

The Rehab Team: Rebuilding a person's strength

Physiatrist



Physical Therapist



Occupational Therapist



Rehabilitation



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President's Message

Becoming Customer-Focused: Analogies for the Chapter

Bev Vincent Davis

We're on the verge of fundamental changes in health care, few deny it, and most of us cheer for it. However well intentioned, we've gotten into a system so filled with bureaucracy, forms,



and overspecialization of staff at every salary level, that we've created the proverbial monster. Why is it that we can scan the patient's body to locate that small metastasis hiding behind the left kidney, but we can't schedule the scan in fewer than 3 phone calls, or have the patient arrive with critical information about his care communicated to the right person?

We're out of touch with the "big picture" for the patient. And we're paying for it—literally. Data from a 3-year study by Booz-Allen & Hamilton indicate that for every dollar spent on health care wages, only 16 cents goes for providing care. That amount barely surpasses the 14 cents spent trying to schedule and coordinate the care. Twenty cents goes for structured idle time—a tech waiting for the next patient, recovery room personnel waiting for the first round of patients in the morning, etc.

What accounts for the biggest part of the dollar? You guessed it. Twenty-nine cents goes for documentation. The

balance includes 7 cents for management, 6 cents for transportation, and 8 cents for patient services.¹

And so it follows that some of today's innovative health-care restructuring efforts are **patient focused**. Organizations are recognizing the importance of being customer-oriented and supporting the people at the front lines of patient care. Thus, everyone's job is either to directly serve the patient or to serve someone who is. (How ironic that focusing on the patient has come to being regarded as innovative!)

How does this relate to PSONS? It occurs to me that customer-focus is an appropriate model for operating and evaluating our chapter. The customers are you—the members. As we think proactively about the health and wellbeing of our chapter, periodically reviewing to make sure that we're going in the right direction, I propose that "member-focus" help us to decide what "the right direction" is. Depending upon what members identify

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From the Guest Editor

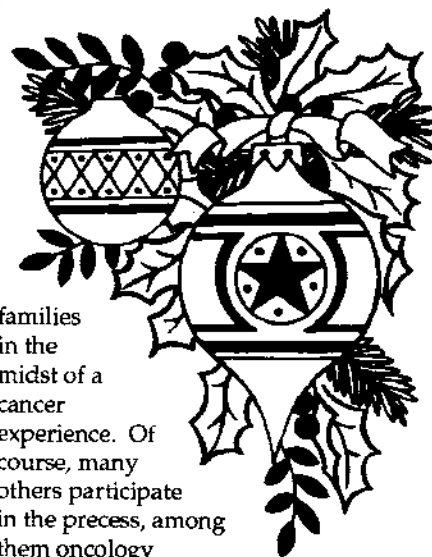
Laura Heard, RN, MS, CRRN
Virginia Mason Hospital

I suspect many of us develop our professional niches not only by design but by taking advantage of some happy unplanned events. For me, early in my stay at Virginia Mason as a rehabilitation clinical nurse specialist, an oncology staff nurse's request for assistance with a patient was pivotal in my developing a special interest in cancer rehabilitation (thanks Marion!). My involvement in the cancer scene so far had been in the care of women who were having mastectomies. But one afternoon, I was asked to see a patient with an aggressive lymphoma who was confused and agitated. "You're a rehab nurse. You must have something for her to do with her hands to keep her occupied and not picking at her lines." Well diversion therapy wasn't part of my repertoire, but I agreed to see what I could do. As it turns out, we figured out some simple activity with yarn to keep her hands

busy. I also learned that this woman was paraplegic from her lymphoma. Now here was something for a rehabilitation nurse to sink her teeth into! I had something to offer, but I also had a great deal to learn.

One thing led to another and soon I was involved with my good friend and colleague, Ann Reiner, developing a cancer rehabilitation team for the oncology unit patients. Our hope was that the interdisciplinary team function, that is basic to the fabric of the rehabilitation unit, might be adapted for the oncology unit. Each week as we meet, the value of that team work is reinforced by the way combined expertise is brought to bear on some very challenging patient situations and by the support given to, and received from, those providing this special care.

In this issue of the PSONS Quarterly, I've asked Sue Hymark to address cancer rehabilitation team/program development and, several representatives of rehabilitation disciplines to speak to their potential contributions to the care of patients and



families in the midst of a cancer experience. Of course, many others participate in the process, among them oncology physicians, oncology nurses, social workers, dietitians, pharmacists, prosthetists, psychologists, counselors, speech pathologists and vocational counselors.

I hope you are inspired to integrate their expertise early and often in the care of your patients.

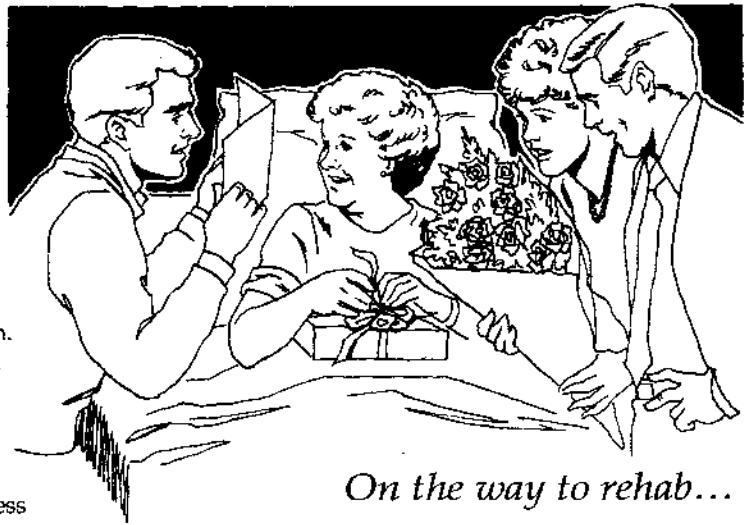
Cancer Rehabilitation Basics

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We describe cancer not only as a group of disease processes, but as a spectrum of concurrent disabilities in personal, physiologic, vocational, and psychosocial function. We consider cancer a chronic illness in many cases with impact over a long period of time. We have become much less willing to accept biologic survival as the primary and/or only goal. Many aspects of the cancer patient's milieu may be affected by disability from the disease process or treatment modality, that is, they produce change in the ability to function. Strategies to ameliorate those kinds of changes and losses in function seem very worthy of pursuit.

