

ABSTRACTS COLLECTION


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Nurses Group Oral Session

NO001

FINANCIAL TOXICITY IN ALLOGENEIC HAEMATOPOIETIC STEM CELL TRANSPLANT PATIENTS FROM A SOCIAL DETERMINANTS OF HEALTH PERSPECTIVE

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Background: Financial toxicity (FT) is an adverse effect of cancer resulting from financial distress experienced by patients, owing to direct and indirect costs of the pathological process. It has been linked to poorer quality of life and higher morbi-mortality. Recipients of allogeneic haematopoietic stem cell transplant (allo-HSCT) could be a vulnerable population to FT due to prolonged hospitalisations, intensive post-transplant follow-up, and oftenly geographic relocation to access highly specialised healthcare which are themselves social determinants of health (SDOH) and generators of social inequalities in health. The aim was to describe FT in recipients of allo-HSCT in the Madrid Health Service from an approach of SDOH.

Methods: Multicentre cross-sectional study in adults with allo-HSCT from three public hospitals of Madrid Health Service between February and October 2022 (ongoing study). FT was measured by FACIT-COST validated scale (range 0–44; lower score, higher FT). Sociodemographic, socioeconomic, clinical and access to healthcare variables were collected through a paper or online questionnaire, self-completed by the patient, except for clinical questions completed by researchers based on clinical history. Descriptive, non-parametric bivariate statistical analysis (Mann–Whitney U test, Kruskal–Wallis test, Spearman’s rank correlation coefficient), and multiple linear regression models were performed. The study was approved by the Ethics Committees. Participation was voluntary and subjects provided written informed consent.

Results: Sixty-six patients participated in the study. Mean age: 52.5 years (SD: 11.5); 50% women; 92.4% Spanish; 28.7% from outside the Community of Madrid (displaced patients); 50% had acute myeloid leukaemia; Median months since HSCT: 11.5 (IQR 4–28.25); 71.4% never received any economic help. Median FT was 20 points (IQR 12–27.25). Median out-of-pocket costs were 295€ (IQR: 105€–700€), higher for displaced patients (Graphic 1). There was significant worse FT for women (Median 16.5 vs 23.1 for men, $p = 0.026$), age <65 years (Median 19 vs 27.75 in ≥ 65 years, $p = 0.031$), non-Spanish, unemployed, on sick leave, with dependent children, with monthly household income $\leq 1000€$, without higher education, who perceived a drop in income after HSCT, residents in rental housing and receivers of economic support (Table 1). No differences in FT were observed in any clinical variable, nor in displacement between regions. In the multiple linear regression, being woman (Coef = -3.26 ; $p = 0.079$) and having perceived a decrease in income after HSCT (Coef = -6.81 ; $p < 0.001$) were associated with higher FT (lower COST values). Furthermore, a monthly household income of $\leq 1000€$ was associated with higher FT than incomes of 1001–2500€ (Coef = 8.29 ; $p = 0.005$) or $>2500€$ (Coef = 15.75 ; $p < 0.001$).

Table 1. Financial toxicity by sociodemographic and socioeconomic variables

	N = 66	Median (IQR)	COST	p Value
Nationality: Spanish	61	21.00 (14–28.6)		0.039
Non-Spanish	5	13 (6.25–16.75)		
Work activity: Working/retired	24	27.5 (21–34.80)		<0.001
Unemployed	12	10 (5.88–18.50)		
On sick leave	29	17 (13–26)		
Education: no education/primary/secondary education	45	19 (10.50–25)		0.02
Higher education	20	26.50 (18–31.50)		
Monthly income: ≤1000€	6	8.45 (5.50–11.50)		<0.001
1001–2500€	34	19.50 (11.75–24.25)		
>2500€	26	27 (19–35)		
Decrease in monthly income: Yes	35	16 (8.50–23.50)		<0.001
No	29	26.50 (18.25–35.50)		
Financial help: Yes	18	14.50 (6.50–20.25)		0.01
No	45	23 (15–28.30)		
Dependent children: Yes	18	16.50 (10.50–25.50)		0.045
No	48	21 (14–30)		
Type of housing: Ownership	39	26 (16–32)		0.009
Rental	15	14 (5–21)		
Provided free of charge	8	22 (12.75–23.80)		

Conclusions: Financial toxicity is present in adult recipients of allo-HSCT in Madrid Health Service. Those at higher risk of FT are women, subjects with monthly household income ≤1000€ and those who perceive loss of income after allo-HSCT. Financial toxicity is evidenced as a social inequality in health, conditioned by the social determinants of health, and requires further research to reveal the complexity of the phenomenon, especially in countries with public health systems.

Clinical Trial Registry:

Disclosure: Nothing to declare.

NO002

SIMILAR OUTCOMES BUT DIFFERENT EXPERIENCES OF GASTROSTOMY VERSUS NASOGASTRIC TUBE FEEDING IN PEDIATRIC BONE MARROW TRANSPLANT: A MIXED METHODS STUDY

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Background: Following conditioning, most children undergoing bone marrow transplant (BMT) are unable to eat and drink, putting them at high risk of malnutrition. Tube feeding becomes required by almost all children, with parents taking care of their use. Nasogastric tubes are the mainstay; however, gastrostomies provide an alternative route yet there is limited evidence of their efficacy in BMT. At the UK center where this study took place, parents are

offered choice between these tubes. This study aimed to quantitatively and qualitatively compare feeding tube complications and outcomes between children fed via both tubes, including parent's decision making and children's experiences of tube feeding.

Methods: Participants were recruited to this parallel mixed methods study between April 2021 to April 2022. Quantitative data on tube complications and nutritional outcomes were prospectively collected from electronic patient records and food diaries, and compared using appropriate para or non-parametric statistics, between children undergoing allogeneic BMT fed via gastrostomy versus nasogastric tube, from admission to six months post-BMT. Qualitative data involved parents and children participating in two semi-structured interviews; on admission and 1–2 months post-discharge. Interviews were recorded, transcribed and thematically analyzed. Child data is not reported here.

