgroups of patients with distinct SOB and state anxiety profiles and evaluate for differences in demographic and clinical characteristics and stress and resilience measures among these subgroups. Outpatients (n=395) completed SOB and state anxiety questionnaires six times over two cycles of chemotherapy. Occurrence of SOB was assessed using the Memorial Symptom Assessment Scale. Severity of state anxiety was assessed using the Spielberger State-Trait Anxiety Inventory. Other measures were assessed at enrollment (i.e., demographic and clinical characteristics, Perceived Stress Scale (PSS, global stress), Impact of Event Scale-Revised (IES-R, cancer-related), Life Stressor Checklist-Revised (LCS-R, cumulative life stress), Connor-Davison Resilience Scale (CDRS, resilience)) Latent class profile analysis was used to identify subgroups of patients with distinct joint SOB AND state anxiety profiles. Differences among the classes were evaluated using parametric and non-parametric tests. As shown in Figure, four distinct profiles were identified (A) Moderate SOB and Low anxiety [38.0%], (B) High to Moderate SOB and High anxiety [20.3%], (C) Very High to Moderate SOB and Moderate anxiety [33.9%], and (D) High changing SOB and Very High anxiety [28.8%]). Compared to Moderate SOB and Low anxiety, other three classes had poorer functional status, lived alone, had higher PSS, IES-R, and LSC-R scores and lower CDRS scores. Study is the first to identify subgroups of patients with distinct joint SOB and state anxiety profiles and their associations with stress and resilience. Patients who had the highest occurrence rates for SOB AND clinically meaningful levels of state anxiety across two cycles of chemotherapy reported higher and clinically meaningful levels of global, cancer-related, AND cumulative lifetime stress, as well as lower and clinically meaningful decrements in resilience. These findings suggest that higher levels of state anxiety and stress may decrease the threshold for the perception of SOB. The role of the hypothalamic-pituitary-adrenocortical activity, as a potential mechanism for these relationships, warrants investigation.

**RS72**

**PATIENT-TARGETED EDUCATION (EPRO-E) TO INCREASE EPRO UPTAKE WITHIN AN ALLIANCE CLINICAL TRIAL (A221805-S1)**

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**Complex Research Designs and Advanced Methods**

The Patient Cloud ePRO app was adopted by the National Clinical Trials Network (NCTN) to facilitate capturing electronic patient-reported outcome (ePRO) data. Although PRO data are frequently captured using paper surveys, electronic data collection (e.g., via ePRO) has many advantages: 1) real time data access, 2) control of data collection timing, 3) accelerated data cleaning, and 4) fewer data entry errors. However, many patients and research professionals prefer paper surveys; ePRO electronic data submission
rates in NCTN trials have been low (17 – 38.7%). The study purpose was to test an intervention (ePRO-E) to increase patient uptake of the ePRO app to submit data electronically. The study objectives were to test whether a patient-targeted ePRO educational resource (ePRO-E) would increase ePRO uptake (number of users) and improve data quality (high quality defined as ≥80% survey submission rate) within an ongoing NCTN R01-funded clinical trial (NCT04137107). The patient-targeted ePRO-E intervention, an educational resource (written material and a 6-minute animated YouTube video), was designed to address ePRO uptake barriers. ePRO uptake and data quality were compared between two groups (N=69): a historical control group and a prospectively recruited intervention group exposed to ePRO-E. Covariates included technology attitudes, age, sex, education, socioeconomic status, and comorbidity. Intervention group ePRO uptake (78.8%) was significantly higher than historical control group uptake (47.1%) (p=0.03). Patients choosing ePRO versus paper surveys had more positive/higher technology attitudes scores (p=0.03). The odds of choosing ePRO were 4.7 times higher (95% CI; 1.2–17.8) (p=0.02) among intervention group patients and 5.2 times higher (95% CI; 1.3–21.6) (p=0.02) among patients with high technology attitudes scores, after controlling for covariates. However, the 80% survey submission rate for patients using ePRO (30.6%) was significantly lower than for those who chose paper data submission (57.9%) (p=0.05). ePRO-E exposure increased ePRO uptake. High technology attitudes scores were associated with ePRO selection. Paper survey submission rates were higher than ePRO submission rates, keeping in mind that research staff monitored paper survey submissions more closely. Acquisition of the highest quality data may require technological innovations and support from research staff to monitor electronic data collection. ePRO-E is an innovative tool for increasing electronic data submission rates, which could indirectly accelerate research outcome dissemination across the NCTN network and beyond.