Rehabilitation is not an event, something that happens once, like a surgery, a course of medication, a series of radiation treatments. Rehabilitation is not a clean up or reconstruction of a process that has already taken place. Rather, it implies integration of its philosophy all along a continuum of care. Priorities are based on needs at a particular point in time, but activities may change depending on patient/family goals, the disease process, and treatment regimen. Because care issues cover a broad spectrum of possibilities, many different health professionals, with some unique and with some shared skills, coordinate the work effort. Though the field of rehabilitation encompasses a specific body of knowledge and skill, it perhaps more importantly implies a *way of thinking* about patient care. Its principles are likely to be operating when any group of health care workers share in the successful management of patients with chronic disease and disability.

Ideally, rehabilitation should be a part of all chronic illness management, including cancer care. It should begin as part of diagnostic and staging processes of management, because people first feel the impact of their disease then. Potential rehabilitation needs are identified, judgements are made about the probability of their occurring, and plans are made to deal with them. Rehabilitation implies an active partnership with the patient and family and other health professionals. It decreases the emphasis on "doing for" and increases the emphasis on "how to" and "why".



On the way to rehab...

An activity terrifically important in the development of productive relationships with patients and families is goal setting, including goal setting apart from the hoped for results of treatment. Of course, we must be prepared for goals chosen not always in synch with ours. As important as long range goal setting, the "now" is what one has influence over. So short term goals become the stepping stones through the cancer experience.

Concrete thinking is required for short term goal setting, both in the psychomotor and social/emotional realms. Some examples might include: "look and touch my chest (after mastectomy) before I leave the hospital;" "walk 2 laps of the hall without loss of balance;" "spend two hours out of bed each day." Changes in goals, both as patients getting better and worse, are given. Some examples might include: "save energy for talking with grandchildren by accepting assistance with bathing and dressing;" and "recapture child care responsibilities by the end of the month."

Since cancer and its treatment have tendency to foster considerable dependency, needs assessments and planning interventions are based on the persistent advocacy for self care. Our sights need focusing on community re-entry; not only does the receiving environment need to be made ready, but the patient and family must be provided with opportunities for rehearsal of new skills with the gradual transition of responsibility for those skills. We are speaking not only of the obvious transitions from hospital to home, and the like, but in the re-entry after treatment as roles and relationships are re-sorted out and the person rejoins the work setting.

The prevalence of cancer far outstrips the incidence. People are living longer with cancer. They are fearful, and often realistically so, of physical, psychologic,

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Developing a Team Approach in Cancer Care

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With increasing numbers of individuals surviving cancer and with the growing demand that quality of life issues be addressed, the role of a cancer rehabilitation service becomes increasingly important. It is the resources of a cancer rehabilitation team that can facilitate individuals through the process from "victim" to "survivor." Such services compliment the acute care of those with cancer in either the hospital, clinic, home or office setting.

The impact of cancer can lead to long term issues such as:

- *Reduced strength and endurance*
- *Limited mobility, self-care and activity*
- *Bowel/bladder/skin care issues*
- *Swallowing and communication problems*
- *Coping issues and communication problems*
- *Body images, self-esteem, sexuality*
- *Family concerns*
- *Legal/Financial and workplace concerns*
- *Leisure and lifestyle changes*
- *Spiritual quest*

These are only a few broad areas of need that a rehabilitation service can address. The goal of such a service is to maximize the individual's level of independence in these areas within the medical limitations imposed by the disease and treatment.

The team composition of specific disciplines are dependent on their availability and interest in cancer. The team may include:

- *nurse, clinical nurse specialist*
- *social worker*
- *physical therapist*
- *occupational therapist*
- *dietician*
- *recreational therapist*
- *rehabilitation counselor*
- *physiatrist*



- *vocational counselor*
- *psychologist/psychiatrist*
- *speech-language pathologist*
- *chaplain*
- *enterostomal therapist*

Teamwork does not happen automatically. Teamwork is more than various team members sharing the same patient. Teamwork requires leadership, communication, a common knowledge base, trust, and flexibility. In developing a team someone must take a leadership role as a facilitator or as a manager. As the interdisciplinary resources are identified and assessed for their level of interest and/or willingness to collaborate, the leader can bring the team together for education. The team needs a common knowledge base about cancer, treatment and side effects, rehabilitation principles and resources, family dynamics and psychosocial impact.

It is an evolution that occurs as disciplines learn about the cancer patient and how to adapt and utilize their skills and knowledge in helping the individual maximize their independence. Clinical goals must correlate with the patient's goals so interventions are relevant both medically and psychosocially.

In developing teamwork or collaborative practice, attention must be given to communication. Team members involved must be current about medical, emotional, family and social issues. Since there may be new information arising frequently, team members must be reasonably accessible to one another whether by phone, location, or pager systems. This collaboration is necessary across treatment settings as well. Many teams use the patient's medical record, log books and interdisciplinary conferences as ongoing mechanisms to facilitate this process.

It is critical in view of the complexity

and numerous changing factors, that someone be in a coordinating role whether it's the team leader or the acute care or office nurse. This person communicates and coordinates the care of other professionals. The role can involve advocacy, patient support and guidance.

There are various ways in which a Cancer Rehabilitation Service can be organized, ranging from informal to formal models.

Coordinated Model: Involves a coordinator, either a separate role or incorporated into the acute care nurse's role.

Mobile Team: With a designated coordinator; the team sees patients in any unit or setting.

Multidisciplinary Oncology Unit: The team's patient population is centralized in this area.

Rehabilitation Unit: Within an existing rehabilitation unit; beds are designated for those with cancer who fit the unit's admission criteria.

