

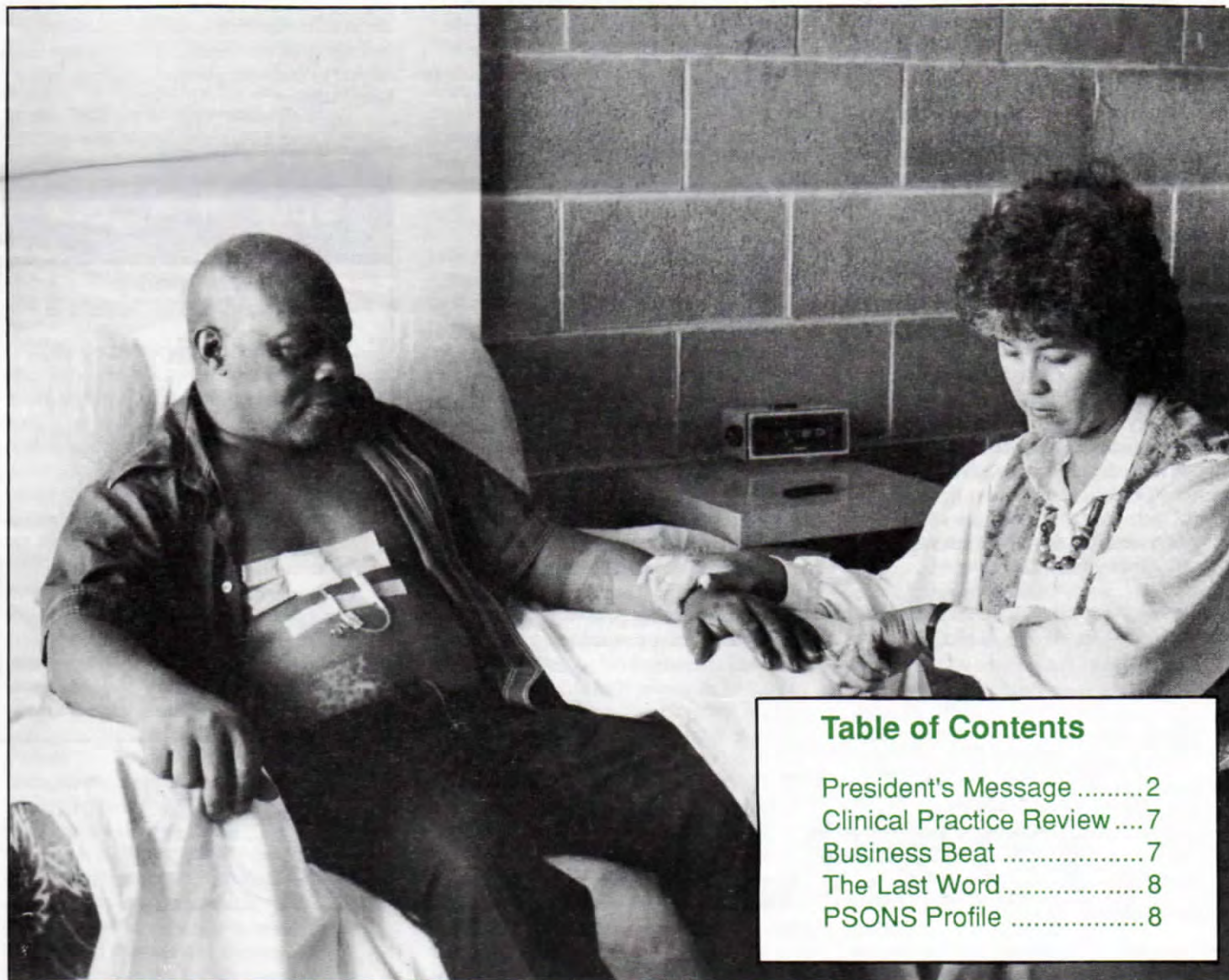
# Puget Sound Quarterly

Vol. 13, No. 5  
Winter, 1990



ONCOLOGY NURSING SOCIETY

## *Can We Keep This Patient at Home?*



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# From the Editor

Anne Marie Maguire, RN, MN, OCN  
Clinical Specialist  
Visiting Nurse Services  
Seattle-King County  
Guest Editor

## Issues in Home Health

The home health care industry grew in size during the '80's as a result of the aging of America, DRG's, and the earlier discharge of more seriously ill patients. Many of the problems that home health agencies are confronted with mirror the problems in hospital. Reimbursement is an ever present issue. Nurses are constantly challenged in their attempts to provide quality patient care within Medicare and Medicaid reimbursement guidelines. As the health care dollar shrinks, agencies scramble to provide cost-effective care. Further belt-tightening (and scrambling) will occur if and when President Bush's proposed budget is implemented. It is also expected that DRG's will be introduced in home care within the next five years.

