Nurses
Tuesday, March 28th
14:30-16:00
NG22: Innovation

A Room of My Own: Experiences of Hematological Patients undergoing Bone Marrow Transplant in Shaare Zedek Medical Center, Jerusalem

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Abstract

Background Three years ago, a unit for autologous bone marrow transplant for hematological patients has been established in Shaare Zedek medical center. The patients meet with the doctors for the treatment plan usually following the diagnosis. From the point of view of a part of the patients, the process appears simple, short term, and promises cure. In reality, the process is long term, including aggressive chemotherapy prior to the transplant. The treatment is highly aggressive and toxic with many physical and mental side effects for the patient and his/her family. The transplant process requires hospital admission for about a month in an isolation room. No one is allowed in the room except for close relatives and the medical staff. The social worker, part of the caregiving staff, accompanies patients and families from the initial diagnosis through this taxing and stressful process. Most patients are young, average 45 years, in the middle of their careers, from a broad spectrum of occupations, education as well as social status, representing Israeli society. Goals To accompany and empower patients by means of giving them tools to cope with the transplantation process which is a crisis situation in the midst of their lives; to teach patients self-awareness; promote quality of life for the patients especially during the stay in the isolation room by way of creating a safe domain. Methodology: The following tools have been utilized: The Empowerment Method: An advanced view of the powers and experiences of patients that constitute resources in addressing crisis; Work of hope: Finding unique meaning in a life crisis. Findings This work is based on therapeutic conversations that took place inside the isolation room with about 30 patients, mostly men; average age was 50, during the past three years. With the understanding that a patient goes from the public sphere to a private one-the isolation room- my entrance into the room was based on the ability and willingness of the patients to go into a treatment dialogue at that point and time. From the narratives of the patients, a few themes were extracted that were repeatedly discussed by most patients: Fear of death, post-traumatic issues, fear of isolation, relationships, mind and body, children, faith, and closure. As S. A., a 49-year-old man, said: “I’m afraid to give up and die. Help me to stay alive. But if I die, I want to know that I have left no unfinished business.” Conclusions: From the therapy sessions it appears that the central issues that bother the patients belong to the private space and the coping with it. The process of treatment helps patients to go from the private sphere back to the public one. Recommendations: It seems essential for the patients in the isolation room, undergoing autologous bone marrow transplant, to have therapy sessions with a qualified social worker as part of the holistic care. ‘Having a room of his own’ in the process enables an opportunity to examine the inner self esteem and strengths of the patients thereby patients learn to contribute to themselves from themselves.

Disclosure of conflict of interest

Between the needs of the patient, and the ability of the hospital to supply it.
Evaluation of the nutritional status in allogeneic patients

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Abstract

Introduction: Hematopoietic stem cell transplantation patients are at risk of malnutrition. The main objective of this study was to evaluate the evolution of the nutritional status of patients at Saint Louis Hospital during the transplantation process. The secondary objective was to search for profiles of patients at risk of malnutrition during the transplantation. Method: All patients over 16 years of age hospitalized at the Saint Louis Hospital from mid-December 2015 to mid-April 2016 were included, 32 patients. Various parameters reflecting the nutritional status of patients such as weight, mid upper arm circumference, muscular strength, albumin, prealbumin were recorded at different times: transplant admission, D30, 60 and 100. Results: 32 patients were enrolled. The albumin, the MUAC and muscle strength do not seem to be correlated in this study with weight variation. There is weight loss between admission and D100. It is not linear but involves various phases. Weight loss until D30, stabilization from D30 to D60 followed by weight gain until D100 without reaching initial weight recorded at admission. The onset of GVHD (graft versus host disease) appears related to weight loss. Patients with more than 5% weight loss before transplantation (28%) have a higher median hospital stay (36 days versus 26 days) and often GVHD. Patients receiving MAC regimens lose more weight between admission and D30 most likely due to the toxicity of treatments. Patients over 65 years of age tend to be malnourished between D60 and D100 following transplantation and present a GVHD at a later time.

Image/Graph

Mean weight change compared to normal weight during the allograft; mean weight change from the usual weight for periods and conditioning; mean weight change compared to the usual weight depending on the period and age. Conclusion: The nutritional care of patients receiving allogeneic HSCT is necessary during hospitalization but also during the pre-transplant period and in follow-up.