RS73 PSYCHOMETRIC VALIDATION OF THE KOREAN VERSION OF PROMIS 29 PROFILE (K-PROMIS-29) V2.1 AMONG COLORECTAL CANCER PATIENTS WITH STOMAS AND THEIR CAREGIVERS

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Complex Research Designs and Advanced Methods

The Patient-Reported Outcomes Measurement Information System 29 profile (PROMIS-29) is a comprehensive measure comprising seven health domains (physical function, anxiety, depression, fatigue, sleep disturbance, social roles and activities, and pain interference) and a single item assessing pain intensity. PROMIS-29 has been translated into a variety of languages and has been widely used in patients and healthy adults. A lack of studies exist evaluating the reliability and validity of the Korean version of PROMIS 29 Profile v2.1 (K-PROMIS-29 v2.1) in cancer patients and their caregivers. The purpose of this study was to validate the psychometric properties of K-PROMIS-29 v2.1 in a sample of colorectal cancer patients with stomas and their caregivers. K-PROMIS-29 v2.1 data were collected as part of a cross-sectional survey conducted at a university hospital in Seoul, South Korea. A total of 103 dyads of patients with colorectal cancer with stomas and their family caregivers participated in the survey (N = 206). We assessed the reliability calculating Cronbach’s alpha for each domain and corrected item-total correlation for each item. We performed principal components analysis (PCA) and confirmatory factor analysis (CFA) to test the construct validity. We examined Pearson’s correlations of K-PROMIS-29 v2.1 with Dyadic Adjustment Scale-7 and Ostomy Adjustment Inventory-23 to evaluate the predictive validity. Findings: Cronbach’s alpha of each domain ranged from 0.743 (sleep disturbance) to 0.966 (pain interference). Corrected item-total correlation, which is the correlation between each item and the total score excluding that item within a domain, ranged from 0.353 to 0.657 at the lowest (sleep disturbance) and 0.904 to 0.938 at the highest (pain interference). In PCA, seven varimax rotated components emerged, explaining 81.8% of the variance. Acceptable model fit indices (CFI = 0.939, SRMR = 0.052, and RMSEA = 0.069) were shown in CFA. Small to medium correlations were identified between the domains of K-PROMIS-29 v2.1 and the ostomy adjustment (r = 0.137 – 0.376) and dyadic adjustment (r = 0.137 – 0.278) scales. This study demonstrated that K-PROMIS-29 v2.1 is an internally consistent and valid measure for use in patients with colorectal cancer and caregiver dyads. Investigating potential language or cultural influences on the current results found in the anxiety, depression, and sleep disturbance domains can be considered. Future studies

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with larger samples that assess psychometric properties separately in cancer patients and caregivers are recommended.

RS74
EXPLORING THE STATUS OF RURAL WYOMING ONCOLOGY RESEARCH
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Health Equity
Currently, there is a significant knowledge gap around the rural/frontier cancer patient experience. According to the Wyoming Office of Rural Health (2021), 68.8% of residents live in rural or frontier settings. The CDC has noted that while cancer occurrence is less in rural areas, mortality remains higher than in urban centers. More research can be done to generate knowledge around the unique experience of the rural Wyoming oncology patient. There is important qualitative research to be done on the rural and frontier oncology patient who lives in Wyoming. This patient population is unique and faces many challenges around a cancer diagnosis, treatment, and survivorship. This poster highlights results from an integrative literature review of both quantitative and qualitative academic research over a period of 23 years (2000 to 2023) with dual lenses: the rural oncology patient and the rural Wyoming oncology patient. This method allowed for a broader summary of the literature as well as knowledge generation that provides improved understanding of the phenomenon of being a rural oncology patient both in general and in Wyoming. Four themes emerged from the data around the general rural oncology patient experience: challenges, specialty care, interventions, and disparities. These themes have associated subthemes which highlight key data in the extant literature around major concerns such as a lack of oncologist participation in rural studies, a lack of access to clinical trials, and an overall more fatalistic view of cancer. An environmental scan and focused review of data around the rural Wyoming patient revealed very little research to draw from, with 6 knowledge loci existing so far: clinical trials, telehealth, barriers to care, cancer screening, survivorship, and psychosocial oncology. This integrative literature review generated important knowledge around the state of research specific to rural and frontier oncology patients. What was revealed was a need for innovative and collaborative strategies to assist rural cancer patients on a variety of levels, from financial concerns to transportation and availability of regional care options. Regarding Wyoming cancer patients, the literature is largely silent around both the healthcare and the client perspectives, and further qualitative work needs to be done to identify and describe patient-informed interventions and pathways of care.

RS75
STRUCK AGAIN: PATIENT EXPERIENCE OF A SECOND PRIMARY CANCER AFTER AN OCULAR MELANOMA DIAGNOSIS
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Survivorship and Palliative and Psychosocial Oncology Care
Ocular melanoma (OM) is a rare and devastating cancer diagnosis. OM is rarely considered cured, but rather is spoken about in terms of remission that accompanies routine diagnostic surveillance. Rates of secondary or second primary cancers is higher for those with OM, and can be devastating to a person who has already lived through difficult treatments. This qualitative study sought to better understand the lived experience of OM patients in remission (or cure) who went on to develop a second primary cancer not directly attributed to OM. The team for this study included a certified oncology nurse researcher, a research assistant, and a patient advisor. This study was guided by interpretive description framework and consisted of two phases. The first phase of this study included semi-structured phenomenological one-on-one digitally recorded interviews either over ZOOM or the phone. The second phase of this study was a dynamic virtual focus group in which interviewed participants interacted with the research team around the themes developing from the transcribed data. Targeted convenience sampling through social media and OM support groups was used to recruit for this study. Out of the 21 potential participants who contacted the team, 9 met the inclusion criteria. The extensive data from this study reveals four key themes that described the lived experience of these exceptional patients. These include: the entangled self, the isolated self, perils of survivorship, and self-advocacy. Also arising from this data were several critical takeaways that inform the healthcare journey including the need for additional, higher-level education as well as a recognition by the oncology team that multiple cancer diagnoses co-exist. This study highlights the OM patient experience through rich description of what this cancer is like as a patient and survivor. The participants in this study described how they discovered their OM, the treatments they faced, and the deep sense of loss from the disruption of sight. This research also reveals the dread that results from a second primary cancer
diagnosis, illuminating cancer as a disease that impacts body, mind, and spirit. This study addresses a unique oncology sub-population and fills a knowledge gap around their experience of having OM with a second primary cancer.

