ONCOLOGY UNIT GUIDELINES AND COMPLIANCE OF SELECTED UNITS

by

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CHAPTER I

INTRODUCTION

Cancer is the second leading cause of death from disease in the United States today (American Cancer Society, 1980). It is a condition characterized by abnormal growth and spread of cells and is a multi-faceted health care problem today. It is not merely one disease, but many diseases having the common characteristics of uncontrolled growth and ability to spread to organs that control life-sustaining activities (e.g., lung, liver, brain). Each disease varies in symptoms, clinical course, and responsiveness to various forms of treatment.

The past 20 years have witnessed tremendous and dramatic strides by medical and scientific researchers toward bringing this major health care problem under control. Epidemiologists, physicists, chemists, virologists, laboratory technicians, psychologists, sociologists, medical doctors, and nurses have waged an all-out war to conquer this dreaded disease. Even the politicians have joined the battle, by establishing the National Cancer Act in 1971, thereby providing monies to support the efforts of researchers (Oregon Comprehensive Cancer Program, 1981).

Cancer is the disease most feared by Americans today. In spite of wide publicity regarding high cure rates for many types of cancer that are detected and treated early, many people are convinced once a diagnosis of cancer has been made, "a death warrant has been signed" (Oregon Comprehensive Cancer Program, 1981). Physicians and other health professionals alike view cancer as a most dreaded disease. The health professionals providing care for persons with cancer may feel frustrated

over their inability to control the disease process or the accompanying symptoms.

Attempts to understand cancer and to find ways of preventing, controlling, and curing it began in ancient times. However, until approximately three quarters of a century ago, an individual with cancer had only a remote chance of being cured. By the 1940s the survival rate was one in four (Oregon Comprehensive Cancer Program, 1981). Today about one-third of all people who get cancer will be alive at least five years after treatment (American Cancer Society, 1981). According to the American Cancer Society's latest statistics, approximately 17% of the individuals who will die of cancer in 1983, might have been saved by earlier diagnosis and prompt treatment.

From 1900, when cancer held seventh place among the major causes of illness and death, until today, when it ranks second, physicians, technologists, and researchers have worked diligently to reduce its incidence (Oregon Comprehensive Cancer Program, 1981). About 58 million Americans now living will eventually have cancer; one in four according to present rates (American Cancer Society, 1981). The American Cancer Society (ACS) predicts that over 835,000 people will be diagnosed as having cancer in 1983. These figures do not take into consideration non-melanomatous skin lesions or carcinoma in-situ. The incidence of non-melanomatous skin lesions is estimated to be about 400,000 (American Cancer Society, 1981). Clearly, cancer is a formidable health care problem.

Surgery was the earliest form of cancer therapy and today continues to play a dominant role (Rubin, 1978). From a nursing standpoint, cancer

patients have always required and continue to require basic surgical nursing skills. However, nursing care has expanded with the advent of new medical information and knowledge regarding treatment of cancer, and with the development of Medical Oncology in the last decade. This subspecialty of internal medicine, devoted to the total care of the adult cancer patient, was officially recognized in 1973 with the administration of the first licensing exam (Cassileth, 1979). The recognition of this new medical specialty with its stress on drug therapy, has brought with it new demands on the other members of the health care delivery team, among them nursing personnel.

Across the country, hospital staffs have come to recognize the special treatment needs of individuals with cancer. In response to these needs, special oncology units have been created. This followed the precedent set earlier when specific units were established to care for individuals with other special treatment needs (e.g. coronary care, intensive care, burn care).

This investigation examines the rapid growth of these new oncology units, how they developed, and how they operate. In response to a survey, over 50 hospitals throughout the country revealed that they have designated units for cancer patients and their families. This study discusses the nature of these units, as described by their administrators, in relation to recommendations adopted to guide their planning and development during a national consensus meeting held in Portland, Oregon, in May 1981. This conference was attended by members of many disciplines; medicine, nursing, social work, counseling and hospital administration. Together the meeting participants developed recommendations to assist oncology units in various stages

of development and functioning.

Review of the Literature

Although the concept of the oncology unit is quite prevalent today, not much has been written about the functions, goals, or efficacy of such units. The Oregon Comprehensive Cancer Program (OCCP) has published the two major sources of information. The first is a booklet entitled Oncology Units: State of the Art (1980). The second is a document generated by the National Conference on Oncology Units: A Consensus Meeting (1981). The substance of these publications is presented below. Following this summarization, the review of the literature concludes with a discussion of the few articles which have described specific oncology units.