Reference


Disclosure of conflict of interest

None
Management of infections by multidrug-resistant organisms in Italian Bone Marrow Transplant Units: are there winners or just losers? The Nurses’ Group of GITMO investigation

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Abstract

Introduction Infections by multi-drug resistant organisms (MDRO) represent a huge problem in Bone Marrow Transplant (BMT) units. The Board of Nursing Referents Section of the Italian Group of Bone Marrow Transplant Society (GITMO) has, among others, the aim to detect and monitor which are the main themes in need of improvement. Material and Methods After a literature review, a questionnaire composed by 72 questions was sent to all 100 Italian BMT centres. Between February and March 2016, the BMT nurse in charge of each centre filled out the questionnaire on a dedicated Google Drive database. The main domains were: infection control (IC), screening, isolation, decontamination, collaboration and communication. Results Seventy-two centres divided into 50 adults, 14 paediatrics and 8 mixed departments replied with a fulfilled questionnaire. Forty-eight units are composed by a BMT centre and a haematology division, 24 are only BMT centres. IC procedures, such as hand hygiene, are performed by 99% of interviewed centres before touching patients and 72% after touching patients or surroundings. Alcohol-based hand rubs are available in 72% of BMT units outside or in the patient’s room. The second domain concerning screening emphasizes that 76% centres perform routinely microbiological search of MDRO on admission. In case of positivity, isolation procedures (third domain) in single room are always fulfilled in 39% of units, 40% has just single rooms and in 21% of cases, isolation is performed if a single room is available; cohorting of staff is possible in 26% of BMT units. Personal protective equipment (PPE) is worn by healthcare personnel before entering the patient’s room in 82% of cases. Decontamination domain outlines that rooms colonised by MDRO are cleaned twice a day in 87% of cases and left as last room to clean in 92% of units. Cleaning personnel is in 91% of the units throughout composed by the same workers. Microbiological controls after final decontamination take place in 57% of BMT departments. Particle count, plates and swabs are the most common procedures to control the effectiveness of decontamination. Collaboration (fifth domain) with other services is good: 99% has contact with the microbiological laboratory, 82% with the hospital IC committee and 75% with the pharmacy. The sixth domain concerning communication occurs in every BMT unit to patients and visitors. Ninety-five per cent of centres inform the consultant specialists about
patient’s MDRO colonisation or infection and 97% of units inform the cleaning personnel. Conclusion The chance to win the war against MDRO is minimal at present; however, many procedures could still be improved and standardised in order to lessen the MDRO burden of colonisation in BMT units.