**RS76**  
**IMPACT OF SOCIOECONOMIC DISADVANTAGE ON SYMPTOM DURATION, TREATMENT INITIATION, AND SURVIVAL AMONG PRIMARY BRAIN TUMOR PATIENTS: A LARGE COHORT ANALYSIS**  
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Health Equity

Higher levels of area deprivation, a regional measure of socioeconomic disadvantage, has been linked to lower treatment access and higher mortality rates among individuals with cancer, but little is known about the effects of area deprivation on primary brain tumor (PBT) patients’ symptom duration, treatment access, and survival. We assessed the association of area deprivation with symptom duration before diagnosis, time to first treatment, and overall survival among a cohort of 666 adult PBT patients enrolled in a large National Institutes of Health (NIH) observational trial (NHS, NCT02851706). We used ordinal logistic regression (odds ratio [OR], 95% confidence intervals [CI]) to assess the association between symptom duration (<6 months, 6 months-1 year, ≥1 year) and area deprivation index [ADI] (less advantaged, more advantaged) and linear regression (beta coefficient, 95% CI) for time to treatment duration and ADI. We adjusted for age at cancer diagnosis and sex (male, female), and stratified results according to residential distance to the NIH (short distance=<200 miles, long distance=200+ miles). We then used Kaplan-Meier estimates to assess overall survival by ADI levels, overall, and by residential distance. All models were then further stratified by tumor grade (low, high). Among 666 patients diagnosed with PBTs, 159 (24%) lived in less advantaged areas, 40% were long distance, and 24% had low-grade tumors. Less advantaged patients surprisingly had higher 5-year survival compared with more advantaged patients (72.01% vs 62.02%, p=0.02) but not when stratified by low (p=0.29) or high-grade (p=0.09). In the overall sample, there were no associations between ADI and symptom duration prior to diagnosis. Time to any treatment was longer for all patients living in less advantaged areas (7.78; 95% CI=0.02,15.65), but especially among those with low-grade PBTs (13.19; 95% CI=12.17,60.20). Among those with low-grade PBTs living long-distance from NIH, the less advantaged group experienced shorter symptom duration (OR=0.30; 95% CI=0.12,0.75). Future consideration should be given to PBT patients from more socioeconomic disadvantaged areas, with low-grade PBTs, and living long distances from treatment centers, as it may take them longer on average to access quality medical care.

**RS77**  
**DESCRIPTIONS OF EXISTENTIAL EXPERIENCE IN PATIENTS WITH CANCER AND MAJOR DEPRESSION PARTICIPATING IN PSILOCYBIN-ASSISTED GROUP THERAPY**  
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Survivorship and Palliative and Psychosocial Oncology Care

Advanced cancer poses an existential threat, raising for patients and caregivers the potential for both multi-dimensional suffering and growth. Despite a high prevalence among those with advanced cancer, existential distress remains insufficiently addressed by modern health care. Psilocybin-assisted therapy (PAT) has emerged as a potential tool to meet the existential needs of patients coping with advanced cancer. Yet, little is known about how patients describe this element of their cancer journey, and how it might be affected by the mystical experience precipitated through PAT, especially in the novel group therapy context. The purpose was to explore how patients with cancer and depression describe their existential journey through the experience of cancer and group PAT. Grounded in the Conceptual Model of Existential Experience in...
Adults with Advanced Cancer, this study is a qualitative analysis of existing data from semi-structured interviews with participants of the psilocybin trial, “The Safety and Efficacy of Psilocybin in Cancer Patients with Major Depressive Disorder” (NCT04593563). Of the 30 participants who completed the clinical trial, 28 participants completed exit interviews. This study uses a qualitative descriptive approach paired with directed content analysis to analyze interview transcripts. Our analysis revealed three overarching themes that shed light on the existential journey of patients with cancer and depression during group PAT. Participants described a deepened lived understanding of their mortality, as well as a reckoning with and a re-prioritization of their attention, relationships, and efforts. Their therapeutic intentions for participating in the PAT trial went beyond relief of depression and extended to gaining a new perspective towards existential worries – about death and dying and grief of actual or anticipated losses – and building spiritual resources to work toward desired states. Lastly, they described the lasting effects of PAT as a healing transformation, noting an enhanced sense of meaning as well as new tools for coping with cancer and death anxiety, revitalized priorities and values, and deepened relationships with self and others. Through investigating how the full breadth of existential experience is described by patients with cancer during group PAT, this study offers insight into the therapeutic mechanism and effects of this emerging treatment modality. While a growing literature describes the experience and impact of individual PAT, this study examines existential experiences of those who receive PAT in a novel group context.