The nursing shortage is present in home health agencies too. The advantages of working in a home health agency include flexible work hours, fewer weekends and holidays worked, and a very autonomous practice. Disadvantages include lower pay than hospital based nurses (except for those in hospital-based agencies) and isolation in the field. With the shortage, staffing becomes a chronic headache. Productivity in home care parallels patient care hours as in the hospital setting. Managers use productivity statistics to make budgetary decisions such as staffing and numbers of FTE's.

With this background, some of you may wonder if you would enjoy home care. I can honestly tell you that no two days are ever alike. When I walk into someone's home, I'm never quite sure of what I'll find. Challenges abound.

The two greatest skills that a home health nurse needs are clinical assessment and patient teaching skills. Some patients need the nurse's help to recover from cancer surgery, manage with chemotherapy or

radiation treatments, or stabilize symptoms such as pain or nausea so they don't need rehospitalization. Many times the task is to help patients die comfortably at home. In addition to managing symptoms, the nurse has the opportunity to teach and support the patient and caregivers in their own environment. Often times this means adapting nursing practice (and scientific rationale) to unusual situations. For example, hanging IV bags on curtain rods with coat-hangers was a new experience for me. I also learned to put the cat out before attempting dressing changes or Foley catheter insertions. Cats are drawn to sterile fields although this fact has never been explained in any nursing texts. The home health articles in this issue deal with rural home care, bereavement services, discharge planning, and the new AIDS waiver program. These articles touch on different aspects of the industry. It is my hope that the articles and this editorial capture your interest in home health and encourage some of you to consider pursuing nursing in the home setting.

# President's Message

Joy Miller Knopp, RN, MN, OCN  
Oncology Clinical Nurse Specialist  
Overlake Hospital Medical Center

Accomplishments of our chapter this past few months include the sponsoring of the oncology certification review course. The course held in Bellevue had 37 attendees and was taught by members of our chapter. We learned a lot from this endeavor, primarily that an 8 hour course may not be feasible for all the information that was given. Many thanks to the planning task force which included Barb Fristoe, Sue Ford, Mary Duff, and Anne Marie Maguire. On September 22, sixty

nurses took the certification exam at the U of W in Seattle.

As a chapter with such wide geographical boundaries we have an ongoing challenge in trying to meet the needs of all of our membership. The board and committee chairs are continually planning for the direction in which our chapter will go. Our organization has had outstanding accomplishments due to the talent of our membership and leadership. I sincerely hope those of you who have not done so will become involved and help us plan for the 90's. A clear benefit of involvement in PSONS is a heightened sense of "professional self-esteem" in oncology nursing.

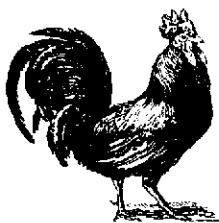
## Special Project

Three volunteers  
needed  
to assist  
with PSONS  
Directory  
development

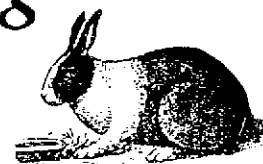
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Please call Pat  
at 326-4221





# Rural Home Care Nursing



Annette Yanisch, RN, BSN, ET, OCN  
Hospice Coordinator  
Assured Home Health and Hospice  
Chehalis, WA

**H**ome care is home care. People are people, or so I thought after I moved from the "big city" of Seattle to rural Washington State. After all, how different could it be? After doing oncology and hospice home care for four years, I thought I had seen it all and done it all. I was in for a big surprise.

The experience that most clearly illustrated the differences occurred soon after I started my new job. I drove to Packwood to see a man with lung cancer and found him breathing at a rate of 60/minute. He already had a large green tank of oxygen in the living room, but used this only once or twice a day when he felt able to get into that room. He had no extension tubing and only enough oxygen to last at most two hours. I called the "local" oxygen supplier and explained his status. I was asked, "Will he be okay until morning?" Accustomed to oxygen within hours of my call, I was astounded by this response. Then I realized where I was. The oxygen supplier was 180 miles round trip away, it was 4 P.M. and a winter snowstorm was setting in. What to do? The local fire department donated their oxygen supply for the night and an oxygen concentrator was delivered in the morning.

The problem was solved and a valuable lesson was learned. When the choice is made to live such a distance from medical back-up and supplies, solutions to problems may be less than ideal, are usually creative, and involve utilization of existing services that may not be intended for your specific need. In other words, when in doubt, punt.

Although I had seen patients of nearly every socioeconomic group in Seattle, I found a certain lack of sophistication in my rural population. Because of the limited education level of many patients, I found myself having difficulties explaining even simple procedures. Oncologists in neighboring communities used terms like "tumor" or "mass" or "growth" and patients did not perceive their problem to be cancer. In attempts to explain in simple terms, often the entire meaning was lost and often it wasn't known that the patient had no understanding because he/she appeared to understand.

People tended to be very isolated and isolating. It was almost impossible to engage a patient or family member in a

discussion about "feelings". Psychosocial interaction had been by forte', but suddenly I was hitting a brick wall. Often I felt like a failure because I was unable to really assess coping by patients or their families. They readily answered direct questions, but rarely volunteered information beyond short responses. It felt like I was dragging information out of them rather than deftly utilizing those sly communication techniques guaranteed to elicit discussion.