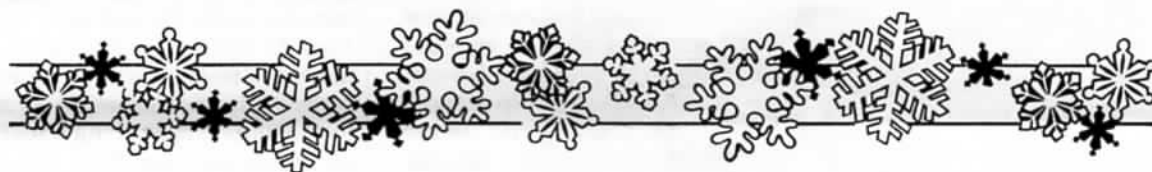
No matter which organizational model is used, the relationships between team members may vary in formality. The least informal being the general use of other disciplines to the most formal involving the designated staff of various disciplines working out of one department.

Once resources and team members are identified as well as their organizational resources, the program itself must be further defined. Depending on the formality of the service, the following areas needed to be decided in developing the program.

- *Develop Mission Statement*
- *Define Population*
- *Identify Resources*
- *Define Scope of Services*
- *Identify Organizational Model*
- *Develop Organizational Chart*
- *Identify Referral Base*
- *Develop Procedures*
- *Develop Communication Methods*
- *Evaluation*

However broad the above areas are defined, it is wise to start a new service as a pilot. Starting with a limited population or scope of service allows the team to develop its working procedures and communication methods. The program can then be expanded as the team is capable of delivering the care needed.

Providing a team approach to cancer care is a very rewarding and satisfying experience. It allows truly comprehensive care to be provided. It compliments the acute medical care in a manner that maximizes the quality of life. It can be an efficient way to maintain continuity of care and accessibility to services for individuals and their families. As caregivers, it allows staff to transfer their sense of responsibility for care to the individual and their family, knowing they have made a difference while fostering the transition of control. And in the process, it provides hope for the individual and their family. A woman with cancer having received the assistance of a cancer rehab team said, "I knew I could die with cancer; what I needed to learn was that I could live with it."



Do you ask yourself, "How can I . . ."

- **EMPOWER PATIENTS** to use their minds in healing?"
- **Give HOPE?**
- **Elicit the WILL TO LIVE?**
- **Enhance the HEALING PARTNERSHIP?**

Geraldine Helwing Robinson, M.S.

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President's Message

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as their major requests from the chapter, this might mean that our primary activities related to information, networking, and education. Not an earth-shattering revelation, perhaps, but in this fast-paced climate, it's easy to lose sight of our focus. Think how many years it took hospitals to decide that they should start focusing on patients again!

I'm interested in any thought you have about how to evaluate the "health" of the chapter, or what makes the chapter "user friendly." And Happy Holidays to you all!

¹ Lathrop, J. Phillip. *Healthcare Forum Journal*, July-August, 1991, pp. 17-20.

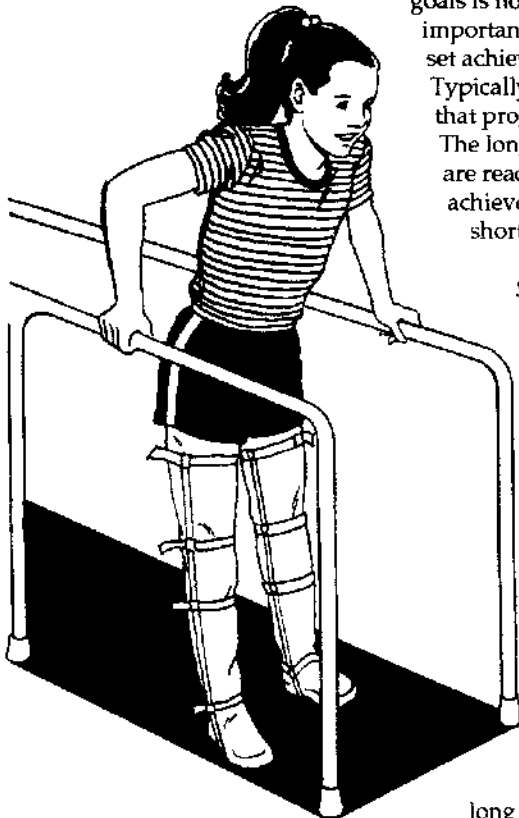
Physical Therapy Contributions to Cancer Care

Sarah Jackins R.P.T.
Chief Physical Therapist
University of Washington Medical Center

Physical therapists enjoy participating as team members in the treatment of patients. This is particularly true for patients who carry a diagnosis of cancer. Along with the rest of the team, including the patient, nurses, physicians, surgeons, social workers, occupational therapists, vocational counselors, radiation technicians, etc., the physical therapist is interested in making things as good as possible for each person. The advantage in working as such a team member is that while each has a particular area of experience and expertise to contribute, each is also interested in the big picture and has an awareness of the other members' contributions. Also, there is some overlap in the areas of each member, allowing each to assist with more than one area and to be aware of a broader area of need. The patient gains tremendously in being a member of such a team.

Within the team's framework, the physical therapist has the opportunity to contribute in the areas of function and comfort. Many, many of our efforts are aimed at maximizing each patient's function. Depending on the condition of the person with cancer at a particular time, the type of therapy and the goals for that therapy will vary. The therapist must always set the goals with the help of the patient and the patient's family or significant others. Actually, once the goals have been set, it is relatively easy to figure

out the treatment. But setting goals is not always easy. It is important to be realistic and set achievable goals. Typically, it is easier to see that progress is being made. The long term ones usually are reached through achievement of a series of short term goals.



Some examples should demonstrate this:

For a person who has had an amputation of her leg above the knee because of an osteogenic sarcoma, her short term goal may be to learn to walk with crutches on the cast that is applied immediately after the amputation. The long term goals may include walking with a walker,

walking with a cane, walking with no assistive devices, running or playing sports, depending on the age, general health, and daily needs of the individual. Along with these functional goals, the therapist will also take into account the importance of skin care, so that when the patient obtains her prosthesis, she understands how to avoid skin problems, and if they do occur, how to minimize them.

Many patients become just generally deconditioned from the cancer and the treatments that go along with it. Therapists are interested in putting people on exercise programs that assist them in maintaining strength and flexibility. Without these being reasonably good, functional activities are just that much harder to maintain. For persons who have had prolonged significant bouts with the debilitating times of their illness, it may be necessary to put considerable effort into the strengthening process, just to get to a level where certain functional activities can be considered.