RS78 SUSTAINING A COLLABORATIVE ONCOLOGY NURSE RESEARCH PROGRAM: LESSONS FROM 25 YEARS OF LEADERSHIP IN ONCOLOGY NURSING RESEARCH

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Survivorship and Palliative and Psychosocial Oncology Care

Supporting nurse-led oncology research is a priority of the Oncology Nursing Society, yet barriers to promoting the training of nurse scientists and retention within research-focused careers have led to a shortage of oncology nurse researchers. The aim of this report is to describe the (1) organizational structure for building an oncology nurse research program and (2) impact of this model of research collaboration and productivity using the University of Pittsburgh School of Nursing as an exemplar. We define the organizational structure as a Cancer Survivorship and Scholarship Hub at the University of Pittsburgh School of Nursing. This Hub is the foundational model for fostering scientific training and collaboration and prioritizes the mentoring of undergraduate, pre- and post-doctoral students and junior faculty into the scientific role. The model creates supportive, open, and collegial structures for faculty, undergraduate and graduate students, and postdoctoral trainees to receive feedback on research ideas, works-in-progress, professional development, and formal collaborations within and outside of our membership. The Hub integrates cross-institutional resources, clinical partnerships, national and international scientific networks, and extramural funding opportunities to support members’ programs of research. We describe current metrics of program success to establish the breadth and depth of oncology nurse research fostered within this model: faculty and trainee publications and grants, interdisciplinary collaborations, and cross-institutional collaborations. Cancer Hub faculty (N=12) and pre- and postdoctoral scholars (N=6) metrics were extracted from 2022. Faculty had a total of $3,578,840 in NIH funding, $1,153,500 in foundation funding, and collaborated with 10 oncology clinics within the University of Pittsburgh Medical Center and 7 outside oncology clinics. Faculty and trainees have active collaborations with over 16 schools and centers within the University of Pittsburgh and 30 outside institutions. In 2022, faculty published 34 senior-authored and 13 first-authored data-based peer-reviewed publications, and students/trainees published 9 first-authored publications. The University of Pittsburgh School of Nursing’s Cancer Survivorship and Scholarship Hub serves as a model for how institutions can train productive, passionate oncology nurses committed to research careers. Fostering research training and sustained growth requires a commitment to collaboration among early, mid, and senior researchers along with institutional
support. This Hub is an innovative, longstanding structure that can be replicated in other institutions to address the need for training and support of oncology nurse researchers.

RS79
THE EFFECT OF THE COMBINED HOME-BASED EXERCISE AND MINDFULNESS BASED INTERVENTION PROGRAM ON CANCER RELATED SYMPTOMS.

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Symptom Science

Exercise is often recommended as a nonpharmacological approach for managing cancer-related symptoms. However, it can initially cause stress and anxiety, especially for those facing performance pressure or physical discomfort. Mindfulness-based interventions (MBI) primarily address psychological symptoms, which can enhance self-discipline and encourage continued physical activity. There is currently limited understanding of how combining home-based exercise and mindfulness interventions affects cancer-related symptoms. This study examines the effect of a combined home-based exercise and mindfulness-based intervention on cancer-related symptoms compared to exercise alone. This secondary data analysis uses data derived from the parent pilot study that examined the 12 weeks of combined technology-enhanced exercise with other nonpharmacological interventions (TEHEplus) on symptoms in cancer survivors. This study randomly assigned participants to either the combined home-based exercise with MBI (TEHE+MBI) group or the home-based exercise alone (TEHE) group. The Patient-Reported Outcomes Measurement Information System (PROMIS-29) was used to measure participants’ symptoms. Descriptive and pair t-test statistic was used to analyze the data using the SPSS [version 27] Statistics software. There were a total of 20 participants (10 participants/group) aged 30 to 78 (mean 58.4± 13.2). The majority were diagnosed with breast cancer (n=8). Participants in both TEHE alone and TEHE+MBI groups reported improvement in fatigue, sleep disturbance, depression, and pain intensity at completion compared to baseline. The pair t-test result showed a significantly higher ability to participate in social activities in the TEHE+MBI group at completion (mean = 49.58 ± 8.69) compared to baseline (mean = 53.80 ± 6.92) (t =-3.097, df =9, p =0.013). The study offers initial evidence suggesting that personalized home-based exercise combined with mindfulness-based interventions (MBI) may positively affect symptoms in cancer survivors. However, the research has several limitations, including a small sample size, reliance on self-reported data, and a lack of assessment of the program’s long-term sustainability. Future studies with larger sample sizes, more objective symptom measures, and long-term follow-ups are recommended to explore these potential benefits further.