Results: Nineteen children comprised the nasogastric group, 24 the gastrostomy (88% recruitment rate). In weeks 4 and 6, more children with a nasogastric tube than gastrostomy developed a tube complication (47.4% v 8.3%, $p = 0.005$; 47.1% v 11.5%, $p = 0.014$ respectively). Major gastrostomy complications comprised 0–20% of episodes, minor 80–100%. Device breakage was the most common gastrostomy complication (24.8% of episodes), being pulled out the most common nasogastric (58.8%). No differences were seen between tubes on contribution to children's calorie, protein and fluid requirements, weight or mid-upper arm circumference changes. Sixteen parents whose child had a nasogastric tube, 17 a gastrostomy, were interviewed. Choice was experienced very differently with spectrums of difficulty and freedom. Some parents had complete freedom to choose, others were told which to have by clinicians. Many parents deferred to the expertise of clinicians whilst others felt they were the experts in their child. Parents valued being given the choice with an appreciation that one size does not fit all when it comes to tube feeding. Influential factors in decision making included length of time in use, the child's age, activity, cosmetic differences, weighing up the risk of gastrostomy surgery, lay advice and prior experiences. Both tubes reassured parents their child could receive everything they needed, particularly medications.

Conclusions: Similar outcomes and frequency of complications occurred between both tubes. Gastrostomy complications were mostly minor but occurred frequently, yet to parents the benefits of a gastrostomy far outweighed their risks. In preparation for a child's BMT, where it is suspected nasogastric tube feeding may not be feasible, a gastrostomy should be considered as an alternative. This decision requires careful consideration of risks, benefits and family preferences. Clinical teams can help parents navigate this complex decision-making process, weigh up their options and make a truly informed choice through collaborative discussions and provision of detailed and balanced information.

Clinical Trial Registry: NCT04804631

Disclosure: Nothing to declare.

NO003

CONTEXT-SPECIFIC ADAPTATION, IMPLEMENTATION AND EVALUATION OF AN EHEALTH-FACILITATED INTEGRATED CARE MODEL WITH CONTINUOUS STAKEHOLDER INVOLVEMENT IN ALLOGENEIC STEM CELL TRANSPLANTATION—THE SWISS SMILE PROJECT

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Background: Allogeneic stem cell transplant (alloSCT) patients could benefit from an eHealth-facilitated, integrated care model (eICM) to enhance health outcomes. By combining implementation, behavioral and computer science methods, we developed an eICM (SMILe) for the University Hospital Freiburg, Germany: It combines a technology (SMILe-App and monitoring interface) with a human component (Advanced Practice Nurse team) to monitor incoming values and to provide face-to-face self-management support from alloSCT until one year after.

For use in the Swiss setting, this version required various adaptations. However, little is known how to contextually adapt, implement and evaluate an eICM calling for sustainable implementation science-powered innovation. We aim to describe:

- (1) how to contextually adapt the SMILe-ICM for the Swiss setting and
- (2) its current evaluation for effectiveness and implementation outcomes at University Hospital Basel (USB, Switzerland).

Methods: 1) This multi-level mixed-methods study combined quantitative and qualitative methods and has been approved by the responsible ethics committee Northwest and Central Switzerland (EKNZ: 2019-00307). Data has been collected from 04/2019–06/2020: Surveys ($n=60$ patients, $n=6$ clinicians) and individual interviews with 10 patients as well as focus groups with 15 clinicians were analyzed descriptively, respectively thematically. Stakeholder involvement ($n=28$), end-user tests (patients = 5, clinicians = 4) and theoretical frameworks (FRAME, ERIC) supported the adaptation.

2) Since 04/2021, the adapted SMILe-ICM is currently under evaluation via a hybrid effectiveness-implementation RCT approved by the responsible ethics committee (EKNZ: 2021-00202). Based on sample size calculation, we targeted a consecutive sample of 80 adult alloSCT patients, who are transplanted at USB with basic German proficiency, elementary computer literacy; have internet access; and provided written informed consent. To evaluate the SMILe-ICM's effectiveness (e.g., re-hospitalization rate, GvHD, survival) and implementation outcomes (e.g., acceptability, feasibility), we are using multi-method assessments (e.g., questionnaires, interviews).

Results: 1) Current clinical practice was mostly acute care driven (Table 1). Patients perceived the importance to develop new technologies to monitor their health behaviors, symptoms and medical parameter as very high (median = 9 on 0–10 scale). All interviewed clinicians expressed high technology openness and valued eICMs for timely and integrated care. Adaptations of the SMILe-ICM were needed primarily at the organizational level. Implementation strategies (e.g., visit first center, create new clinical teams) were modified to the Swiss setting.

Table 1. Patients' and clinicians' perspectives on practice patterns and self-management support in view of Chronic Illness Management