If a person is an inpatient in the hospital, the goal may be to regain enough strength to allow either independent transfers from wheelchair to bed, or minimal assistance with those transfers. Then the ball is passed to the home agency nurse and therapist who work with the patient in his own home. Being able to do the transfers may be enough to allow him to be discharged home. Then, continued therapy at home may assist the patient in regaining the strength, endurance, and ability to walk around home without any or with just minimal assistance. Or, continued therapy may just be necessary to assist in the transition home. It may involve teaching caregivers how to maintain range of motion to prevent contractures, thereby making mobility and hygiene easier.

For patients with neurological involvement, training in compensatory functions may be needed in order to remain as independent as possible. The person with a spinal cord tumor who becomes paraplegic will need to learn transfers, how to compensate for loss of balance and protective sensation, all the while, perhaps, feeling ill from effects of chemotherapy and other treatments. The therapist with expertise in the management of patients with cancer can assist such a patient in guiding them toward realistic expectations for themselves and energy-saving techniques. It may be very important for a patient to feel that it is OK to not do absolutely everything for himself, and to save his energy for the things that are most important to him.

As we all know, caregivers of patients with cognitive deficits need the guidance and support of all the team, including the physical therapist, to understand and

manage this change in status that can be so upsetting, as well as devastating to independence. This patient may or may not have significant physical changes. The goals particularly important will be those involving safety, while still trying to allow the person as much independence as possible. Families may need support in how to ask for and get assistance. Anyone on the team can recognize these needs and should always be aware of them and assist in getting needed help.

In addition to functional goals, everyone wants the patient to be as comfortable as possible. Range of motion exercises are often comforting to the person

who has to spend most of the time in bed, in addition to the effect of preventing contractures. There are some modalities, like superficial heat and cold, transcutaneous electrical nerve stimulation (TENS), and massage that provide temporary relief of discomfort. While these can be used in the physical therapy setting, it is frequently more practical for the patient and caregivers to know how to use these safely and effectively at home.

In the acute care, rehabilitation, hospice, nursing home, or home settings, the therapist acts as a resource person and a coach, helping in the patient's efforts to maximize their independence. Physical

therapists spend considerable one-on-one time with patients. During these times, there are opportunities to observe and listen to the patient about aspects other than those involved in P.T. It is important for the therapist as well as all the other members of the team to be aware of areas beyond their field needing attention and to make other team members aware of these. Therapists also get support from the rest of the team, as these patients go through very difficult or discouraging times. The therapist can get discouraged as well, and should be aware of the need for themselves to have support. The team approach has many strengths for all involved.

Highlights of Occupational Therapy in Oncology

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Puget Sound Therapy Services
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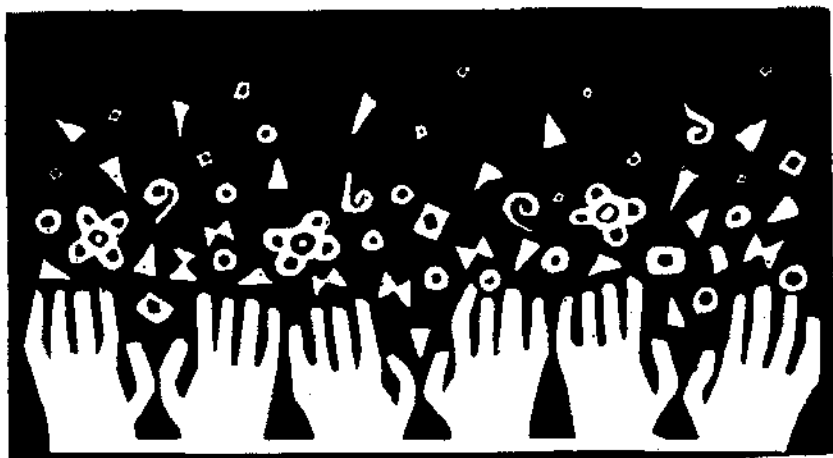
Occupational Therapists have a variety of skills that would benefit a significant number of persons having an experience with cancer. These services could be provided in a variety of settings including hospitals, schools, outpatient clinics, skilled nursing facilities, and/or home. A person with cancer is up against many challenges, some of them because of the disease and others related to the treatment. There are many symptoms that may prevent a person with cancer from living an independent lifestyle. These symptoms may include pain, nausea, vomiting, fatigue, weakness, and other areas creating challenges. Persons with cancer may have a sudden or an insidious decline in their activities of daily living (ADL). ADLs vary from person to person, depending on age, gender, lifestyle, and social roles. People who have undergone surgery, chemo, radiation therapy or any combination of these are often deconditioned and may find even simple ADL's overwhelming. The Occupational Therapist (OT) may assist with environmental modifications to reduce energy expenditure in the home, work place, or with leisure activities that would allow a person to participate as completely as possible. The OT may also provide evaluation of a person's home or work environment and assist in making modifications to make these environments safe and functional. Frequently, by problem solving with the therapist, family

members and the person being assisted, solutions can be found and initiated that will provide a safe environment with minimal restrictions.

When indicated, personalized conditioning programs to improve functional strength and endurance can be designed and directed by the OT.

Mental status can be significantly impacted by people's physical health and the way in which they are able to interact with their environments, family members, and society at large. The way we perceive ourselves is often related to our level of independence and productivity, which can have a major impact on self esteem.

Activities of daily living include such things as personal hygiene, dressing, eating, household tasks, and any activity basic to an individual's independence. The loss of independence in any one, or a combination of daily living activities, can be devastating to that person or others associated with him or her. Early recognition of those experiencing either a temporary or permanent disability affecting their self-care independence is essential. Occupational



Therapists can provide ADL training to persons with cancer to allow them to maximize their level of independence. This training may be to teach work simplification and pacing techniques that eliminate or modify tasks in a way so that energy is conserved and success is certain. Occupational Therapists have been educated to look at the whole person and assist with transitions that may occur during experiences related to cancer. By being aware of the services Occupational Therapists can provide for their patients, health care professionals can make the necessary referrals to connect patients early in their care. Occupational Therapy could be the missing piece of the much larger medical puzzle that makes the difference for those persons experiencing a loss or decline in functioning.