Accustomed in Seattle to occasionally alienating a patient or family member by something I had said or done, I was totally unprepared for the results of a such an instance in a small town. After what I perceived to be a minor faux pas (I said the word "cancer" rather than "mass") I was shocked to hear about "that damn visiting nurse" being discussed openly in the town's biggest (and only) restaurant. I was devastated. I had done nothing wrong—in Seattle it would have been considered appropriate, but "out here" I was now the object of angry gossip.

The best "war" stories in rural home care generally involve animals. The rabbit who bit through grandma's Foley catheter, or the chicken perched on the shoulder of the patient leaving "presents" next to someone's coffee cup, or the ducks swimming in the swimming pool. Or, how about the oxygen concentrator that was used as an incubator for hatching eggs? It's difficult to maintain sterility in a home where there is no running water and the pan they pour boiling water into is dirty. Drawing blood with your last needle or messing up on a catheterization with your last cath kit can be more than frustrating. You can't just run to the nearest pharmacy or back to the office when that may be 80 miles away!

Any major illness in a rural community can be a challenge for treatment. Cancer care presents special challenges. Medical oncology care may be hours away. Daily radiation treatments may involve nearly half a day in travel and preparation. Both patients and family members are exhausted and frequently tolerate treatments poorly because of the extra effort required. Physicians frequently don't realize just how far away the patient lives—it may require superhuman effort to get that patient in to see that doctor again—and to go any every three days to get a "pain pump" filled may be a ridiculous expectation. There are no

buses or mobile transport systems to get them there. Extreme side effects may be unnecessarily tolerated because the patient didn't realize it was that bad, and they thought that "you're supposed to get this sick with chemo".

Despite the distance involved, generally it is preferable to keep patients under care of their oncologist rather than to be referred back to their local M.D. I have struggled with physicians who "don't think it's a good idea" to increase pain medication in a terminal patient or who insist on an office visit for every medication adjustment. This is not intended to criticize the abilities or rural M.D.s; their expertise lies elsewhere, but the specific and complicated care needs of oncology patients are best addressed by someone familiar with those problems. Those who are office oncology nurses, bear with us as we continue to call when you thought the patient was referred back out. Most of the time the local M.D. would welcome knowledgeable input into pain and symptom management. We need you.

So why would anyone want to work in a rural setting. There are benefits. For one thing, I never find traffic jams along country roads. I now find I'm irritated when I even have one car I have to follow. The area is beautiful and peaceful. I like to take my bicycle along and go for a 5-10 miles ride at the end of the day, wherever I end up. Although all home care nurses are needed and usually appreciated, in the rural setting most people are used to "getting by without". The presence of visiting nurses is frequently the only thing keeping someone safe at home since most of the terminal patients will never leave their homes.

There are not multitudes of agencies to meet various needs. Our agency supplies food, as well as equipment and supplies to patients. We are truly a vital part of the community — not just another agency. We are the agency. When I moved here, I thought I was kissing my career good-bye. No more chance to be a big cancer nurse in the city. In actuality, my opportunities have increased. My expertise is greatly valued and utilized. I do more here than I ever could have in Seattle—I'm a big fish in a small sea.

# From Acute Care to Home: Facilitating the Journey

Carol M. Taylor, RN, BSN  
Cardiopulmonary Nurse Clinician  
Visiting Nurse Services  
Seattle-King County

**W**ith the advent of DRG's in the early 1980's the discharged planning process became an integral and legitimized part of quality patient care. The process, however, is only as good as the players involved and is enhanced by information gathered early in the hospitalization. Nurses in the acute care setting can clearly establish the role of identifying potential discharge needs. They can evaluate red flag patients who have a need for post hospital care. The following questions will aid in this process.

- 1) Does the patient live alone? How will he/she prepare meals, manage personal care or procure medications?
- 2) Are there architectural constraints or safety issues in the home environment? Is there a telephone?
- 3) If the patient needs a caregiver is there a willing and able family member or friend to manage the care?
- 4) Will the outcome of this episode cause a change in the patients self-management at home? Medications changed? New therapies?
- 5) Does the patient have a previous history of this type of illness? Newly diagnosed? Any history of nonadherence to the medical regimen?
- 6) Will there be functional deficits associated with this illness? Will they need home physical therapy, occupational or speech therapy? Will they need home health aide services?
- 7) Does the patient have access to reliable transportation?
- 8) What are the families/patients coping assets? Previous patterns of coping with crisis? The ability of social work to intervene early with these at risk patients will provide for a smoother transition to the home setting.

The role of educating the patient and family while in the acute care setting is a valuable step in the discharge process. Short demonstrations that are repeated frequently and return demonstrations as

well as quality, written materials will enhance the knowledge and confidence of the patient and care providers.