RS80
FACILITATORS AND BARRIERS TO PHYSICAL ACTIVITY DURING STEM CELL TRANSPLANT: A QUALITATIVE DESCRIPTIVE STUDY

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Symptom Science

Physical activity may slow the effects of immobility, such as loss of muscle mass and deconditioning associated with prolonged hospitalizations required for stem cell transplant (SCT). Patients experience increasing symptom severity that peaks around seven days post-SCT, making physical activity incredibly challenging during hospitalization. Social cognitive theory proposes that personal and environmental facilitators and barriers are associated with behavior, including physical activity. Existing evidence lacks qualitative exploration of perceived facilitators and barriers to physical activity during hospitalization for SCT in the United States. Understanding patients’ perceptions of personal and environmental facilitators and barriers to physical activity during hospitalization for SCT can inform nurse-led interventions to increase physical activity and improve outcomes in patients undergoing SCT. This study aims to explore the perceived facilitators and barriers to physical activity described by patients during hospitalization for SCT. This qualitative descriptive study, guided by principles from social cognitive theory, enrolled adults (age ≥19) admitted for SCT and able to walk independently. Semi-structured interviews were conducted in the participants’ hospital rooms 9-10 days after SCT. Deidentified interview transcripts were analyzed using directed content analysis. Responses were first grouped into two themes: facilitators and barriers. Facilitators and barriers were then sub-categorized as personal or environmental. Twelve participants (6 female, 6 male), all non-Hispanic white, median age 53 years (IQR=19.5) were
interviewed. Most (75%) received allogeneic transplants. Diagnoses included acute myeloid leukemia, multiple myeloma, aplastic anemia, myelodysplastic syndrome, and lymphoma. All participants identified walking as their primary physical activity during hospitalization. Personal facilitators to physical activity included family support, belief in the benefits of physical activity, and modifying physical activity when symptoms were severe. Environmental facilitators included support from nurses, including recognition of participants' physical activity efforts (a key environmental facilitator) and encouraging participants to track the number of laps walked. Personal barriers to physical activity were described as physical symptoms related to therapy, such as fatigue, mouth pain, diarrhea, weakness, and sleep disturbance. Environmental barriers included crowded hallways and a lack of assistive devices. Promoting physical activity may improve patient outcomes during hospitalization for SCT. Nurse-led interventions focused on acknowledging and rewarding physical activity and enhancing the environment are crucial actions that matter to patients and may increase physical activity during hospitalization for SCT. Further research with a more diverse sample is needed.

RS81
FACTORS ASSOCIATED WITH GRIEF AMONG OLDER ADULT FAMILY CAREGIVERS OF PATIENTS WITH ADVANCED CANCER
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Survivorship and Palliative and Psychosocial Oncology Care
Pre-loss grief is a maladaptive response to loss that affects 25-40% of older adult family caregivers (FCGs) of persons with advanced illness, negatively impacting current and future health outcomes. Pre-loss grief is influenced by high levels of caregiver burden, low preparedness for death, and low level of communication about dying. Known risk factors for pre-loss grief include spiritual distress, insufficient social support, lower educational level, and relational dependency with the patient. Post traumatic stress is frequently reported among caregivers who eventually develop prolonged grief disorder, however the relationship between pre-loss grief, post-traumatic stress, and other risk factors for pre-loss grief have not been adequately explored. The purpose of this study is to examine pre-loss grief and its associated risk factors among older adult caregivers of persons with advanced cancer. In this prospective, descriptive study, 30 older adult family caregivers of patients with cancer completed measures of grief, post-traumatic stress, stressful life events, optimism/pessimism, attachment style, social support, global health, medical morbidities, and demographic data. Relationships between pre-loss grief and the other variables were examined using Pearson's and Spearman's correlations and logistical regression. The majority of participants were female (73.3%), white (93.3%), and spouses (93.3%) to the care recipient. The mean age was 68.9 years (range 59-85, sd=6.48), and the mean length of time as a caregiver was 43.5 months (range 3-252, sd=53.81). Higher levels of caregiver grief were associated with higher post-traumatic stress symptoms (r=-.54; p=.001), higher levels of medical morbidity (r=.40; p=.014), increased incidence of other stressful life events (r=.39; p=.017), lower levels of social support (r=-.485; p=.003), worse mental health (r=-.365; p=.024), and less optimistic outlook on life (r=-.397; p=.015). Age, time spent as a caregiver, and attachment style were not significantly associated with pre-loss grief. Post-traumatic stress was independently associated with pre-loss grief (F (1,28) = 11.546, p=.002). Significant relationships between pre-loss grief and post-traumatic distress among family caregivers of patients with advanced cancer suggest that addressing previous and current trauma could positively improve caregiver well-being. The significant relationships between pre-loss grief, medical morbidity, and mental health outcomes reinforce the need for enhanced caregiver resources and support.