The Role of Physiatrists in the Management of Cancer Patients

Dr. Ty Hongladarom
Physiatrist
Virginia Mason Medical Center

A physiatrist is a medical specialist who is board certified by the American Board of Physical Medicine and Rehabilitation, after having completed a postgraduate residency training program and passing the examinations. A physiatrist utilizes physical modalities such as thermal, light, water, electricity, mechanical agents, and therapeutic exercises in addition to pharmacologic agents in the treatment of diseases. Rehabilitation involves specialized care and training of a patient with long-term and significant loss of function so he/she may attain the maximum potential for normal living physically, psychologically, socially, and vocationally. The first objective of rehabilitation is to eliminate the disability if possible. The second objective is to reduce the disability. The third objective is to maximize the patient's performance and to create the most optimal environment for the patient to live in with what he/she has left.

I see physiatrists as functional enhancers or removers of disability. When I see a patient with cancer, I am most interested in how the patient is functioning. What does the patient want to accomplish in terms of function? As a physician, I know the physiological effects of cancer and its treatment on the patient as well as the psychological, sociological, and financial impact on the patient and the family. The first thing I would ask, is there anything I can do to prevent additional disability brought on by the patient's inability to maintain activities? A large percentage of rehabilitation goes to the correction of secondary complications such as joint contractures, muscle weakness, and deconditioning from inactivity. These complications can be prevented by simple preventive measures if early rehabilitative care is initiated. Proper positioning is also

very important when the patient must have bedrest to, again, prevent contractures or pressure neuropathy.

As a physiatrist, how do I mobilize the residual strengths of the patient, the support of

the family, and the expertise of other rehabilitation team members to overcome disability? Using the knowledge that physiatrists have about the abilities of physical therapists, occupational therapists, prosthetists, orthotists, speech pathologists, psychologists, enterostomal therapists,

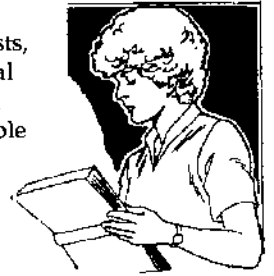
nutritionists, respiratory therapists, pharmacists, medical social workers, and nurses, my major role is to draw on their strengths, maximize their expertise, and coordinate their contributions and efforts to help patients achieve their goals. This ability to work with a team is critical in rehabilitation.

Another important aspect of my evaluation is to look at pre-existing conditions that by themselves may not cause disability but, together with the current impairments resulting from cancer or its treatment, create disabilities. For example, a patient with a pre-existing amputation of the leg may be able to get around well using his prosthesis until he develops secondary neuropathy from chemotherapy, which impairs his ability to ambulate.

Physiatrists are also trained in using adaptive devices to maximize the patient's function. An elevated toilet seat may make the difference in the patient's ability to get on and off a toilet independently. An adaptive device may also allow the patient to maintain independence in dressing or feeding. Physiatrists are knowledgeable in prescriptions and training in the use of prosthetic and orthotic devices. The appropriate prescription for a prosthesis will allow the patient with an amputation to walk or the appropriate prescription of an ankle-foot orthosis can help to stabilize the ankle and knee and make it possible for the patient to ambulate more safely. A spinal orthosis may decrease pain from metastases to vertebral bodies.

We all know the psychological impact of cancer and its treatment on the patient and the family, and this needs to be emphasized. Family support and the environment to which the patient will return are of the utmost importance. We need to eliminate physical barriers and assure that adequate support is available before the patient is returned home. These psychosocial and emotional problems must be dealt with directly. It is also important to recognize that the despair, frustration, anger, depression, and other psychological impacts on the patient and the family can be remarkably decreased once the distressing physical problems are minimized, for example, after being able to achieve better pain control.

In conclusion, a physiatrist is most interested in helping the patient achieve goals in relation to his/her ability to function and to continue to live optimally in spite of the cancer.



PSONS Profile

Laura Heard

I've been doing these interviews of oncology nurses just long enough to begin to be quite fascinated by their accounts of how they arrive at their present positions. The routes are as interesting as the destinations. Take Laura C. Heard. Her route started at the University of Washington in 1970. She was working on the Rehabilitation Unit during the period when several famous women revealed that they were treated for breast cancer. There was an outpouring of concern by women in the Seattle area about screening for breast cancer. Laura joined with several other nurses to provide education for women about breast self exam in a clinic setting on a weekly to bi-monthly basis. The Army then stepped in and moved Laura and her husband to Texas where she continued to be involved in breast examination education through an American Cancer Society Outreach program.

At that time, there were few oncology or rehabilitation graduate nursing programs. Laura entered Texas Women's University (a.k.a. "TWU") and finished a Masters in Medical-Surgical Nursing in 1978. Her thesis was on women's compliance doing BSE. Drawing from a clinic population, she found that women were motivated to learn BSE not by their fear of breast cancer, but by their interest in positive health habits. Home again to Seattle, Laura went to work at Virginia Mason Medical Center, under Barbara Brown, who directed Laura to form a mastectomy program. She did, hoping to

bring a rehabilitative perspective to the care of these women. She and Ann Reiner also started the Cancer Rehabilitation Team.

Assisting women facing breast cancer continues to be one of the joys of her professional life. she may learn many things from colleagues, but the best teachers are the hundreds of patients who enrich her professional experience. She is able to see outpatients and inpatients as a staff member of Virginia Mason Medical Center. This also allows her to follow women over time, e.g. when they return for problem management.

One of Laura's professional interests is in the area of lymphedema. She's concerned with the lack of literature regarding,

"when one gets it and why." For instance, does early shoulder mobilization reduce future lymphedema incidence? Additionally, she feels we need to

collectively look at functional outcomes for people with cancer. It is not enough to fix the tumor. Part of quality of life is a person's functional ability. Integrating rehabilitation thinking and interventions along the way can help people get through the cancer experience.

What of other interests: She has a "neat family" and a busy and satisfying professional life. Outside of these, there is race walking, quilting, and making music (she is violist with the Cascade Symphony in Edmonds). When all of these are in place, she is a happy woman.