Home health nurses are an important link in the health care continuum and incorporating them in discharge planning early can assist in this transition. Their insights and expertise can frequently facilitate the process. Although thought of by some as a less "challenging" field of nursing, home care has kept pace with technological advances. It is common to care for patients with complex care needs such as feeding tubes, intravenous, or subcutaneous infusions and ventilator management. The challenges are many and maintaining the comforts and dynamics of home in an atmosphere that could represent a mini intensive care unit is highly important. Working with patients on their "turf" requires unique skills. While hospital staff are often bombarded with information, home care nurses frequently make their expert assessment with minimal information known about the client. Independent judgements and good critical thinking skills are necessary in the successful home care clinician.

In addition to evaluating the patients status and making pertinent recommendations to the physician, patient education is an important element of the treatment plan. The continuity of the patient and family teaching process can be enhanced by sending home a check list of issues taught and any specific care instructions. It is common to find patients who have been well taught by the hospital staff, but due to the stress of hospitalization cannot apply the information with they arrive home.

When making a referral, the following information should be communicated by telephone:

- 1) Demographic information
- 2) Primary physician information
- 3) Billing/insurance information
- 4) Dates of hospitalization and surgeries
- 5) Discharge diagnoses
- 6) Specific services requested
  - a) nursing
  - b) physical therapy
  - c) occupational therapy

- d) speech therapy
- e) home health aide
- f) medical social work
- g) medical equipment/supplies
- 7) Orders and Treatments  
- note if equipment or needed supplies are being sent home with the patient or are needed on the first home visit.
- 8) Vital signs/pertinent lab values
- 9) Diet
- 10) Functional limitations
- 11) Psychosocial issues / continuity issues

The following information should be provided to the home health agency.

- 1) Admission history and physical
- 2) Relevant consultation reports
- 3) Copy of nursing care plan
- 4) Rehab or social work summaries if appropriate

Whether the goal of home care is to restore the patient to a more independent level of self care or to support throughout the dying process, the patient benefits when the communication links between all health care providers are strong.

## Recommended Readings

1. Ruschm S.C. Continuity of Care: From Hospital Unit into Home. *Nursing Management*, 1986 17(12):38-41.
2. Clark, L.K. Discharge Instructions for Wound Catheters . . . Your Jackson Pratt Wound Drain. *Society Otorhinolaryngology Head Neck Nurses*, 1987 5(1):31.
3. Eggland, E.T. Home Health Care . . . What Services or What Alternative are Available? *Nursing* 87, 1987 17(10):75-79.
4. Rabinow, J. Discharging Patients: Do you know all your legal risks? *Nursing Life*, 1987 7(2):25-27.
5. Hartigan, E.G. Discharge Planning: Identification of High Risk Groups. *Nursing Management*, 1987 18(12):30-32.
6. Hardy, C. Home Care of Patients with Technically Complex Nursing Needs. *Nursing Clinics of North America*, 1988 23(2):315-328.
7. Hays, J.C. High Technology and Hospice Home Care: Strange Bedfellows. *Nursing Clinics of North America*, 1988 23(2):329-340.

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# Bereavement Services: Help for Those Left Behind

Jinny Tesik, M.A.  
Bereavement Service Coordinator  
Group Health Hospice

**I**t is not easy to understand or accept the loss of a loved one. Many emotions surface which take time to sort out, to understand, and finally to resolve. A caring support system is important during this time. Many people, especially those who have been long term caregivers for terminally ill loved ones, need permission to now focus attention on themselves and allow themselves to begin the grief process. Many worry whether they are grieving in the "right way", and wonder if their feelings are normal. The surviving family and friends need trusted and compassionate people who are able to listen to them empathetically and nonjudgementally and who are able to provide them with information about the grief process and with supportive community resources.

Grief support after the death of a loved one is an integral part of our Group Health Hospice care. We make every effort to offer personal, on-going support to our families for a year after the death. We begin the outreach to our families at the time of death with a sympathy card. The card, very simply stating that we are thinking about them, is passed around in the team meeting and signed by all who participated in the care and support of the patient and family prior to the death.

The primary nurse, social worker, or spiritual counselor makes a follow-up call and/or final home visit to the family. At that time they take a booklet to the family about the grief process and introduce them to our Bereavement Program. The primary nurse fills out a Bereavement Assessment on each client for review by the Bereavement Coordinator, who is responsible for maintaining contact with the survivor during the next year. The assessment gives as much information as possible to the Coordinator about the physical, mental, and emotional state of the survivors.

With the help of dedicated volunteers, periodic letters are sent to the family at one month, 3 months, 6 months, and a year. There is also a special letter sent during the holiday season with tips for coping with the holidays. All mailings include educational materials about the grief process. There is also a self-addressed card which the survivors can send back if they are interested in information about support groups

or in having one of our well trained Bereavement Volunteers contact them.