Dimensions	Instrument, items, measurement and scoring	Results
Dimensions	Instrument, items, measurement and scoring	Results
Patients' perspective		$N = 60$
Practice Patterns: Placement of follow-up care appointment	BRIGHT patient self-report ^{1,2} , adapted to alloSCT ³ Swiss setting; one item asking for follow-up care only at the TX center (yes/no).	
	<ul style="list-style-type: none"> • Only at transplant center, n (%) • Also at external center, n (%) 	35 (58%) 25 (42%)
Patient's perspective of CIM implemented in follow-up program	Short version of the PACIC instrument ⁴ : 11 items (e.g., "satisfied how my care is organized"): 5-point Likert scale ('1 = never' to '5 = almost always'), mean, SD (range)	30.6 ± 7.8 (11–55)
eHealth openness	Extract from the adapted PICASSO-TX ⁵ Questionnaire: Please imagine that you would be provided with a freely available health application (*App) by your clinic. Would you agree to input your well-being, your vital signs and symptoms?	
	• Yes, once a week, n (%)	23 (38%)
	• Yes, daily, n (%)	15 (25%)
	• Yes, every third day, n (%)	12 (20%)
	• No, I wouldn't agree, n (%)	10 (17%)
Clinicians' perspective		$N = 5$
Level of CIM implemented in alloSCT- program	CIMI-BRIGHT Clinicians' Questionnaire ^{1,2} , 55 items: 5-point Likert scale ('1 = strongly disagree' to 4 = strongly agree' (5 = don't know; set to missing)), mean, SD (range)	2.92 ± 0.58 (2.49–3.87)
Preparedness of the alloSCT team in view of CIM	BRIGHT Clinicians' Questionnaire ^{1,2} , 5 items: 5-point Likert scale ('1 = strongly disagree' to 4 = strongly agree' (5 = don't know; set to missing)), mean, SD (range)	3.14 ± 0.40 (2.80–3.70)
Competencies of the alloSCT team in view of CIM	BRIGHT Clinicians' Questionnaire ^{1,2} , 24 items: 5-point Likert scale ('1 = strongly disagree' to 4 = strongly agree' (5 = don't know; set to missing)), mean, SD (range)	3.00 ± 0.59 (2.42–3.67)

Note. Assessment of Chronic Illness Management (CIM) level from patients' and clinicians' perspectives.

Abbreviations. alloSCT program = allogeneic stem cell transplantation program, BRIGHT = Building Research Initiative Group: Chronic Illness Management and Adherence in Transplantation study, CIM = chronic illness management, PACIC = Patient Assessment of Chronic Illness Care, SD = standard deviation.

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2) In June 2022, recruitment was completed 9 months ahead of time without any organizational or technical problems indicating successful first steps for sustainable implementation. Almost all (98%) intervention-group patients use the SMILE-App on a daily basis and express high satisfaction. Preliminary feedback indicates an increased sense of security and sensitivity to symptom change and health deterioration. Effectiveness and implementation outcomes will be available 09/2023.

Conclusions: Combination of methodologies supported context specific adaptation and the tailoring of its implementation strategies. This foundational phase with continuous involvement of key stakeholders has the potential to increase acceptance and sustainable implementation in clinical practice. Our dual focus on implementation and effectiveness will both inform optimization of the SMILE-ICM and provide insights regarding implementation pathway. If effective, SMILE can serve as a blueprint for further settings and populations.

Clinical Trial Registry: ClinicalTrials.gov. Identifier: NCT04789863. <https://clinicaltrials.gov/ct2/show/NCT04789863>

Disclosure: Nothing to declare.

NO004

EXPERIENCES AND COUNSELING NEEDS OF PATIENTS AND FAMILY CAREGIVERS AFTER TREATMENT WITH CD19-DIRECTED CAR T-CELL THERAPY: A QUALITATIVE STUDY TO IMPROVE PATIENT CENTERED AFTERCARE

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Background: Since May 2020, chimeric antigen receptor (CAR) T-cell therapy has been approved in the Netherlands for adults with relapsed or refractory large B-cell lymphoma after two lines of treatment. Considering this is a short period of time, little is known yet about the long-term experiences and counseling needs, whereas the treatment process prior to CAR T-cell therapy can be long and intensive. Additionally, the treatment itself causes different side-effects in comparison to previous treatments with high-dose chemotherapy. The most well-known side-effects are cytokine release syndrome (CRS) and immune effector cell-associated neurotoxicity syndrome (ICANS). Family caregivers play an important role to monitor these side-effects after hospitalization. Therefore, the aim of the study was to get insight into the experiences and counseling needs of both family caregivers and patients after treatment with CAR T-cell therapy. It aims to give an overview of key considerations to improve aftercare.

Methods: The qualitative design included semi-structured face-to-face interviews with patients who received CAR T-cell therapy individually or patients together with their family caregiver. To explore their experiences and counseling needs, the following topics were discussed: general experiences, impact on daily-life, supporting factors and professional care. The interviews were audio-recorded and transcribed. Data-analysis was performed iteratively using ATLAS.ti.

Results: In total, twelve patients were included with a type diffuse large B-cell lymphoma, transformed follicular lymphoma or primary mediastinal lymphoma, with a median age of 59 years old, of whom six males and six females. Additionally, seven family members were included, five females and two males with a median age of 56 years old. During data-analysis, the following themes were identified: (1) emotional impact, (2) impact on daily-life, (3) individual coping strategies, (4) social support,

(5) professional care. Attention to these factors is needed to tailor aftercare to the individual counseling needs that have emerged from the analysis of the interviews, which could include the use of complementary care.

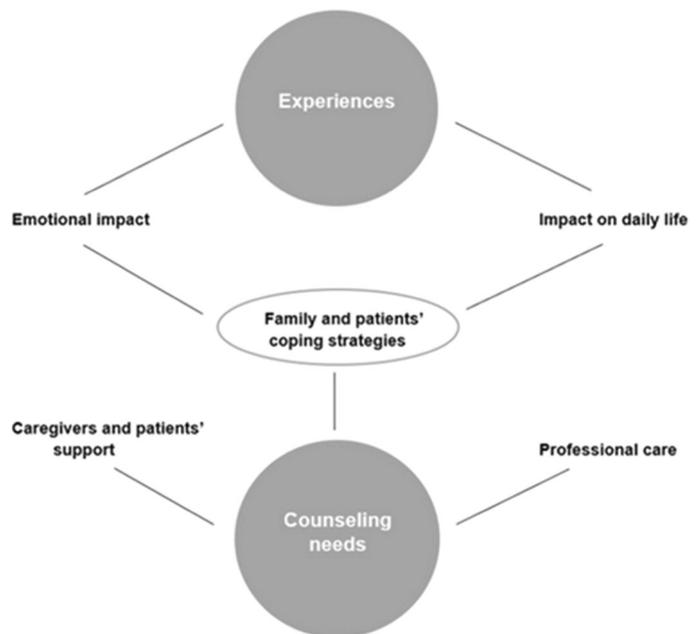


Figure 1. Conceptual framework of experiences and counseling needs after CAR T-cell therapy

Conclusions: There is still little research available on experiences and counseling needs of patients and family caregivers after treatment with CAR T-cell therapy, due to the relatively short period during which the treatment is available. Therefore, the results give new insights into experiences after treatment so that it can be used to improve aftercare. Different experiences and individual coping-strategies influence the counseling needs of patients and family caregivers after treatment with CAR T-cell therapy. Early identification of these factors is necessary to provide appropriate aftercare and to increase satisfaction after treatment.