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PSONS NEWSLETTER

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Editor: Renee Yanke

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Business Beat

Judy Kornell

Research Committee:

(Diana Wilkie, Chair) Remember hearing about the Research Grants available for PSONS members? Do you have some intriguing clinical question you would like to answer? It's time to put those New Years' Resolutions to work and apply for a grant. The deadline is **April 1st, 1993** (every year). Call the PSONS office for an application for more information—you'll get the info. within days!!

Government Relations:

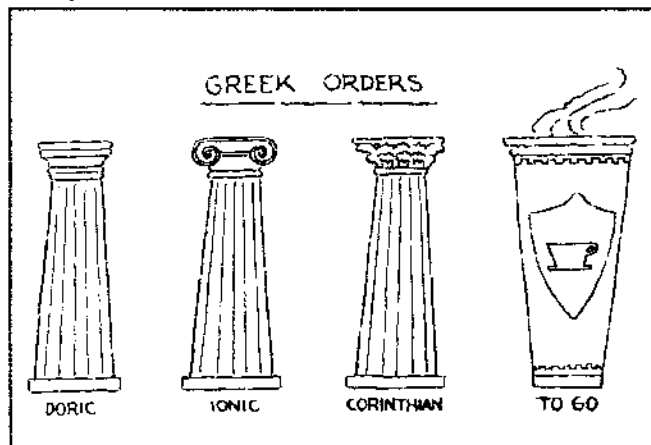
Pat Jordan is calling a meeting of the committee to order on Wednesday, January 20, 1993 at 6:30 p.m. to discuss directions and goals of the group. The meeting will be at her house at 8621 - 5th NE, Seattle - phone: (H) 525-3727 or (W) 654-4221.

Membership:

(Louise Granger, Chair) It is time to renew your 1993 membership to PSONS. Get in your renewal before January 20th and you will be eligible for a drawing to receive a great textbook or a \$50 gift certificate to Nordstrom's. The membership fee remains \$20 again this year.

PSONS membership provides excellent opportunities for support and exchange with area oncology nurses, notices of regular and special topic chapter meetings, reduced rates for the spring symposium, and opportunities for chapter committee involvement. Membership also includes a resources directory and the acclaimed PSONS *Quarterly* (now at five issues per year).

Use the membership form in this *Quarterly* to mail in your dues. A reminder will arrive in the mail early January. Go ahead and write comments on the form regarding what other membership benefit ideas you have.



Symposium:

(Ann Winkes-Breen, Chair) Plans for February 26 and 27 of 1993 are moving right along—you may see some of the flyers around your place of work, or may have received a brochure by this time. The topics are interesting with a theme of "Integration of Innovation...Building the Future." Topics range from the changing health care environment/reform to latest technologies in Cancer Care. Something new is the "Meet the Local Experts" session, where you will be able to learn things you never knew about some everyday technologies! The "Cerpig" process is commencing, and the program will be Cerpiped through ONS again. The Symposium is again being held at the Sea-Tac Marriott. *The reception after the first day's program will be held in the Atrium—Why leave right after the meeting and fight traffic? It will be much more fun to stay for awhile and enjoy the party. Once again, have your swimsuits with you to use the pool or hot tub!!*

Fall Institute:

(Yes, this is a new listing!) **Local Committee Members Needed for Fall Institute, October 1993.** The 4th Annual ONS Fall Institute will be held October 29-31, 1993 in Seattle at the Convention Center. I (Ann McElroy) am proud and excited to have been selected as the Chair of Local Arrangements for the program. I am writing the PSONS membership because I will need a dynamic, creative, and high energy group of approximately 6-7 PSONS members to organize the best Fall Institute yet!

No experience is needed, but organization, humor and commitment are required. The National Committee will have met in Seattle December 1992 so I will have much more information by the time you read this request. The work of the Local Committee will not start until after

our own Symposium in February. This work will include: local color, local tours, volunteer recruitment, information booth at Congress, entertainment for the Welcome Reception, and other fun stuff.

So, if you want to be part of a national ONS program, and help show off the Pacific Northwest to your ONS colleagues, call or write or FAX me before **January 30, 1993.** Ann

McElroy, 6521 Dibble Ave. N.W., Seattle, WA 98117. Phone: w: 583-6541 @ Virginia Mason or h: 781-8985. FAX: 223-7604, digital pager: 997-5101.

Education Committee:

(Carla Jolley, Chair) October's meeting featuring **Mary Erseck RN, PhD**, speaking on "Unrealistic Hoping" was well received and prompted interesting discussion and case examples from the group. James Congdon, MD, who focused on hypercalcemia at November's meeting was an excellent speaker and presented the latest information related to this topic.

Our January meeting will be "The Art of Intraspinal Analgesia: Making It Work for the Cancer Patient", and interactive presentation by **Anna Williams RN, MN** from Swedish Home Health and Hospice and **Stuart Du Pen, MD** of Swedish Hospital. It will be January 13 at Highline. Please be sure and RSVP; we expect a large turnout. February will be the Symposium, and the March meeting will be announced in an upcoming flyer.

Funding Opportunities

(Not obtained on the golf course.)

Again, a reminder that **scholarship forms** for the February PSONS Symposium, "Integration of Innovation...Building the Future," are available, by request, at the PSONS office. Selection will be in a lottery format, and are due **January 15, 1993.**

Two Scholarships will be available for the Annual Whatcom County Oncology Nurses' Symposium being held on Friday, **March 19, 1993** at the Semi-ah-Moo Resort, Blaine. **Application deadline is February 15, 1993.** For more information about the program, contact Louise Granger, RN, MN @ 738-6766 or Kathy Millson, RN @ 671-0070. For Scholarship applications, call the PSONS office—*Note on your application which symposium scholarship you are applying for!!*

Washington State Cancer Pain Initiative:

The first Role Modelling Conference was held December 4 & 5, sponsored by the Washington State Cancer Pain Initiative and Virginia Mason Medical Center, with an educational grant from Knoll Pharmaceuticals. It was attended by over 90 nurses, physicians and pharmacists from across the State.

Chapter members who spoke or acted as group leaders include Ann Reiner (V.M.), Diana Wilkie (UW), Anna Williams (Swedish), Debi Combs (Group Health-Spokane), Mary Duff (Holy Family,

Spokane), Sue Ford (Tacoma Community College), Ann McElroy and Gayle Olsson (V.M.), Vicki Whipple (Providence, Everett), and Renee Yanke, (Whidbey Island).