Oncology Units: State of the Art: 1979 Survey

The intent of this manual was to inform and guide hospital personnel interested in establishing oncology units by describing the experiences of existing units. The OCCP had conducted a survey in 1979 of approximately 350 hospitals in the United States, identified by the American College of Surgeons as providing cancer care. Representatives of 44 (13%) of these hospitals responded, and it is on these responses that the authors of the booklet largely relied for their knowledge and recommendations regarding procedures and problems in planning and implementing oncology units.

Based on the information collected, the authors listed these steps in planning a unit: identification of benefits to be derived from a unit, documentation of need and resources, constitution of a planning group, formulation of a philosophy, designation of desired facilities, and consideration of costs. Among the benefits listed by the respondents

were facilitation of continuity of care, and the increased effectiveness of care through specialists' working together in the same area. "The fact that the team is knowledgeable and experienced with the treatment or protocols administered, as well as familiar with the disease and its symptoms, eases the role of the physician and the nursing staff" (p.2). Still other advantages were mentioned, including the possibility of better pain and symptom control, participation in clinical research, and a focal point for coordinating a cancer program.

Documentation of a need for a unit was considered essential to its subsequent establishment. Data serving such a purpose include: the number of cancer patients in relation to total inpatient census of the hospital, past, present, and projected into the future; types of cancer therapies and treatments currently offered in the hospital; statistics on types of patients as determined from the tumor registry; and extent and forms of services for cancer patients provided elsewhere in the geographic area served by the hospital. Approximately 30% of the respondents indicated that a minimum of 200 new malignancies within the hospital per year, excluding skin cancers, would justify establishment of an oncology unit.

The existence of sufficient resources -- staff, equipment, and supportive agencies in the community -- was also considered a prerequisite to establishing a unit. Almost all respondents agreed that qualified nurse leadership, and nursing and medical personnel trained in oncology should direct the unit (58%), or an administrator should serve (30%). There was also somewhat less consensus on the necessity for available radiation therapy equipment (55%) or the existence of a tumor registry (58%) or tumor board (50%).

Following documentation of needs and resources, the next step in establishing a unit was the formation of a planning committee. Little agreement was apparent on the ideal size, and the planning groups in the hospitals surveyed varied in number from 3 to 28 members. Most groups had included a hospital administrator, and medical oncologist and nurses delivering care to cancer patients. There was agreement that representatives of all disciplines involved in cancer care should be included on the committee. Among the many possibilities enumerated were dietitians, clergy, laboratory technicians, engineers, pharmacists, discharge planners, mental health workers, and consumers.

The tasks designated in the report as essential to the planning committee were formulation of a philosophy of care, determination of type of unit to be developed and consideration of facilities and costs. A philosophy of care was deemed essential to provide direction, and to assist in determining type of unit. Type of unit could and did vary widely, and depended in part on the philosophy adopted. Some hospitals defined the population to be served in narrow terms, and admitted only those patients who fit the criteria. Other hospitals offered a wide spectrum of treatments for a wide spectrum of patients. Such variation was considered acceptable but it was emphasized that every unit should define the services and treatment to be provided, and admit patients according to treatment plans.

With regard to facilities, some units provided overnight accommodations for patients' families and some provided kitchens, lounges, conference rooms, and even libraries. Costs did not appear to be an issue for most of the planning units, in that only a few hospitals had problems with reimbursement.

Implementation follows planning, and poses additional and different problems. Oncology Units: State of the Art addresses these also, reporting the experiences of the surveyed units with respect to policies, staff, staff education and training, patient support services, costs, and the possibility of creating out-patient units.

Policy was seen as needed for the issues of admissions, discharges, staffing and types of patients to be treated on the oncology unit. The respondents were equally divided among those assigning responsibility for admission policy to the nurse-supervisor, the head nurse, and the medical director. Discharge planning was usually viewed as the joint responsibility of the social worker and the nurse involved in the individual patient's care. In regard to staffing, in most cases the head nurse or supervisor for the oncology unit either separately or jointly shared the responsibility for hiring and firing nurse staff. Policies regarding patients focused on questions of possible age limitations, consent of the patient, and admission of non-oncology patients.