Disclosure: Nothing to declare

NO005

THE IMPACT OF EDUCATION ON PATIENTS' PSYCHO-EMOTIONAL STATUS DURING ALLOGENEIC HEMATOPOIETIC STEM CELL TRANSPLANTATION: A MULTICENTRE PROSPECTIVE STUDY BY THE GRUPPO ITALIANO TRAPIANTO MIDOLLO OSSEO

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Background: Depressive disorders are the most common manifestation of psychological distress in allogeneic hematopoietic stem cell transplantation. No study has yet systematically assessed the relationship between therapeutic educational interventions and outcomes in these patients with specific attention to those related to mental health. Aim of this study was to understand how much educational intervention can represent a protective factor in preventing psycho-emotional distress-related issues in this setting.

Methods: A prospective observational study of a multicentre cohort was conducted in adult patients undergoing allogeneic hematopoietic stem cell transplantation. A pre-transplant therapeutic educational programme was offered to a cohort of adult patients undergoing allo-HSCT recruited in ten transplant centres of the GITMO network between May 2018 and January 2019. Depression, Anxiety and Stress scale was used to collect data on psycho-emotional distress at admission, at the day of transplant and at discharge. Descriptive data were collected and reported, and comparative analyses were done among patients who were compliant with the pre-transplant educational intervention and those who did not (for any reason).

Results: A cohort of 133 allo-HSCT patients were observed. In patients who did not receive pre-transplant educational intervention, higher levels of depression at admission ($p = 0.01$) and at the day of transplant ($p = 0.03$), higher levels of anxiety ($p = 0.01$ and $p = 0.01$ respectively) as well as higher levels of stress ($p < 0.01$ and $p = 0.01$) were observed. Problem solving and "face to face" interview were the best methods to provide education to patients. Patients who received pre-transplant education through "face-to-face" interview reported significant low levels of depression during the whole hospital stay period ($p < 0.01$; $p = 0.01$; $p = 0.01$) and less anxiety and stress at admission ($p < 0.05$ and $p = 0.01$ respectively).

Conclusions: Our study demonstrated that pre-treatment therapeutic educational programs with specific learning modalities can be effective in limiting the potential risk of developing moderate-to-severe anxiety-depressive states and stress symptoms related to allo-HSCT. Further studies are needed to confirm our results and to understand whether containing psycho-emotional distress can have any relationship with medium- and long-term post-transplant complications.

Disclosure: The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

NO006

SYMPTOMS AFTER ALLOGENEIC STEM CELL TRANSPLANTATION: PATIENTS' VOICES

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Background: The impact of symptoms and its effect on patients' daily life has been a topic in several studies of patients going through allo-HSCT, where fatigue, sleep disturbances, nausea, lack of appetite and indigestion such as obstipation and diarrhoea being the most prevalent reported symptoms. These are primary physical symptoms and there is a lack of knowledge about other symptoms such as social, psychological, and existential, that is multidimensional symptoms and experiences. The aim of the present study was to describe patients' expressions of physical, psychological, social, and existential symptoms and experienced problems post allo-HSCT.

Methods: The present study was a part of a retrospective cross-sectional survey of former patients who had undergone allo-HSCT between 2017–2020 due to a haematological illness at one centre in Sweden. Data collection was made during first two months in 2022, including both quantitative data, about symptom occurrence, and qualitative data from open-ended questions regarding patients' expressions of physiological, psychological, social experiences and existential symptoms were collected. Descriptive analyses were used for both quantitative and qualitative data.

Results: In total 126 of 211 (61%) former patients chose to participate in the survey. Most patients were 50 years or older and married, and 52% reported to have been to hospital for emergency visits. Most patients (58%) reported having less than 5 coexisting symptoms during the first-year post-transplantation, although 33% reported between 5–10, and 8% more than 10 concurrent symptoms during this period. Patients primary expressed physical symptoms ($n = 105$) such as fatigue, GVH, symptoms from the gastrointestinal tract, other mucous membranes and eyes, and from the skin. Social symptoms ($n = 66$) were e.g., regarding the family, feeling isolated, avoiding contacts with others, and work. Existential symptoms ($n = 63$) were e.g., thoughts about life and death, the future, the meaning and sometimes a wish to die. Psychological symptoms ($n = 54$) were e.g., anger, anxiety, worries, fear, and a feeling of panic.

Conclusions: Patients experience a variety of multidimensional symptoms after allo-HSCT, and healthcare professionals must both assess and be prepared to discuss physical but also psychological, social and existential symptoms both during and after allo-HSCT.

Disclosure: Nothing to declare

NO007

NUTRITIONAL RISK MANAGEMENT IN PATIENTS UNDERGOING HAEMATOPOIETIC STEM CELL TRANSPLANTATION: EXPERIENCE FROM A TERTIARY CARE CENTER

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Background: Malnutrition is a frequent condition in cancer patients: it affects between 30 and 50% of subjects, with negative effects on Quality of Life (QoL), prognosis and tolerance to treatments. Awareness of the prevalence and negative consequences of malnutrition in patients with haematological malignancies is poorly understood among health care providers.

In 2019 the Bone Marrow Transplantation (BMT) department group of the Careggi University Hospital (Florence, Italy) introduced dietitian to its multidisciplinary team.