Disclosure of conflict of interest

None
THE QUALITY OF SLEEP IN PATIENTS UNDERGOING HAEMATOPOIETIC STEM CELL TRANSPLANTATION: AN ITALIAN STUDY

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Abstract

Introduction. Sleep disorders are a common problem in onco-haematological patients with a prevalence ranging from 35% to over 50%. The prevalence of sleep disorders in patients undergoing HSCT was recorded in 32% in patients at pre-admission, 77% during hospitalization and 28% after discharge. Sleep disorders can lead to an increased number of negative outcomes, such as chronic pain, respiratory distress, obesity, stress and anxiety. Objectives. The study has two main objectives: 1) assessing the quality of sleep of adult patients undergoing HSCT at time of pre-transplant (T0), at day +30 after transplantation (T1), at day +100 (T2), at day +180 (T3) for autologous and allogeneic transplant and at day +360 (T4) after allogeneic HSCT; 2) identify possible determinants of sleep disorders in relation to some variables such as age, diagnosis, type of transplant conditioning regimen and the development of complications such as infectious events and GvHD. Methods. A longitudinal-prospective multicenter exploratory research design was used with a convenience sampling strategy for the period from 1 March 2015. The inclusion criteria are: patients aged > 18 years, undergoing HSCT in Italian BMT centers and make the follow-up at the same transplant program where they have had the HSCT for at least 6 months for autologous transplantations and for at least one year for allogeneic transplantations. Sleep quality was measured by administering the Italian version of the Pittsburgh Sleep Quality Index (PSQI) at different moments (T0- T4). The sleep diary was filled out by the patient every morning during hospitalisation. Other data such as fatigue and pain were collected through the visual analog scale CLAS and numeric rate scale (NRS) respectively. Results. The total of enrolled patients were 221; here we report the partial data of 40 patients with a mean age of 53.6 years, including 22 males and 18 females were analyzed. Forty-five per cent of patients had a diagnosis of leukemia, 30% of plasma cell disorders, 22.5% lymphoma and 2.5% other. Half of the patients were subjected to allogeneic transplantation and the other half to autologous transplantation. The results of the analysis of the sleep diary showed that: during the second week of hospitalization, there was an increase in sleep onset latency (30-38’ to get to sleep), the number of awakenings was from 3.1 to 4.1 per night, the wake-time after sleep onset was 1 hour and 54 minutes for allogeneic and 1 hour and 30 minutes for autologous patients and the time spent in bed was 8 hours and 22 minutes for allogeneic and 8 hours and 15 minutes for autologous HSCT recipients. The sleep efficiency was 68% for patients undergoing allogeneic HSCT and 80% for autologous HSCT. Sixty-five per cent of patients undergoing allogeneic transplantation and 50% of patients undergoing autologous transplantation did not take sleep-inducing therapy, while 30% of patients undergoing allogeneic transplantation and 40% of autologous patients started taking therapy for sleep disorders during hospitalization. Conclusion. These partial data show that during aplasia, there was an increase of sleeping problems for both types of transplantation, which is also reported in the literature. It emerges that the patients’ sleep quality during hospitalization of patients who underwent autologous transplantation is better compared to that of allogeneic HSCT recipients.

Disclosure of conflict of interest

None
Telemedical follow up visits after allogeneic stem cell transplant; working to improve patient care in northern Sweden

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Abstract

Introduction The Hematology Department at the University Hospital of Umeå is responsible for the allogeneic stem cell transplants for adults in The Northern Medical Region of Sweden. The region makes up nearly half of Sweden geographically and the distance from north to south is more than 1000 kilometres. Approximately 140 allogeneic patients are followed up on a regular basis and as the patients come from the entire region it is a challenge to conduct these follow ups. Frequent contact with the patient after an allogeneic stem cell transplantation is important both for monitoring GvHD and the management of immunosuppressive treatment. A follow up visit for a newly transplanted patient can take up to three days; one day to travel to Umeå, one day for the visit at the hospital and the journey back, and one day for recovery at home. The frequent travelling is a burden for the patient, and creates a need to reduce the number of hospital visits.

Method A telemedical project funded by the Regional Cancer Centre was launched in 2014. Webcams were purchased and routines set up for the visits in collaboration with our hospitals IT department to ensure a sustainable and technically secure solution. Visits are generally done from the patient’s home, using their own computer. A hyperlink sent to the patient is used to reach a virtual meeting room where the visit is conducted. After a year the patients and physicians evaluated the telemedical visits using a survey of questions pertaining to: Overall impression; technical quality; the experience of personal contact in a telemedical visit; whether the patients experienced addressing their problems via the hyperlink as equally safe as doing it in a physical meeting; the experience of having decreased the number of hospital visits. Results From the start a great interest was shown in the telemedical visits from both patients and physicians. Visits were initially conducted with only allogeneic patients but have over time been offered to other patients as well. A recent development is that emergency visits can also be conducted via hyperlink. A patient who calls and presents a problem can immediately be connected for a telemedical visit. Visits that could previously take several days for the patient now take only 30 minutes. The reduction in travel expenses has also meant an economic gain for the entire region. Imunosuppressed patients generally travel unaccompanied in a taxi. The need for expensive taxi rides from the different parts of the northern region to the hospital in Umeå has thus been reduced. The evaluation of the telemedical visits has shown that both the patients and the physicians experience the same level of personal contact and security at telemedical visits as at regular hospital visits. They also appreciate the reduction in travels. Conclusion Telemedical visits have successfully been introduced at our hematological department. Aside from the purchase of webcams, the telemedical visits are done within the framework of existing economic means. The reduction in travels will hopefully lead to reduced strain and increased quality of life for the newly transplanted patients. Since the introduction of this method the number of patients who are followed by telemedical visits has increased dramatically. Evaluations of telemedical visits will be made continuously and the aim is for every coworker to be able to send a link for a telemedical visit from their work e-mail.

Disclosure of conflict of interest
None declared