RS82
TEMPORARY TOILET LIDS MINIMIZE CONTAMINATION OF BATHROOM SURFACES WITH HAZARDOUS DRUGS
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Translation / Implementation Science
Excretion of hazardous drugs (HDs) and/or their metabolites in the urine of patients receiving such drugs has been documented in the literature (Eisenberg et al, 2021). Particles of excreted HDs, which are aerosolized when an uncovered toilet is flushed, settle on bathroom surfaces (Arnold & Kaup, 2019; Chauchat et al., 2019; Walton et al., 2020). Absence of toilet lids in hospitals’ bathrooms increases the risk of surface contamination. Chronic exposure of patients, healthcare workers, and janitorial service staff to HD residues predisposes them...
to potential adverse effects through dermal contamination (Hon et al, 2015; Hon et al, 2014). Recognizing the risk associated with flushing uncovered hospital toilets, the Oncology Nursing Society recommends covering the toilet while flushing. A commercially available temporary reusable toilet lid has been suggested to minimize aerosolization of HD particles during toilet flushing. Purposes were to test the effectiveness of a temporary toilet lid in blocking HD particles from aerosolizing when the toilet is flushed in the bathroom of a hospitalized patient receiving intravenous chemotherapy; and to compare the effectiveness of bleach vs alcohol-based sanitation in removing HD residues from the toilet lid after use. This descriptive research study was conducted on the Oncology Unit of a Magnet-recognized hospital in Southern California. The hospital’s Institutional Review Board approved the study. Six surface areas in a bathroom used by a 26-year-old male patient (BSA 1.97 m2) receiving intravenous Etoposide 50mg/m2, Vincristine Sulfate 0.4 mg/m2, and Doxorubicin HCL 10mg/m2 for lymphoma were swabbed for HD residues. Swabbing and swab handling were performed as per manufacturer’s instruction. Swabs were shipped to the laboratory using the laboratory’s safe handling guidelines. Data analysis was performed using SPSS software version 28. Comparisons were performed using paired samples t-tests. The number of particles from the 3 HDs were measured in nanograms (ng). Contaminations were statistically significant for the toilet flush handle, toilet seat and doorknob for each of the three drugs (p<0.05). Wiping temporary lids after use with bleach for 15 seconds was more effective than using alcohol-based wipes in eliminating HD residues. Our results are consistent with results from other published studies. Based on these findings, we recommend using a temporary toilet lid in bathrooms used by patients receiving HDs to increase safety and minimize unnecessary exposure.

**RS83**

**ANALYSIS OF THE RELATIONSHIP BETWEEN GENE EXPRESSION OF ADRENERGIC RECEPTOR AND NOREPINEPHRINE TRANSPORTER GENES AND REPORTED WORST PAIN IN WOMEN WITH BREAST CANCER**

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Genetics / genomics / biosignatures

Chronic musculoskeletal pain (MSKP) is a common adverse effect of aromatase inhibitors (AIs) and often results in the discontinuation of therapy. Norepinephrine decreases pain by binding to 2-adrenoceptors but can increase pain via 1-adrenoceptors. Evidence supports that dysregulation of adrenergic function is present in women with MSKP. In fact, both 1-antagonists and 2-agonists have been investigated as treatment for MSKP pain disorders, and evidence from our group as well as others support a role for pain inhibition via 1-agonists. We hypothesize that gene expression levels of adrenergic receptor and norepinephrine transporter genes could be an important factor in the development of AI-associated MSKP. Purposes were to describe the relationship between gene expression of adrenergic receptor and norepinephrine transporter genes and self-reported worst pain in women with early-stage hormone-receptor positive breast cancer at baseline and after six months of AI therapy. The Brief Pain Inventory Worst Pain (BPI-WP) item (score range 0-10; higher scores designate greater pain) was categorized by level of pain severity for n=78 women with early-stage hormone-receptor positive breast cancer. Gene expression was measured via sequencing of RNA extracted from peripheral blood in 11 candidate genes (ADRA1A, ADRA1B, ADRA1D, ADRA2A, ADRA2B, ADRA2C, ADRB1, ADRB2, ADRB3, SLC6A2, SLC6A3). The R Bioconductor package DESeq2 was used to test differential expression based on a model using the negative binomial distribution. Log2 fold change and adjusted p-values were used to compare gene expression levels in women who reported moderate/severe pain to those who reported no pain. RNA-sequencing results for peripheral blood samples from women with hormone receptor positive breast cancer revealed that the top differentially expressed gene between women reporting moderate to severe pain and those who report no pain regardless of timepoint is the 2C-adrenoceptor (Log2 Fold Change = -30, adjusted p-value = 4.25E-19). Differential regulation of the 2C-adrenoceptor gene may be related to the development of MSKP in women with early-stage hormone-receptor positive breast cancer. This research may provide insight into the biological underpinnings of MSKP and guide cancer symptom management by using gene expression profiles to identify patients at risk for MSKP who may benefit from preventative measures.