The primary endpoint of the following retrospective study is to measure the impact of the interventions of the multidisciplinary team on involuntary weight loss in subjects undergoing HSCT.

Methods: A retrospective analysis was conducted on 712 medical records, of which 538 met the following inclusion criteria: adult patients undergoing HSCT who had completed their hospital stay in the BMT ward from 2017 to 2021. Clinical data regarding transplantation, weight loss and clinical advice from dietitian were stored electronically, using REDCap®, a secure, web-based platform that supports data capture. Statistical analysis was performed using STATA vers. 13.1 (Stata Corporation LLC, College Station, USA).

Results: A total of 538 patients were included. The mean age was 52.9 years (range 20–71 years), 55% were male and 45% women; 61.9% underwent autologous transplantation, 36.1% allogeneic transplantation, 2.0% has received Car-T treatment.

The data obtained showed a worsening of nutritional conditions. Linear regression models found a positive correlation between hospitalization days (p value < 0.0005), allogeneic transplantation (p value = 0.004) and patients' percentage weight loss: a weight loss greater than 10% was found in 12.3% of patients with a hospitalization of less than 30 days, 52.5% with a hospitalization between 30 and 60 days, and in 83.3% of people who have had hospitalization longer than 60 days. Only 10.5% of autologous transplant patients have had a percentage weight loss greater than 10%, compared to 47.4% for those who underwent allogeneic transplantation.

The introduction of the dietician into the team is bringing about change: the increase of dietician clinical advices in recent years has led to a decrease in annual percentage weight loss from 8% to 6%.

Early management of these patients should be enhanced, without neglecting those with less obvious nutritional deficiencies: in fact, among subjects with a body mass index greater than 25 at the hospital admission and a weight loss greater than 10% at discharge, only 13% have received dietary counseling since the introduction of the service.

Conclusions: The data emerging from the research, despite the limitations of its retrospective nature, highlights that the management by a multidisciplinary team helps to reduce percentage of weight loss of subjects who underwent HSCT, improving the nutritional status of patients.

The thoughts emerging from the study should be the basis for the implementation of proposals that may have a positive impact on clinical practice and quality of assistance provided by nurses.

Disclosure: Nothing to declare

NO008

WHAT ARE THE EXPERIENCES OF PATIENTS WITH GVHD FOLLOWING ALLOGENEIC HAEMATOPOIETIC STEM CELL TRANSPLANTATION? A LITERATURE REVIEW

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Background: Allogeneic haematopoietic stem cell transplantation (HSCT) is a widely employed yet risky treatment modality for patients with a haematological malignancy. While survival rates are improving, graft-versus-host-disease (GVHD) remains a major iatrogenic complication of HSCT, associated with increased morbidity and mortality. GVHD is a systemic illness with the potential to affect anywhere in the body. Although there is acknowledgement of the detrimental impact GVHD has on post-HSCT patients' lives, a more in-depth understanding from a qualitative perspective is warranted. The aim of this systematic review of qualitative research was therefore to critically understand and explore the experiences of patients with GVHD following allogeneic HSCT.

Methods: Following ENTREQ guidelines, a systematic search was carried out on six diverse electronic databases (British Nursing Index, CINAHL, MEDLINE, PubMed, PsychINFO and AMED). The search strategy consisted of terms pertinent to 'HSCT', 'GVHD', 'experience' and 'qualitative research'. All included studies were assessed for quality using the Critical Appraisal Skills Programme (CASP). Thomas and Harden's three-stage approach to thematic analysis was utilised, moving from line-by-line coding, to descriptive themes and then finally to overarching analytical themes.

Results: Eleven qualitative studies were included in the literature review. Thematic analysis identified four overarching themes which influence patient experiences of GVHD: 'interference with daily life', 'burden of uncertainty', 'mastering life with GVHD' and 'individualised information needs'. Despite these overarching commonalities there were discrepancies within each theme, demonstrating clear heterogeneity in patient experiences of GVHD.

Conclusions: There are distinct frustrations and limitations to daily life as a result of GVHD, but the impact of this and the way that individuals cope with these limitations is variable. Healthcare professionals (HCPs) need to remain cognisant of this and offer individualised assessment, education, care and support throughout the HSCT trajectory in order to optimise patient experiences of those with GVHD. Further research is required, including prospective, longitudinal research which explores patient experiences of GVHD in correlation with their potentially changing GVHD severity; and research which evaluates the impact of interventions (e.g. psychosocial) to address the needs of patients with GVHD.

Disclosure: Nothing to declare.

NO009

PATIENTS' EXPERIENCES OF PERSON-CENTRED CARE IN THE CONTEXT OF ALLOGENEIC STEM CELL TRANSPLANTATION

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Background: In healthcare today person-centred care (PCC) has emerged as a primary approach to meet individual needs and it has shown a significant effect of patients' preparedness for treatment, patient outcome, patient-safety as well as quality and safety of hospital care. Using measures that can provide insights into practice is important, and particularly in identifying areas for improvement of PCC. Therefore, the aim of this study was to explore patients' experiences of person-centred care in the context of allogeneic stem cell transplantation.

Methods: In a cross-sectional study data was collected during the first two months of 2022 from patients that had undergone an allogeneic stem cell transplantation during 2017–2020 at a single centre in Sweden. An invitation to participate in the study by answering an online questionnaire was sent by post to all eligible patients ($n=211$). The PCCoc/rheum was used, which is an instrument developed for measuring person-centredness for different aspects of care in out-patient care in rheumatology, developed and validated by Bala et al. in 2017. The questionnaire contains 24 items, rated on a four category response scale. Descriptive statistics was used for data analyses.