Within two months of the death (unless an earlier contact is indicated) the Bereavement Coordinator makes a personal call to introduce herself and remind the bereaved of the services available. She also inquires as to how they are coping with their loss and addresses any current questions or concerns. If a volunteer is requested, the Coordinator assigns a volunteer to the bereaved as soon as possible. The volunteer may make periodic follow-up phone calls to assist the bereaved through their grief process.

Group Health Hospice offers both day and evening Grief Support Groups. The groups meet twice a month and are open free of charge to the community. In addition to these groups we are able to refer to other support groups in Seattle and Western Washington. By sharing with others the bereaved learn that they are experiencing natural and normal grief responses. They receive permission to grieve and validation of their emotions. They are given a safe, confidential place to accept support and to offer it to others. Support Groups help the bereaved gain a sense of perspective about their loss and offer insight into the process of grief.

Once a year we remember the patients who have died with a memorial service. The Hospice Team plans and participates in the service, and...all the family and friends are invited. As candles are lit by all members in the congregation, we read the names of those who have died. It is a very special time of healing both for ourselves and for the family and friends.

The bereaved need a variety of avenues to receive support and guidance. Each individual finds their own way to cope with loss and grief. As service providers, it is important to offer ongoing opportunities for education and support to the clients we serve. If any part of the Group Health Hospice Bereavement Program sounds like it could be applied to your programs to better serve your clients I would be happy to share more information with you. I can be reached at 326-4265, or in care of Group Health Hospice, 83 So. King St., Suite 515, Seattle, WA, 98104.

# Understanding the New AIDS Waivered Services for Home Care

Pat Philbin, R.N.  
AIDS Care Coordinator  
Group Health Cooperative  
Seattle, WA

In July of this year the state of Washington began providing Medicaid waivered services for individuals living with HIV/AIDS. This is a brief summary of the services provided and the criteria for eligibility. As of September 15th only one individual has gone on the waiver which is managed by the office of HIV/AIDS Programs. The waiver's purpose is to provide additional services at home in lieu of hospitalization during the last three months of life. The Medicaid waiver program is referred to as the Coordinated Community AIDS Service Alternatives, CCASA. CCASA services are provided in addition to state plan services. The services that can be provided under the waiver include:

- Hourly Skilled Nursing
- Respite Care
- Therapeutic Home Meals
- Attendant Care
- Nutrition Consultation
- Psychosocial Services

Eligibility for the waiver requires that the individual is Medicaid eligible and has a Title XIX case manager. In addition, the individual needs an AIDS Class IV diagnosis and needs to be considered in danger of hospitalization. Once a client is determined eligible for services a certificate from the client's physician or nurse practitioner stating that the patient has a prognosis of three months or less and stating that the client is in danger of hospitalization should enhanced home care services not be available (please see table). In addition a detailed assessment of how many hours of the above listed services are required, at what cost, and by what provider must be submitted by a discharge planner, home care agency, or case manager. The individual can go on and off the waiver if their condition improves. The average time on the waiver is expected to be 3 months, but if the client lives longer they will not be cancelled from waivered services.

The CCASA Medicaid waiver does have a CAP for services, essentially the total

dollar value of waivered services can not exceed \$1,530 per month of service with additional state plan services totalling approximately \$1,655 for a monthly total of \$3,185. It is the role of the state CCASA nurse and the case manager to evaluate the total cost of services. If a client is on extensive state plan services, i.e. home IV's, multiple medications, etc. they would not be eligible because their state plan services would be over the CAP.

The ideal candidate for the waiver would most likely be an individual with neurological impairment needing attendant care who is not receiving aggressive treatment. Other candidates might have care givers who would benefit from using

attendant care as respite services or to provide meals. Individuals can not be on multiple services at the same time so a person could not be on COPES and the CCASA waiver at the same time. It is hoped that since the process for the CCASA waiver is similar to COPES that an individual who is receiving COPES services could easily switch to CCASA services when it is appropriate. An individual can only be on one waivered service at a time, thus can't be on Medicaid hospice waiver and CCASA waiver at the same time. Additional information as well as applications for clients can be obtained by contacting the State Program on HIV/AIDS, Mail Stop LJ-17 B, Olympia, WA 98504.

## *Findings Considered to Put the End-Stage HIV/AIDS Patient at Risk for Hospitalization*

### Diagnoses

- Neurologic Disease (CNS AIDS, Dementia)
- Atypical Mycobacteria (Disseminated)
- Lymphoma
- Advanced KS (Visceral Involvement)
- Toxoplasmosis
- Progressive Multifocal Leukoencephalopathy
- Cryptococcal Meningitis
- CMV Retinitis

### Signs and Symptoms

- Nutritional
  - Spiraling weight loss beyond 10% of body weight
  - Chronic/intractable diarrhea > 2 weeks
  - Persistent dehydration
  - Albumin < 2.0 g/dl
- Respiratory
  - Hypoxemia: PO<sub>2</sub> < 86 mm Hg. on room air
  - Respiratory impairment (dyspnea, tachypnea)
- Hematologic
  - Lymphocytes < 150
  - Platelets < 140,000
- Other
  - Persistent debilitating pain required skilled pain management
  - Debilitating fatigue