Policy was needed not only with respect to the hiring and firing of nursing staff, but with respect to staff composition as well. All units reported using "oncology" nurses to provide cancer patient care. No specific guidelines were suggested to define the role or qualifications for the "oncology" nurse. Other staff included: medical oncologists, radiation therapists, social workers, occupational therapists, volunteers, surgical oncologists, LPNs, chaplains, dietitians, rehabilitation therapists, pain specialists, psychiatrists, mental health nurses, clinical nurse specialists, and public health

nurses. While conceding the importance of all team members for the unit's success, inasmuch as only the nursing staff was available 24-hours a day, emphasis was placed on determining the type of nursing care provided. Various combinations of primary nursing and team nursing were reported by the responding hospitals. That decision seemed to have been based in part on the other support services available in the rest of the hospital. For instance, if an intravenous therapy (IV) department was avilable to deliver the IV medications, then less professional nursing staff might be required. Various methods of determining the type of care needed on an individual unit were addressed. Emphasis was placed on the needs of individual units and the importance of developing solutions relating to the needs of the specific units.

All hospitals considered staffing education and training to be essential. Inservice education, conferences, and workshops were identified as the usual means to provide on-going education for nursing staff on an oncology unit. Library and individual study were also recognized as important means of staff education.

Staff support was also judged important. More than 50% of the respondents reported that psycho-social support was available to staff members of their units, and was needed to combat staff burnout or the tendency of staff to lose all emotional feelings for their patients and/or their work. Suggestions to deal with the problem of burnout were as follows: vacations, time off to attend workshops, talking with colleagues, leaves of absence, weekly group meetings, individual counseling when needed, long weekends when possible, occasional parties, options for nurses to float for one month rotation, stress management, and psycho-social conferences.

Support services for patients were generally provided, with communication and education emphasized as the essential components. Patient and family group meetings, homemaker programs, a friendly visitor program, and nutrition classes were specified as possible services for individual patients and their families. The question of conjugal visits was handled differently by different units, some permitting and some not.

Costs could not be estimated from the survey responses. It appeared that cost was not often evaluated on a unit-by-unit basis. The OCCP suggested that financial information about the implementation of an oncology unit might be helpful for future planning.

In summary, the following conclusions were drawn from the data provided by the 1979 survey:

> "It is evident that there is a lack of standardization, either in methods or definitions, in the developmental and operational stages of units.
>
> There is much experimentation in form, size, administration, types of services. Staffing patterns are particularly undergoing experimentation, i.e., staff-patient ratio and type of patient care rendered. A movement from team nursing to primary nursing is noted.
>
> The total number of oncology units in the United States is not known, but it appears that many are beginning or are in the planning stage.
>
> Careful planning, involving all the relevant disciplines is essential to the success of a unit.
>
> A stated agreed-upon philosophy is a necessary first step in the planning process.
>
> Support from hospital administration is seen as very important to the success of a unit and should be considered as a factor during feasibility studies.

> Evidence, so far, suggests that hospitals are finding oncology units do serve a need. Many cancer patients can indeed be served best in them.
>
> A lack of knowledge concerning the "state of the art" and a desire to know how other oncology units are functioning is in evidence.
>
> Oncology-trained R.N.s are important but a strong medical-surgical background is preferred.
>
> Understaffing in R.N.s for most units exists.
>
> Questions and frustrations in staff burn-out and coping methods exist." (Oregon Comprehensive Cancer Program, 1980, pp. 23-24)

National Conference on Oncology Units: 1981 Survey

The booklet by the Oregon Comprehensive Cancer Program has been discussed thoroughly in this review of the literature because it forms the basis for the next publication to be reviewed and for the study that will be conducted. In the follow-up to the survey described above, the Oregon Comprehensive Cancer Program sponsored a national consensus conference in May 1981 in Portland, Oregon to consider the planning and development of the oncology unit. It also conducted a second survey. Over 100 cancer experts from 50 hospitals from 18 states attended the meeting. They were divided into seven groups to answer seven questions and to develop consensus statements around these questions. The purpose of these statements was to provide guidelines and support for newly developing and presently functioning oncology units.

The questions addressed were as follows:

#1 - "What is the philosophy/purpose/goal of the oncology unit?

#2 - Who is the oncology unit patient?

#3 - When is establishment of an oncology unit appropriate and feasible?

#4 - What is the necessary staff for an oncology unit?

#5 - What are the facility and equipment requirements of an oncology unit?

#6 - What educational efforts are necessary to train and maintain staff of an oncology unit?