The conference, invitational in nature, was titled "Cancer Pain: Implementing Change." The purpose was to empower and recognize nurse-physician-pharmacist triads as experts in cancer pain management. The triad model, established by the Wisconsin Cancer Pain Initiative and David Weissman - an oncologist - as medical director, is successful in demonstrating increased cancer pain management skills among practitioners in Wisconsin.

The plan is to maintain contact with the

attendees by newsletter and mail and, to hold another invitational conference in 1993 in order to reach other individuals who can serve as leaders in their communities. If you are interested in attending, or would like to recommend nurses, physicians or pharmacists, please call, FAX, or write the WSCPI @ 667-PAIN, 667-3531(FAX), or 1124 Columbia, FB600, Seattle, WA 98104.

Forty-eight evaluations were returned and contained excellent suggestions for future discussion including new information on opioid regulations, how to communicate effectively with other disciplines, continue the liaisons with nurse, MD and pharmacists and, to include community pharmacists.

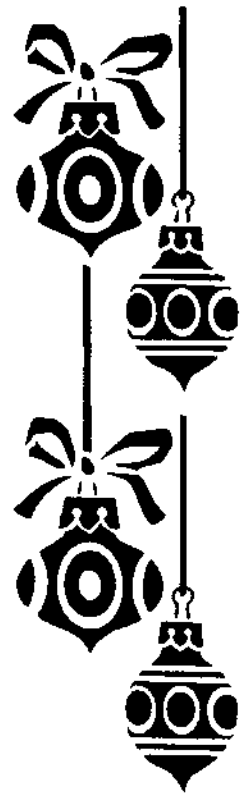
The Core Nursing Education Group met after the sessions, including PSONS Chapter members: Dionetta Hudzinski (Yakima), Diane Ronson for Louise Granger (Bellingham), Debi Combs (Spokane, Lyn Sullivan (Seattle), Cindi Phillippi (Wenatchee), Renee Yanke (Whidbey Isl. & Skagit Co.), Diana Wilkie (UW & Chairperson) and Judy Kornell (WSCPI). Discussion was lively as people described aspects of getting "the word out." Many areas have committees complete with physician support/interaction and meetings, and most areas are doing some sort of needs assessment with surveys and questionnaires. Lots of exciting things happening, so keep your ears open!!

EDUCATIONAL OPPORTUNITY:

Viewer Discussion Group Forms for PBS Television Mind-Body and Medicine Series

A local viewer-discussion group is forming in conjunction with the **February 1993** airing of the five-part PBS television series, *Healing and the Mind with Bill Moyers*. This series explores western clinical medicine and current knowledge of mind-body interactions.

The TV series is funded by the Fetzer Institute, which supports bodymind research. The Institute of Noetic Sciences, an international organization that is a leader in the mind-body connection, is helping to establish local viewer groups nationwide. The purpose of the group is to discuss the television programs and help disseminate study materials such as books, program guides, and videocassettes. The group is facilitated by Geraldine Robinson, M.S., South Whidbey Island psychotherapist, Minnesota Licensed Psychologist, and survivor of major illness. Robinson is former Adj. Asst. Prof., St. Mary's Graduate College, Minneapolis and listed in *Who's Who in Allied Health Professionals and World Who's Who of Women*. The Puget Sound viewer group is open to health care professionals and interested lay persons. Continuing Education credits may be claimed for members of state health care organizations. Nurses may claim Independent Study CNE credit. Costs will be kept to a minimum. To register, contact Geraldine Robinson, Robinson Resources, PO Box 1197, Freeland, WA 98249, AC (206)331-HEAL.



Rehab Basics

Continued from Page 3

social and economic consequences of their disease. By intervening to

maximize functioning throughout a cancer experience, we provide a great service. No matter how bad a situation is, there is almost always something that

can be done to make it better, something to help the patient and family do the best they can with what they have to work with.

There are as many different ways to implement team discussions as there are systems. For the nurse-driven inpatient cancer rehabilitation team conference at Virginia Mason, these are the guidelines that bring structure to the weekly team meetings.

Virginia Mason Cancer Rehabilitation Team Conference Guidelines

1. The meeting coordinator will solicit volunteers at the beginning of the meeting for the purpose of writing notes on the patients presented.
2. The primary nurse or designee will give a brief patient report. For patients new to the cancer rehabilitation team, this report should include a short medical history (age, diagnoses, current treatment, current condition, current disposition plans). For patients who *have* been presented to the team, the primary nurse or designee should give a brief update only.
3. Other team members report if they have had contact with patient/family
4. Team discussion
5. Meeting Coordinator summarizes discussion and recommendations.
6. Chart documentation.
 - notes will be written at the conclusion of the meeting.
 - each note should be entered on the "progress record" and titled "Cancer Rehabilitation Conference."
 - the content of the note should be organized by problem area, summarizing the problem, actions taken, recommendations, and estimated time required to accomplish plan.
7. Problem areas to be considered include:
 - **Activities of daily living (ADLs)** — bathing, dressing, feeding, grooming, adaptive equipment, medication administration.
 - **Mobility** — bed mobility, transfers, ambulation, range of motion, strength, endurance, community access, adaptive equipment
 - **Nutrition/Swallowing**
 - **Symptom Management**
 - **Living Environment/home maintenance**
 - **Bodily Functions** — e.g. bowel and bladder management, skin, oral care
 - **Psycho-social** — including relationships among family members, support systems, sexuality, body image, coping skills, economic support, vocational concerns, avocational concerns.
 - **Spirituality**
 - **Discharge plan** — follow-up care, contingency plans



Are you on the lookout for a new job?

Do Head Hunters call you looking for possible prospective job applicants?

Now you can fill out the form on the back of the PSONS membership application and send it to the PSONS Secretarial Service.

They will keep it on file and refer Head Hunters to You!