**RS84**

**DISPARITIES IN TYROSINE KINASE INHIBITOR USE FOR TREATMENT OF LUNG, COLORECTAL, AND BREAST CANCER AMONG ADULTS LIVING IN SOUTH CAROLINA**
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Health Equity
Tyrosine kinase inhibitors (TKIs) are innovative therapies often used extensively to treat certain cancers, such as non-small cell lung cancer; therefore, early and equitable access to TKI treatment is critical. Using innovative data linkages that can only be implemented in states such as South Carolina (SC), we developed a racially and socioeconomically diverse cohort of lung, colorectal, and breast survivors to examine disparities in TKI use. Purposes were to describe and compare overall, and by race, gender, and geography (rural/urban): 1) patterns of TKI use, and 2) patient adherence to TKI therapy. We conducted a retrospective cohort study guided by the National Institute on Minority Health and Health Disparities Research Framework. Using previously published methods, we linked medical and pharmacy records data from SC’s Medicaid Program and SC State Health Plan to cancer cases from the SC Central Cancer Registry (2011-2021). Adults ≤ 65 years with lung, colorectal, or breast cancer receiving TKI therapy (non-hormonal therapy, molecular) were included in the cohort. Adherence was defined as the Medication Possession Ratio (MPR) based on refill service dates and number of TKI pills dispensed (adequate adherence ≥ 80%). We performed descriptive statistics to characterize the cohort and assessed group differences using chi-square, Fisher’s Exact, and t-tests. Multiple variable general linear and logistic models were used to assess racial and rural disparities as well as predictors of MPR or 80% adherence as appropriate. The cohort’s (N=5,580) median age was 48.7 (+ 7.8) years; patients were 37.7% black and 22.4% male. When comparing individuals prescribed TKIs to no TKI prescription, there was a significant difference in marital status (p=0.09), rurality (p=0.08), stage/grade (p<0.01), and cancer site (p<0.01). Utilization modeling suggested that 1) among white breast cancer survivors, there were no differences in TKI utilization by PR status, and 2) black women with breast cancer who were PR negative were significantly less likely to receive TKIs. Final multivariable modeling of predictors of non-adherence (MPR < 80%) indicated that compared to cancer survivors who were married or partnered, single cancer survivors taking TKIs were 2.39 times more likely to be non-adherent. Findings provided useful information for TKI utilization and adherence, which will inform the development of future multilevel interventions and serve as a model for other states to ensure patients with cancer receive the most innovative treatments available.

RS85
“IT’S JUST STRESS OF GOING INTO WORK AND NOT REALLY KNOWING WHEN I WAS GOING TO BE TRIGGERED”: A QUALITATIVE FOCUS GROUP STUDY OF RETURN-TO-WORK EXPERIENCES OF NURSES DIAGNOSED WITH CANCER
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Survivorship and Palliative and Psychosocial Oncology Care
Nurses face an elevated cancer risk while also encountering unique challenges in resuming their work after a cancer diagnosis. Understanding nurses’ return-to-work experiences when dealing with cancer can enhance their support systems, potentially promoting nurses’ well-being. Despite acknowledging the potential benefits and limitations of returning to work, there is a notable knowledge gap regarding how nurses diagnosed with cancer manage this transition and the specific factors that affect it. This study aims to explore return-to-work experiences, clarify facilitators and barriers, and uncover germane concepts among nurses diagnosed with cancer. Registered nurses with prior invasive cancer diagnosis and experiences attempting or fully returning to nursing positions were recruited through nursing organizations and social media. Seventeen of twenty-four consented nurses participated in five focus groups through encrypted video conferencing. Seven nurses did not participate due to schedule conflicts or health issues. The analysis was conducted by three trained researchers and using descriptive content analysis methods with a constant comparative approach. Member checking was performed to validate the results. Participants were female, average 51.8 years old (standard deviation=9.2), mostly White race (94.1%), and non-Hispanic or Latino ethnicity (88.2%). The most reported cancer type was breast cancer (47.1%). Around 65% of the participants...
were staff nurses and working full-time. Half of the participants changed their employment/work and took medical leave during cancer treatment. Four themes were identified: (1) Reasons that prompt nurses to return to work: financial reasons, intrinsic reasons, and support from workplace; (2) Challenges that impede nurses from returning to work: cancer symptoms and workplace challenges arising from nurses’ cancer (i.e., worries of reacclimating to work, concerns about preserving the privacy of health, colleagues’ reactions, and difficulties navigating medical leave and benefits); (3) Coping strategies for work demands: work adjustments (i.e., changed work schedules, work responsibilities) and strategies dealing with cancer impacts at work; and (4) Reflections on returning to work experiences: invaluable insights from cancer journey into patient care, a newfound understanding of nursing roles, managing emotions triggered by patient care. The findings of this study shed light on the complex process, barriers, and facilitators that nurses face when returning to work after being diagnosed with cancer. Clarifying factors influencing return-to-work in nurses diagnosed with cancer can inform actionable steps for healthcare leaders to promote the health and retention of nurses.