# Clinical Practice Review

**Anna R. Williams, RN, MN, OCN**  
Pain Consultation Service  
Swedish Hospital Medical Center

Home care is my first love. I learned a lot about nursing, about oncology, and about people as a home care nurse, and I had a lot of fun. During the five years of my home care experience I developed an acute appreciation for the significance of pain management in the care of advanced cancer patients. The home care nurse is frequently the one who identifies that a patient has a pain problem or has *increasing* pain. Home care nurses communicate with the doc to discuss utilization of "around the clock" meds, or makes a case for switching to a long acting morphine product. Pain assessment - so important in developing the care plan - incorporates etiology, location, character, duration, and any particulars

such as nighttime pain, movement pain, or pain associated with swallowing. Unlike the hospital environment, we don't control the patient's activity when he/she is "on the outside." The plan of care may need to incorporate pain problems associated with working in the garden, traveling long distances by car, or having "active" grandchildren for the weekend. Patient and family education with respect to drug schedules, side effects, and evaluation of efficacy is crucial to reaching the goal of pain relief. With regular visits or phone follow-up the home care nurse can establish if the pain management plan is working, and if not, make contingency plans. The use of sublingual morphine or concentrated oral solutions are frequently needed for breakthrough pain - and a good home care nurse knows just which pharmacies in town stock them.

High-tech pain management in home care requires intensive patient and family education and very close follow-up. Utilization of patient controlled analgesia (PCA), subcutaneous infusion, and the epidural route have become common in treatment of intractable cancer pain. The skills of the home care nurse in assessing the caregiver's knowledge of technical equipment is of paramount importance in maintaining a safe home environment. With proficient caregiver support in the home, the nurse makes routine visits anywhere from weekly to daily, to evaluate pain control, monitor equipment, and titrate pain medicine within a prescribed range.

I have been privileged to be a part of the home care experience with many patients / families who touched my life in very personal ways. Thank you. I will remember.

# Business Beat

**Judy Kornell, RN, MN, OCN**  
Pain and Toxicity Research  
Fred Hutchinson Cancer Research Center  
Symposium: Patricia Buchsel

The theme of the 1991 symposium will be Change, Challenge, and Coping. Save the dates now, February 22nd and 23rd, at the Bellevue Concourse. Instructional sessions will include immunology, a review of current oncology therapy, pain, and an "intellectually stimulating innovative session" (stay tuned for more).

**Education: Betty Gallucci**

"Supportive care of the Chemotherapy Patient" will be held on November 28th at 7 PM at Tacoma General Hospital. This interactive/reactive teleconference gives us the opportunity to discuss practice issues with some California chapters of ONS and should provide for a very stimulating meeting. This effort will be hosted jointly by PSONS and Tacoma General.

**Government Relations: Margot Hill**

Margot Hill has agreed to chair this group as Ingrid Nielsen is moving to Texas. The next meeting coming up very quickly is November 8th from 7:30 to 8:30 AM at the Elliott Bay Book Store—come get involved!! Pam Ketzner attended a recent T.A.C.C. (Tobacco Addiction Coordinating Council) meeting and reports that this is a really diverse and active group! Individuals representing many major organizations such as the American Lung Association, the American Cancer Society, and the Wash-

ington State Medical Association, to name a few, come together to discuss legislative efforts to reduce morbidity and mortality associated with tobacco in our state. At PSONS's September meeting we voted to donate \$150.00 to T.A.C.C. for its work in this effort. Focus areas for the coming year are restriction of tobacco sales to minors, second hand smoke, and tobacco education. A big thank you to Pam Ketzner for representing us so well at T.A.C.C.

**Membership: Susan Ford**

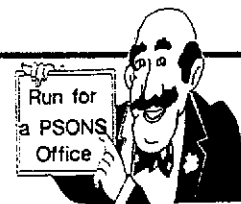
Dues renewals will be sent out in December so put aside \$20 to remain an active PSONS member. Sue is heading up the effort to recognize our members in the PSONS Profile featuring Barb Fristoe in this issue. Keep up the good work!

**Research: Patra Grevstad**

The Research Committee is resuming activities after finishing up their project exploring oncology nurses opinions and attitudes about ONS—we'll have a newsletter featuring the outcome of this work coming up in January. Patra invites any interested folks to call her at the Tumor Institute, 386-2442.

**Historian: Ann Reiner**

We need information on members who have been active locally in a variety of professional endeavors. Ann welcomes photographs and bits of information on our shy colleagues who we know are out there making a difference.



**"The Test" Barbara Fristoe**

Sixty nurses took the Oncology Nursing Society Exam for certification/recertification on September 22nd in Kane Hall on the UW Campus. Test-takers will be notified within 6 weeks of their test scores.