#7 - How does the oncology unit concept relate to the community hospital?" (Oregon Comprehensive Cancer Program, 1981)

The consensus statements represent the most specific information in the literature to date on the development of an oncology unit. The specific guidelines include statements in response to the above questions and are incorporated into the running text of the document. The guidelines need to be extracted from the narrative, and organized into a convenient format for reference. This organization was one of the tasks set for the author of this study. The format will be described in the section on Methods and the instrument will be presented in the section on Results and Discussion.

Description of Specific Units

No studies have been completed which compare and contrast oncology units, or which evaluate the effectiveness of such units in the treatment of cancer. However, two case studies by McCorkle (1979) and Katterhagen (1981) are available that describe the development of inpatient oncology units in the Puget Sound area of the State of Washington. In the first of two articles, McCorkle (1979) discussed issues similar to those identified in the OCCP survey conducted in 1979. She indicated the importance of providing for patient privacy, family access to a unit kitchen, family sleeping accommodations, and a bright and comfortable environment. She also stressed the importance of open communication for promoting therapeutic relationships among

nurses, physicians, patients and patients' families. She reported that the physical layout of the unit was dictated by the desire to facilitate this open communication. McCorkle also reported that staffing patterns of the new unit were based on the results of a time-and-motion study conducted prior to opening the unit. Finally, she mentioned that the nurses on the unit articulated a philosophy of nursing to guide them in their practice on the unit.

In a second article about the same unit, McCorkle (1979) described the staff development and orientation program. The orientation program included discussions of needs assessments, primary nursing, problem-oriented recording, contract staffing, staff development, peer review and evaluation, and a quality assurance program. The development of group cohesiveness through increasing group interaction skills was also stressed.

In a presentation at the consensus meeting of the National Conference on Oncology Units in Portland, in May 1981, Katterhagen recounted the history and development of an oncology unit since its founding in 1976 at Tacoma General Hospital. That unit incorporated in-patient, out-patient and hospice services, and restricted services to patients receiving medical oncology treatment or radiation therapy. Katterhagen emphasized the need for oncology units to develop from a pre-existing cancer program in the institution. He identified the health care personnel essential to teams treating the cancer patient as medical oncologists, radiation therapists, clergy, and psychologists and he stressed the importance of well trained oncology nurses for the success of a unit. He concluded by strongly recommending official recognition

for the oncology nurse through certification based on her knowledge and skill level.

In addition to these case studies, an article from the Winter, 1981, issue of Oncology Nursing Forum evaluated the effectiveness of a "scattered-bed" versus specialty unit care for cancer patients. In this article, Jones cited several reasons why the University of Rochester Cancer Center used a scattered bed approach, which provides comprehensive care to cancer patients housed on different nursing units rather than concentrated in one geographic area. First, the scattered bed approach was considered less costly. It was difficult to justify the large investment required for a special unit at the Center in view of the fact that only 3% of all cancer patients treated there were inpatients who might benefit from the unit. Second, at the Center, patient admissions were not separated by diagnosis, and so a major change in policy would be required throughout the system. Third, since such a high proportion of total hospital admissions were for treatment of cancer, one ward or geographic area of the Center could not house all eligible patients. Finally, it was claimed that comprehensive care was already available to patients throughout the entire hospital due to its multidisciplinary approach.

Jones also reported two disadvantages of the approach. First, cancer patients returning for further care were often readmitted to different units, thus creating a potential problem for continuity of care. Second, continual inservice educational programs were needed to ensure skilled cancer nursing care.

In the same article, Miller and Wegmann (1981) focused on the limitations and benefits of the specialty unit approach to cancer patient care. They claimed the specialty approach provided better continuity of care for patients and their families, and more comprehensive care. They argued that the nursing staff on a specific unit is usually self selected, making an active decision to be involved in the care of cancer patients. They also argued that staff members support one another better when located on a specific unit. Nevertheless, Miller and Wegmann noted greater staff burnout and fluctuating patient census as two potential disadvantages of the approach. In their opinion, both the stressful nature of cancer patient care and the inclusion of non-oncology patients on the specialty unit have detrimental effects on staff and patients.

It is important to note that Jones based his conclusions on the experience of one particular institution, and these conclusions might not apply to other units in other institutions. It should also be noted that Miller and Wegmann presented no data to back their views.

From the above review of the literature, it would appear that empirical research regarding oncology units is limited to a few descriptive accounts. To date, systematic studies into the nature, functioning and effectiveness of such units have not been undertaken. Noting this, Katterhagen (1981) has challenged professionals in existing units to document care in a manner permitting future evaluation. It is evident that such studies will be required to justify the development and continuation of separate oncology units to care for cancer patients.