Results: A total of 126 persons chose to participate in the study, which is a 60% response rate. The participants were evenly divided male and female, aged 18–79 years (>60% were 50–69

years old), a large majority (>70%) were married or co-habiting. A majority (87-99%) of the participants were satisfied with the level of person-centredness for 22 of the 24 items. The participants agreed or strongly agreed that: the care environment was welcoming, having been seen as a person and listened to, having been taken seriously and having had a good collaboration with the nurses, equality in the care meeting and a coordinated care. For two items participants responded that they disagreed or strongly disagreed with the fulfilment of the aspects in care—family members involvement (14%) and the possibility to influence the care (16%).

Conclusions: A large majority of the persons that had undergone an allogenic stem cell transplantation agreed or strongly agreed with the fulfilment of person-centredness for most aspects of the care investigated, but two central aspects—the possibility to influence the care and family members' involvement were rated lower, which indicates that there is room for improvement.

Disclosure: The authors have no conflict of interest to disclose.

NO010

OUTCOMES OF ANXIETY AND DEPRESSION REPORTED BY CAR-T CELL THERAPY CANDIDATE PATIENTS

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Background: CAR-T cell therapy is a personalized immunotherapy in which T-cells are genetically modified to express a chimeric antigen receptor (CAR) which will bind to malignant cells. Tumor recognition by CAR T-cells leads to their activation that leads to tumor death. Patients receiving CAR-T cell treatment have relapsed or refractory disease. Besides having an extensive history of refractory disease, most patients and caregivers need residence relocation next to CAR-T centre for 6-8 weeks, adding considerable financial, personal and psychosocial burden. Current practice recommends regular mental health assessment using a validated tool. We performed a study to describe anxiety and depression in patients who are candidates for CAR-T cell therapy.

Methods: An observational study was conducted from January 2022 to October 2022. Approval of the Ethics Clinical Research Committee (HCB/2021/1170) was obtained. Patients ≥18 years who underwent CAR-T cell therapy were included.

Sociodemographic, clinical care, Hospital Anxiety, and Depression Scale HADS, and quality of life (EORTC QLQ-C30) variables were collected through the systematic review of the medical records.

Results: Ninety patients were included. 51% were men with a median age of 54.7 years (range 19 to 76). 55% came from another community and 96% had a caregiver. 70% of the participants were relocated and 56% use public transport to travel. Main diagnosis were non-Hodgkin lymphoma (36%), acute lymphoblastic leukaemia (23%) and chronic lymphocytic leukaemia (36%). 73 (81%) of the candidates were accepted for CAR-T therapy. No information was obtained from 2 patients.

Sixty-eight (77%) participants had anxiety and depression using the HADS scale and 66 (75%) had impaired Emotional functioning using the EORTC QLQ-C30. 100% were assessed by a social worker, 17% were followed up by a psychologist from other center and it was maintained telematically and 69% were referred to a psychologist at our centre. We found no differences between presence of anxiety and depression with accepted candidate (p 0.133), with site of origin (p 0.056), with diagnosis (p 0.841), nor

with psychological care at origin (p 0.583). However, we did find differences between presence of anxiety and depression with psychological care at our centre (p < 0.0001). The intraclass correlation index was evaluated to determine the degree of agreement between the assessments made with HADS and Emotional functioning with EORTC QLQ-C30, obtaining a good correlation (ICC: 0.973).

Conclusions: This study provides evidence that the use of a validated scale for patients who are candidates for CAR-T therapy allows us to identify those who present anxiety and depression and thus provide a referral to the psychology team for a better management of mental health. Seventy-seven percent of our participants had anxiety and depression and only 17% had a psychological follow-up prior to coming to our centre. We have found an adequate correlation between the results of the HADS scale and Emotional functioning using the EORTC QLQ-C30 scale.

Disclosure: Nothing to declare.

NO011

INCREASE OF HAND HYGIENE ADHERENCE AND HAND HYGIENE PRACTICE QUALITY ACCORDING TO REGULATION GUIDELINES AT THE PEDIATRIC HEMATO-ONCOLOGY AND BONE MARROW TRANSPLANT DEPARTMENT (PHOBMTD)

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Background: Patients hospitalized at the Pediatric Hemato-Oncology and Bone Marrow Transplant Department of Sheba Medical Center are immunocompromised due to an extensive exposure to chemotherapy treatments and broad-spectrum antibiotics. The aim of this study was to prove that gamification technology can facilitate a behavior change that will lead to and increase in hand hygiene adherence and improvement in hand hygiene practice quality among the health care personnel.

Methods: Information regarding department hand hygiene adherence was retrieved from computerized data and nurses' documentation. Information regarding personal hand hygiene adherence and personal hand hygiene practice quality was collected by the CleanMachine Pro & SoapyWisdom cloud platform. Information regarding behavior change was also reported through an anonymous survey of the healthcare team of the PHOBMTD. Data collection of pre intervention was from July 4th 2022–July 18th 2022. Data collection of post intervention was from August 1st 2022–September 30th 2022. The interventions included staff training of a proper hand hygiene practice, gamification and competitive score 24/7 sharing the hand hygiene personal quality score of the healthcare providers with the rest of the team. The primary intervention was the implementation of the CleanMachine Pro at every room entrance replacing the manual sanitizer dispensers.

Results: Adherence to hand hygiene reached 98.2% an increase of 15% compared to the previous year. Furthermore, healthcare team hand hygiene practice quality increased to 99% for rub and scrub time (increase of 58%) as well as 87.5% rate for executing all expected gestures for rub and scrub technique (an increase of 62.5%). The compliance rates were achieved within 2 weeks of implementing the use of the CleanMachine Pro and SoapyWisdom cloud reporting platform and remained with the same level during the entire time of the intervention and after it.

Conclusions: The positive gamification effect as well as supporting educational technology, shifted a behavior change and influenced team thinking about how they practice hand hygiene rub and scrub technique. The positive shift in adherence,

as well as hand hygiene practice quality, supported the leadership's decision to implement the same technology as a standard in other departments at the Sheba Medical Center. The results reported are preliminary results and further research is required to show a reduction in Hospital Associated infections and a reduction in hospitalization days.