**RS86**

**THE RELATIONSHIP OF CANCER FATALISM AND RISKY HEALTH BEHAVIORS AMONG ADULTS LIVING IN THE US. POPULATION-BASED STUDY**

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**Data Science**

Limited research exists to understand the role of fatalism in risky health behaviors which is associated with increased cancer risks. This study investigates the relationship between risky health behaviors (tobacco smoking, electronic cigarette use, and heavy alcohol drinking) and fatalistic cancer beliefs among adults without a history of cancer. We used cross-sectional data from the 2020 Health Information National Trends Survey (HINTS) 5 Cycle 4. Study sample included noninstitutionalized adults (aged ≥18 years without a self-reported cancer history (n=2,437). The outcome variable was risky health behaviors comprised of tobacco smoking, electronic cigarette use, and heavy alcohol drinking. We combined these three risky behaviors into a binary variable as 0=not having risky health behavior and 1=having ≥1 risky health behavior. The key independent variable was cancer fatalistic beliefs. We used descriptive statistics and multivariate logistic regression analyses. Overall, 50% of the sample were women, 64.7% of participants self-identified as non-Hispanic White, 16.4% as Hispanic, and 10.5% as non-Hispanic Black. About 43.3% of participants reported having at least one risky health behavior. Our findings showed that while holding all other factors constant, each unit increase in cancer fatalism score is associated with 33.0% higher odds of increased risky health behaviors (OR=1.31, 95% CI 1.02-1.73, p=0.035) among adults without a history of cancer. By understanding the relationship between cancer-related fatalistic beliefs and risky health behaviors, healthcare providers, especially nurses working in community health, can personalize cancer prevention outreach programs to suit the unique needs of specific individuals and communities.

**RS87**

**EFFECT OF THE ACUPRESSURE ON CANCER RELATED SYMPTOMS**

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**Symptom Science**

Patients with cancer commonly experience a variety of symptoms, both physically and mentally including fatigue, pain, sleep disturbance, depression, and anxiety etc. Acupressure has gained recognition in clinical and community practice. However, there is a need for more empirical support for its potential benefits in alleviating cancer-related symptoms. Objectives were to examine the effect of a 12-week acupressure intervention on multiple symptoms in cancer patients. This is a secondary data analysis of a pilot randomized controlled trial (JHM - IRB00154198) that examined the feasibility and compared the effects of 12-week combined non-pharmacological interventions on cancer-related symptoms among solid tumor cancer patients aged 21 or older. For this report, we included participants in the acupressure intervention and control groups. Cancer-related symptoms were measured using PROMIS-29 and Insomnia Severity Index (ISI). Descriptive analysis using STATA was conducted to examine changes in symptoms before and after the intervention. A total of 29 acupressure or
control group participants were enrolled (mean age 56.8 ± 11.6, age range 33-74) and completed the study. The majority were white (n=23, 79.3%) and participants with breast cancer diagnosed (n=12, 41.4%). A total of 22 participants (75.9%) received acupressure treatment. Among participants who received acupressure, 36.4% of participants reported improvement in physical function, 31.8% in anxiety, 36.4% in depression, 45.5% in fatigue and 40.9% in sleep disturbance. Additionally, the average change in self-reported fatigue was decreased by 7% from baseline. This secondary analysis provides initial evidence to support the potential benefit of acupressure on multiple physical symptoms in cancer survivors including fatigue, sleep disturbance, pain intensity depression and anxiety. The result of this study is limited due to a small sample size and the nature of patient’s self-reported outcomes. Larger sample size and additional measures of each symptom should be included and investigated in future studies.

RS88
ONCOLOGY PATIENTS’ SELF-REPORTED SATISFACTION AND QUALITY OF LIFE: A COMPARISON OF THREE LOCATION-SPECIFIC CARE DELIVERY MODELS
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Healthcare Delivery
Increases in the number and longevity of cancer patients receiving care in a traditional ambulatory infusion center (AIC) may result in prolonged wait times, longer visit durations, and increased patient visit volumes. These factors may diminish care-related patient satisfaction and Health Related Quality of Life (HRQL). This quasi-experimental design study evaluated adult oncology patients’ self-reported satisfaction and HRQL when receiving care in an AIC compared to a home cancer model (HCM) or hybrid care involving both AIC and HCM. Primary outcome variables included HRQL and patient satisfaction, with structural support assessed as a secondary outcome. The sample (n=213) consisted of adult oncology infusion patients receiving care through a nationally recognized cancer care center. All data was collected using REDCap. Participants in the HCM group had higher HRQL than participants in the AIC group. This clinically significant finding neared statistical significance (p<0.09). Participants whose cancer had metastasized had significantly lower HRQL than non-metastasized participants (p=0.02), and females had significantly lower HRQL than males (p=0.03). Participants with a hematologic malignancy had significantly higher levels of satisfaction compared to those whose cancer had not metastasized (p=0.03). A statistically significant and clinically meaningful relationship existed (p <0.01) between patient satisfaction with treatment and HRQL in patients receiving care in the different models. Additionally, patients in the hybrid group had significantly lower HRQL compared to other racial groups (p=0.04). Further, Black/African American participants had a statistically significant lower treatment satisfaction (p <0.01). Participants with higher social support had higher HRQL (p=0.01) and satisfaction (p<0.01). Qualitative descriptive analysis of patient open-ended responses revealed that while the different care model positive and negatively impacted satisfaction and HRQL, the HCM patients more frequently identified a positive contribution of the care model’s on patient satisfaction and HRQL. In conclusion, the findings suggest that it will be important for the oncology healthcare industry to continue to explore viable HCMs. Given the associated positive outcomes and improved convenience, providers, nurses, and health systems should consider developing and researching patient centered options and pathways fully or partially supporting home-based oncology care delivery while also exploring the specific needs of the identified vulnerable sub-populations in relationship to care delivery models. Lastly, further examining the relationship between care delivery model and HQRL in a larger sample is warranted.