Instead of racking your brains for names of prospective applicants—refer the Head Hunters to the PSONS Hotline—(206) 361-4736



JOB AVAILABILITY FORM

Name _____

Home telephone _____

Work telephone _____

Address _____

Best time to reach me _____

Can be contacted at work? Yes _____ No _____

Type of position desired _____

Desired geographic location _____

Years of experience _____

Managerial experience Yes _____ No _____

Highest Degree _____

Certifications _____

Additional Comments _____

Signature _____ Date _____

By signing this form I am allowing the PSONS office to release my name, telephone number and address to recruitment services or personnel officers.

Return this form to PSONS, 2611 N.E. 125th Street, Seattle, WA 98125-4357

PSONS MEMBERSHIP

Membership Application - 1993

PUGET SOUND CHAPTER ONCOLOGY NURSING MEMBERSHIP

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Employment: Full Time _____ Part-time _____ Not Employed _____
Career Area: Patient Care _____ Administration _____ Research _____ Education _____
Patient Population: Adult _____ Pediatrics _____
Specialty: Chemo ___ XRT ___ Surg ___ BMT ___ Immuno ___ Home Care ___ Other ___
Highest Degree: Diploma _____ Associate _____ Bachelor _____ Master _____ Doctorate _____

New _____ Renew _____
ONS# _____ Exp. Date _____
Legislative Dist. _____

Last Name _____ First _____ Middle _____
Preferred Mailing Address:
Street _____
City _____
State _____ ZIP Code _____

Business Address (if not preferred):

Institution _____
Address _____
Street _____
City _____
State _____ ZIP Code _____
Phone (H) _____ (W) _____

_____ Dues \$20.00 _____ Donation PSONS _____ Donation ONF _____ Late Fee \$5.00

\$

TOTAL

Return this form to PSONS, 2611 N.E. 125th Street, Seattle, WA 98125-4357

The Last Word

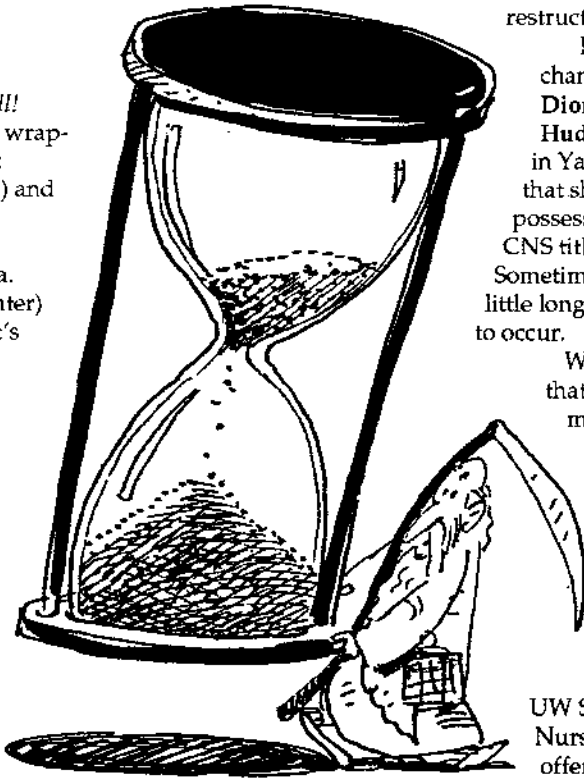
Susan Ford
Pam Ketzner

Happy Holidays to all!
Here is a kind of wrap-up from the year 1992:

Barb Fristoe (CNS) and **Kay Lanier** (Nursing Director) at Tacoma General Hospital (a.k.a. Multicare Medical Center) accepted the President's Award for Quality Service for a staff development and support project they designed on the Oncology unit. I also understand the Oncology Unit received a generous grant for nursing education at TGH. Ever wonder why Barb has a new car? You've got to get to those educational programs, don't ya?

Julia Fanslow was an early holiday present to the students at PLU. Last fall, Julia returned to the halls of the School of Nursing down in Tacoma.

Trekking up into Seattle, **Kathi White** has come on board at Group Health Coop. as the Hospice Program's In-patient Liaison Nurse. **Pat Jordan** is formulating the position of Hospice Clinician in the Community Health Department's



restructuring project.

Name badge
change alert...

Dionetta Hudzinski, over in Yakima, reports that she now possesses the official CNS title.

Sometimes it takes a little longer for change to occur.

We all know that jobs and money are getting tight, rumor has it that if research funding and grants start to dry up, the

UW School of Nursing will be offering a new class: "Three

Easy Lessons in Golf and How to Talk Funding On the Course." Call their new faculty member, Billy Joe, for details.

Holiday season always brings together fond memories, family, and friends. Pam and I would like to hear from *OUR* Membership, some of your stories of this holiday season. We have lots of Moms with new additions this year—what was this holiday like? How about students, and

members new to the Pacific Northwest who might be spending their first Christmas away from family (Ask **Renee Yanke** about the X-mas calf)!!! We want to hear from YOU!!

During the Holiday Season, we often think about others who might need some help. Late in November, **Carla Jolley** and her family lost their house in a fire. They escaped safely and are all doing well, and are now working to rebuild their home. Needless to say, the top priority items to save were *not* Carla's nursing journals—now she is trying to rebuild her professional library. She will greatly appreciate it if anyone would send her a favorite article and/or teaching tool. She works in Home Health Care & Hospice as the Oncology Clinical Nurse Specialist. Please send articles/tools to her at:

Home Health Care of Whidbey General
P.O. Box 400
Coupeville, WA 98239

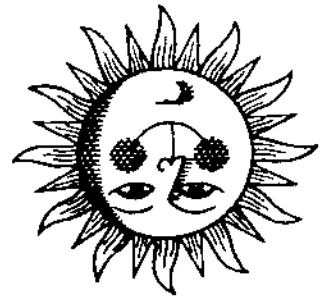
Note: I remember the holiday when I went to Susan's family's for Christmas—and the Christmas calf that was born that day. Her family met me on the ferry to Poulsbo at midnite after I worked the evening shift. I had a wonderful time celebrating with her family

(during my first Christmas away from home) at the Christmas tree farm, and I hear that Susan is still advertising the trees! That Christmas was special to a newcomer to the PNW!



— Renee

**HAPPY NEW
YEAR!!!!**



American Cancer Society
Washington Division, Inc.
2120 First Avenue North
Seattle, WA 98109



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