Clinical Trial Registry: Sheba Medical Center. Tel Hashomer
Disclosure: Nothing to declare

NO012

DISCHARGE PLANNING OF COMPLEX PAEDIATRIC STEM CELL TRANSPLANT PATIENTS: A CASE STUDY REVIEW

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Background: Great Ormond Street Hospital (GOSH) undertakes more than 100 paediatric stem cell transplants and CAR T cell therapies per year. Patients are referred from a range of immunology, haematology/oncology and metabolic backgrounds and are becoming increasingly complex demanding high levels of nursing expertise. Inpatient admissions are consequently lengthy with families removed from familiar home support mechanisms. This has recently included increasing numbers of refugee families displaced from their home country who present a unique challenge.

Methods: Complex patients have multiple, long-term treatment sequelae requiring intensive input for months post-transplant. This involves multiple allied professionals and supporting specialities requiring multi-layered and effective communication. As a tertiary centre, with no direct readmission capability, the transplant unit at GOSH relies heavily on the support of non-specialist shared care hospitals and children's community teams post discharge. Moreover, the complexities of the patients are reflected in the high demands now placed on carers to meet ever increasing clinical needs placing additional practical and emotional burdens on families many of whom have depleted coping mechanisms and lack appropriate practical or financial support. Furthermore, the increasing pressure on bed capacity means timely discharges are imperative. It is therefore essential that robust and effective discharge planning is instigated from admission. At GOSH, we have established and recently expanded an inpatient clinical nurse specialist (CNS) service and part of this remit is to manage and co-ordinate discharges to establish a safe, effective patient pathway to meet this increasing demand.

Results: A case review of 2 complex discharges undertaken at GOSH to examine the discharge planning process and the central role of the CNS to underpin the process. These cases not only present demanding clinical complexities, but additionally incorporate challenging psychosocial and cultural complications, all of which impact on effective and timely discharges. These examples will demonstrate the discharge pathway we have developed and demonstrate the need for a multi-disciplinary, multi-centred discharge approach. Discharge planning continues throughout the transplant trajectory as discharge plans continue in parallel to acute inpatient care. In recognition of the partnership between shared care hospitals and the community teams, we have developed a new pathway: key professionals are identified on admission and provided with frequent updates about the child and family including clinical progress and psychosocial

concerns. This innovation was recently reviewed through questionnaires sent to 30 shared care units and of the 20 responses received, all rated this additional communication as invaluable for forward planning at discharge. Furthermore, these case studies establish that family support and education underpin successful discharge planning and it is essential that this is co-ordinated by a central role such as a CNS working alongside the families.

Conclusions: The case studies presented demonstrate that dynamic and early discharge planning lies at the heart of effective post-transplant care. The inpatient CNS is a unique resource to effectively co-ordinate and manage these increasingly complex patients. This improves clinical safety and multi professional communication with the ultimate aim of improving the family experience and subsequent quality of life at home whilst minimising the risk of readmission.

Disclosure: Nothing to declare

NO013

NURSES' EXPERIENCES WITH LIMB PAIN IN PEDIATRIC HEMATOPOIETIC STEM CELL TRANSPLANTATION

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Background: Pediatric patients who receive an allogeneic HSCT often endure pain, such as mucositis and abdominal pain (Harden et al, Children, 2022). In our clinical practice, we also observe limb pain regularly. This limb pain looks like myalgia or skin pain and might be a combination. Hemoglobinopathy as underlying disease seems a risk factor for having these pains, possibly in combination with treosulfan as part of the condition regimen (Van der Stoep et al, Sci Rep, 2021).

To illustrate this, a patient case. A boy, ten years old, has been admitted to the hospital for an HSCT for sickle cell disease. The conditioning regimen consisted of ATG, thiopeta, fludarabine and treosulfan. Starting four days before HSCT up to seven weeks post, the patient experienced pain when being touched, having blood pressure measured, undergoing central venous catheter dressing changes, standing, and walking. Pain medication included paracetamol, tramadol, morphine and gabapentin. Despite these painkillers, the patient still experienced pain in his legs.

Since this limb pain impacts a substantial part of our patient category and affects their comfort, it is crucial to get insight into this pain and effective methods to relieve this pain. It is necessary to have nurses skilled in recognizing this pain and deploying interventions. Therefore, we aim to get insight into the experiences and needs of nurses working with patients experiencing limb pain.

Methods: A questionnaire with 6 closed and 1 open-ended question was drafted. First, function and years of experience were asked. Next, three questions focused on experienced competence using a Likert scale from zero to five. Finally, nurses were asked for their needs to improve nursing care in a multiple-choice question and which interventions they thought to be useful in an open-ended question. The questionnaire was offered digitally, with a link and a QR-code distributed by e-mail and WhatsApp.

Results: The questionnaire response was 63% (N = 28). Of these respondents, 14 were senior pediatric nurses, seven pediatric nurses and seven pediatric nurses in training. Overall, nurses

Table 1. Outcomes questionnaire limb pain HSCT.

	Competency in recognizing pain Mean (SD)	Competency in preventing pain Mean (SD)	Competency in limiting pain Mean (SD)	Intervention needed for improving care n (%)			
				Protocol	E-learning	Education	Standard nursing care plan
0–2 years of experience (n = 12)	2.7 (0.8)	2.3 (1.1)	2.4 (1)	7 (41)	5 (83)	9 (43)	1 (20)
2–5 years of experience (n = 2)	4 (0)	4 (0)	3.5 (0.7)	2 (12)	0	1 (5)	0
5–10 year of experience (n = 5)	4 (0.7)	3 (1.4)	3.4 (1.5)	4 (23.5)	1 (17)	3 (14)	3 (60)
>10 years of experience (n = 9)	4.3 (0.7)	3.7 (1.2)	4 (1)	4 (23.5)	0	8 (38)	1 (20)
Total group	3.5 (1)	3 (1.3)	3.2 (1.2)	17	6	21	5

scored their competency in recognizing limb pain with a mean score of 3.5; competency in preventing limb pain 3 and competency in limiting pain 3.2. For differences between groups see Table 1. Regarding interventions needed to improve care, education was mostly mentioned (21), followed by a specific protocol (17), e-learning (6), and standard nursing care plan (5). In response to the open-ended question asking for meaningful interventions during HSCT, several suggestions were given, such as mobilization, diet, heat therapy and medication.