**Nominating: Brenda Nevidjon**

The 1991 PSONS elections are approaching, but the Nominating Committee says it is not too late to submit your name to run for President-Elect or Treasurer. PSONS is one of largest chapters in ONS and is known for its creativity and leadership. As ONS continues to grow, the chapter structure increases in importance for meeting the local and regional needs of the members. Being an officer brings with it responsibility, but also a great amount of pride and satisfaction.

Pat Jordan, current President-Elect, has found that PSONS is a good group to give her energy to and encourage others to do so as well. Said Jordan, "By being more actively involved with PSONS, I am impressed by the caliber of the people who are providing cancer care and give time to PSONS. It wasn't an easy decisions to commit my time and energy to the chapter but I'm glad I did. If you haven't sent in an application yet or would like more information, please contact Brenda Nevidjon (583-6541 or Teresa Coluccio (326-5946).

# The Last Word

**Renee Yanke, RN, MN, OCN  
Oncology Clinical Nurse Specialist  
Whidbey General Hospital**

Summer is over, kids are back in school and the rerun season on T.V. is over. As we get back into the swing of work—here's the latest scoop from around the PSONS region!

First - the interest in the Pain Curriculum Development has been great, and I'll be in touch soon to set up a meeting time.

Debi Coombs (Group Health-Spokane) called a couple of weeks ago with a question. Remember the rule about avoiding venipunctures and BP's in the arm on the side of the mastectomy? That standard originated when radical mastectomies were the norm. Does anyone have any information about current practice? Is that precaution necessary with today's modified radical mastectomy? What parameters are there for using the affected arm? What about women who have bilateral mastectomies? Contact Debi Coombs at 1-509-838-7992 or write to her at Group Health Cooperative, South 501 Bernard, Spokane, WA 99204. Let's hear what you have to say!

Here on Whidbey Island, I'm pleased to report that our outpatient clinic had over 1000 visits in the first year. We provided chemotherapy for a medical oncologist one day a week and provide support services for people with cancer, AIDS, and a variety of other problems throughout the week. It's great being able to talk to some of you about patients seen up here!

Pat Jordan (Group Health Hospice-Seattle) has started a new project and is looking for people interested in working on it. She is developing a directory for PSONS members including member specialties and community resource listings that we can use in our practice. Contact Pat if you're interested in helping out!

**Now for the "Welcome to Seattle" and "Good-bye, Good luck" messages!**

The welcome wagon goes out to Diana Wilkie, RN, Ph.D., newly arrived from UCSF. She is joining the UW faculty as an Assistant Professor in the Department of Physiological Nursing. Diana recently received her Ph.D. from the University of California at San Francisco and has a special interest in pain. Her accomplishments are many with her most recent work in the field of pain assessment in adults and children reflected in *Nursing Research* (39:36-41) and

*Pain* (41:151-159). Welcome Diana—it's great to have another resource in Pain Control!

Wedding bells rang October 7th for Ingrid Nielsen (DSHS, Cancer Control Division-Olympia). She married Bob Rakita, an Infectious Disease doc at the UW. To make things interesting they are moving to

Houston, Texas, in November, where Bob has a position with the University of Texas in the Division of Infectious Disease. We'll still hear from Ingrid though, as she finishes her term as core member of the Legislative Committee of ONS in May (she also has family in the northwest). Congratulations and Best Wishes Ingrid. We'll miss you.

## Good Bye Party! for Ingrid Nielsen

Come by and say thanks and *Bon Voyage!*

November 18

2-4 p.m.

at Patty Jordan & Gloria Felde's place

RSVP for more info & directions • 525-3727 or 326-4221 (Patty at work)

Continued on Page 9

## PSONS Profile

### BARBARA FRISTOE

**Susan Ford, RN, MN, CS, OCN**

When you become a nurse, especially an oncology nurse, you rarely envision yourself being a nurse at home as well as at work. That's what Barbara Fristoe, our PSONS Profile, thought when Gus (one of her two feline companions) was diagnosed with lymphoma. At this writing, Gus is rehabilitating without problem at home. "You can sure appreciate what families go through when you are on the receiving end. Gus used to howl all the way up I-5 from Tacoma to Seattle when we would go to see the "Kitty Oncologist" says Barb after her experience.

Barb's usual role is that of Oncology Clinical Nurse specialist at Tacoma General Hospital. She works with families to help them understand their disease and to prepare them for what lies ahead after discharge from the hospital. Barb also carried a leadership role on the hospital's oncology unit by educating and providing a role model for the nursing staff.

Barb sees the CNS role as a crucial element in the ever changing health care system. "Patients are sicker, their care is more technical and complex. The staff nurse is going to be much more accountable for nursing care in the future. Hopefully, as a CNS I can help nurses meet the expectations the system will impose upon us all," Barb says.

Fifteen years as a nurse should help Barb meet those demands. After receiving a degree in Poli Sci, Barb decided to turn to



Nursing for a career that was "income producible"! After completing her BSN she decided to continue her nursing education and was accepted at the UW and graduated with her MN from the oncology pathway of the nursing school's physiological department. Barb's expertise and empathy lead her colleagues to agree that nursing has benefitted from the political world's loss.