Conclusions: The questionnaire shows that nurses feel moderately competent in observing, preventing and limiting limb pain. Nurses felt most competent in recognizing limb pain and more experienced nurses felt more competent than novice nurses. More attention and awareness are required to this subject, especially education and a specific protocol. Both are planned for the upcoming year. A prospective study is needed to get more insight into this specific limb pain to provide more comfort for the pediatric HSCT patients.

Disclosure: Nothing to declare.

NO014

THE BENEFITS OF TEACHING PILL SWALLOWING TO CHILDREN AND YOUNG PEOPLE POST STEM CELL TRANSPLANT

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Background: Children and young people are discharged from hospital on liquid medications due to habit and reluctant to convert to tablets by parents and staff. Tablets are safer and more effective, then liquids and often have a large cost saving.

Children and young people post stem cell transplant are often required to take many prophylactic medications for many months most transplant. They are often on high doses of medications leading to high volumes. If they are unable to take tablets patients often end up with a nasogastric tube to the administer their medications. If a nasogastric tube is required at discharge, then it essential that the carers are trained to managed this in the community. If taking the medications orally it can be a lengthy process to convert from intravenous to oral due to nausea and reluctant to take the volume of liquid required.

There are recognised pill swallowing techniques which are suitable to be used with patients over the age of 5, who do not have any neuro disability. It would seem that patient post stem

cell transplant would be a prime group of patients to integrate pill swallowing teaching into discharge planning.

Methods: Over a 2 month period patients were identified on the inpatient stem cell transplant unit who met the following criteria; over the age of 5 years old with no neurodisability, being prepared for discharged to the outpatient setting, on oral medications, medications being given via an NG tube or patient receiving liquid preparations to take orally. Using the pill swallowing technique taught to staff by the Kidzmed project at Great North Children's Hospital, identified patients were taught the recognised pill swallowing technique.

Results: Two patients were successfully identified within the 2-month period who fully met the require criteria to complete the pill swallowing teaching. Both patients successfully completed the teaching and were able to be converted from liquid preparations of their medications to tablets. This resulted in an approximate saving of £7800 over a 3-month period. It also prevented one patient from requiring a nasogastric tube insertion to be able to continue to take his prophylactic medication, and the requirement to train his parents to manage the nasogastric tube at home therefore shortening his stay in hospital. The carers commented on the ease of administration of the medications once converted to tablets and the patients reported feeling less nausea post medication administration once converted to tablets.

Conclusions: Pill swallowing teaching in post-transplant patients should be considered as part of discharge planning. For children and young people who are able to successfully complete the training, it could potentially shorten their inpatient hospital stay, reduce the length of time they require a nasogastric tube or prevent the need completely, and reduce nausea. Using tablets is safer for administration by carer and easy to teach them pre discharge, carer may need to ask for less prescription.

The use of tablets over liquids can also have a huge cost saving for the NHS trust even with the relatively small number of post-transplant patients.

Disclosure: Nothing to declare

NO015

THE BED SIDE SHIFT REPORT A TOOL TO ENHANCE THE NURSE'S SKILLS IN HAEMATOLOGY AND ENCOURAGE PATIENT EMPOWERMENT

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Background: Nurse bedside shift report, or handoff, is the transfer of responsibility and accountability for patient care from one provider or team of providers to another (Australian Medical Association, 2006)¹. In the literature has been defined as a process of exchanging vital patient information, responsibility, and accountability between the off-going and oncoming nurses in an effort to ensure safe continuity of care and the best clinical practices². There are different types of nursing reports described in the literature, but the four main types are: a written report, a tape-recorded report, a verbal face-to-face report conducted in a private setting, and face-to-face bedside handoff³. The nurse bedside shift report involves the use of certain communication rules: a proper preparation, avoid using jargons and abbreviations and use a closed-loop communication to keep away from misunderstandings. The moment of the passage of information between one shift and the next should require particular attention by all operators.

Methods: This is a prospective observational study opened with a literature search in January 2022 on the Pubmed and Cinahl databases.

The study was presented to the nursing team through two meetings.

Four focus groups were organized prior to the start of the study to assess nurses' perceptions of nursing report prior to the introduction of BSR.

Two Likert scale evaluative questionnaires, one for patients and one for nurses, were created through backtranslation and administered 1, 3, 6 and 12 months after the start of the study.

Results: The nursing team is made up of 14 nurses and 1 head nurse. The initial evaluation at time 0 was performed through a focus group. 57% defined the tool used adequate. 50% nurses answered little about the setting. 75% did not know the BSR method. The perception of nurses: at the first evaluation (one month after the start) 50% of nurses say BSR is an effective and efficient means of passing information. 50% of the team agrees that BSR generates stress. The second assessment was carried out 3 months after the start. 42% agree that BSR helps to prevent patient safety issues and they feel informed about the care pathway. 36% of nurses say BSR is not completed within a reasonable time.

The patient's perception: one month after the start of the BSR, the questionnaires administered to patients were 11. Most patients felt comfortable, they appreciated the clear and satisfying educational approach. 43 questionnaires were administered to patients three months after the start, the patients agree strongly on teamwork, and they appreciate involvement during delivery.

Conclusions: After the first two phases of the study, we can say that there is difficulty in the timing of the passage of information, the BSR is a safe and clear tool for the passage of information, and it increases patient compliance.

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