As for a home life, Barb says that all she's got since she bought one. "Now that I'm a home owner, I can't afford to do anything else!"



## Puget Sound Chapter of the Oncology Nursing Society

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ONS Newsletter: Brenda Nevidjon, Editor

### PSONS NEWSLETTER

Published quarterly by the Puget Sound Chapter of the Oncology Nursing Society with the support of the American Cancer Society.  
Editor: Anna Williams

Letters, articles and announcements are requested from all PSONS members and other readers on topics of interest. Neither Puget Sound Chapter of the Oncology Nursing Society, the Oncology Nursing Society, the editorial board of the Quarterly, nor the American Cancer Society assume responsibility for the opinions expressed by authors. Acceptance of advertising does not indicate or imply endorsement by either of the above-stated parties.

Submit materials for publication to Anna Williams, PSONS Editor, Lake City Professional Center, 2611 N.E. 125th St., Suite 305, Seattle, Washington, 98125-4357. (206) 386-2013

### PUGET SOUND CHAPTER HOTLINE!

PSONS has a telephone answering machine. For questions, concerns and comments regarding Chapter activities, please call:  
(206) 462-5385  
24 Hours

Leave your message, name, telephone number and best times to reach you, on the tape recording.

## Good Bye! and Best Wishes!

By Brenda Nevidjon, RN, MSN  
Virginia Mason Medical Center

In the early days of PSONS, when it was called RONS, the phone lines and I-5 were important connections for the oncology nurses in Seattle and Vancouver, BC. In those early days, some of the Canadian nurses were an integral part of the developing interest group and served in many capacities.

Barbara Warren was one of the Canadian nurses who has long been a part of PSONS. She has recently left Vancouver for the Director of Nursing position at the Manitoba Cancer Treatment and Research Foundation. That may surprise some PSONS "old timers," because Barb symbolized the oncology clinical nurse specialist, having

been one at the Cancer Control Agency of BC for over 12 years. But, in recent years, she's been heading in an administrative direction.

One of the early officers of RONS (PSONS), Barb (and the other Barb—McDermott) were faithful attendees at the annual symposium and at many ONS Congresses. In the mid-1980's, Barb was part of the group that founded the BC Oncology Nurses Interest Group and the Canadian Association of Nurses in Oncology (CANO). She is the current president of CANO. She maintained her membership in PSONS, however, because she felt a strong connection with the members.

PSONS wishes you well, Barb. We'll think of you in February and are happy you've been a part of our history.

### 1990-1991 BUDGET

#### Projected Revenue

Dues	\$ 8,000.00
Educational Programs	800.00
Symposium	27,000.00
Newsletter Ads	1,250.00
Mailing List	300.00

**TOTAL** \$ 37,350.00

#### Expenses by Committee

(Approved Committee Budgets)

Symposium	\$22,000.00
Newsletter	4,140.00
Education	1,670.00
Clinical Practice	1,500.00
Government Relations	300.00
Board	1,500.00
Research	300.00
Membership	1,000.00
Nominating	50.00
Historian	50.00

**TOTAL** \$32,510.00  
+ 3,650.00

**TOTAL EXPENSES** \$36,160.00

Questions? Comments? Drop a letter to the Editor:

Anna Williams, PSONS Editor  
Lake City Professional Center, 2611 N.E. 125th St., Suite 305, Seattle, WA 98125-4357



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Membership Application - 1990

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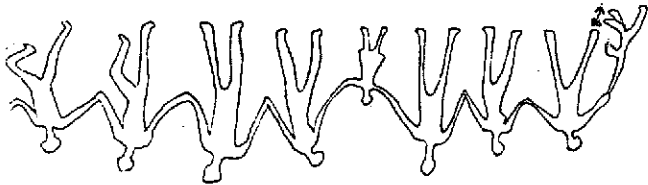
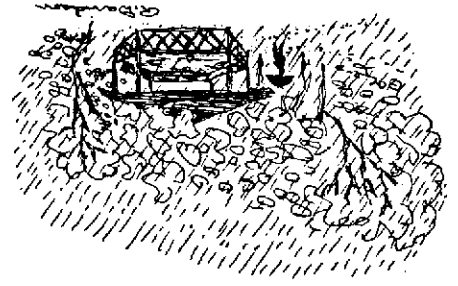
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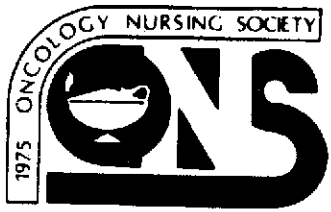
\_\_\_\_ Dues \$20.00 \_\_\_\_ Donation PSONS \_\_\_\_ Donation ONF \_\_\_\_ Late Fee \$5.00 \$ \_\_\_\_\_ TOTAL



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