Statement of the Problem

No comprehensive guidelines were available for staff to use in developing an oncology unit prior to the OCCP National Conference on Oncology Units held in mid-1981 in Portland, Oregon. It is also the case that the recommendations published by the Conference are not at present articulated in a convenient and readily applicable form to assess the adequacy of any given unit. A major purpose of this study was to prepare a usable set of guidelines for oncology unit development which adhere to the intent of the Conference participants. A second purpose of this study was to describe and compare the goals, structure and functions of a sample of existing oncology units in relation to the guidelines created by the Conference participants. This comparison could provide baseline data for future revision of the guidelines themselves, and for future evaluation of units.

Rationale

The potential for comparing the experiences, problems and successes of individual oncology units exists. Until explicit standards are described, it is not possible to measure the compliance of units, nor to compare oncology units. However, analysis and interpretation of the 1981 OCCP survey data may aid in identifying trends in cancer patient care and in evaluating levels of care.

The ultimate goal of this investigation is to contribute to improvement in the quality of care given cancer patients and their families. Particularly in time of economic distress, hospital administrators are very cost conscious. Special care units, such as oncology units, may not always be the most cost-effective way of providing good care from

the institution's standpoint. This is especially true if the third-party payers do not recognize the oncology unit as a special care unit. By reviewing the information collected on various units throughout the country, it might be possible to balance the benefits of these units against the costs so that knowledgeable decisions may be reached. Until guidelines are adopted and analyses are complete, this valuable information will not be available.

CHAPTER II

METHODS

Sample

The original intent of the National Conference on Oncology Units (1981) was to obtain information on the total population of existing oncology units in this country. The first task was to develop as complete a list as possible. A partial list of 44 units was available from the 1979 hospital survey conducted by the OCCP. Additions to this list were made by (1) contacting members through the Washington, D.C., office of the Association for Community Cancer Centers, (2) contacting participants in a conference on oncology units held in Northern California in 1979, and (3) sending inquiries to a number of knowledgeable persons in administrative settings. In these ways, over 200 units were identified.

Surveys were then mailed to administrators of these units, and representatives from the units were invited to attend a National Conference on Oncology Units in Portland, Oregon in May 1981 to arrive at consensus regarding the desired form and functions of such units. Responses were received from representatives of 42 oncology units (a return rate of approximately 20%). Respondents represented medicine, nursing, social service, counseling, hospital administration, and the tumor registry.

These 42 units, then, comprised the sample for the present study. In view of the limited response rate, the sample cannot be considered representative of the total population of oncology units. However, much diversity was evident within the sample. The units were drawn

from a wide geographical area. Eighteen states were represented, including states from the East coast, the South, the Midwest, Northwest and Hawaii. Hospitals in which units were located varied in size from 95 to 1103 beds. The population base served by the hospitals ranged from 4,500 to 3,300,000.

Design and Procedure

The initial step in this study was to convert the 51 page narrative and descriptive contents of the deliberations of the Consensus groups into a concise and usable form. Using the format of the Joint Commission for Accreditation of Hospitals Standards for Special Care Units, the investigator thoroughly reviewed the contents of the narrative report and developed the Guidelines for Oncology Units. Every effort was made to reflect the intent of National Conference participants through the information provided in their narrative report. In accordance with the JCAH format, a Self-Assessment Tool based on the guidelines was developed to allow individual hospitals to assess their own units by the established guidelines.

The second part of this study is in essence an evaluation study, in which oncology units are assessed, by data collected from a survey, against guidelines established from recommendations generated by the National Conference on Oncology Units. Surveys completed by participants of the conference regarding their individual units provided the data for comparison. Since the survey was developed prior to the Conference, there is a lack of congruence between the information provided on the surveys and the information required by the Self-Assessment Tool to be used in conjunction with the Guidelines. Only

those areas of unit form and function could be compared which were covered both by the Guidelines and by the survey.

Data

The purpose of this study was two-fold: to develop concise guidelines and a self-assessment tool for evaluation of individual oncology units, and a comparison of selected oncology units in terms of those guidelines, and through use of the self-assessment tool. The dual purpose required evaluation of two sets of data. First, the 51 page narrative report that was generated by the National Conference on Oncology Units: A Consensus Meeting was analyzed by the investigator. Each statement from the seven work groups that participated in the Conference was categorized in relation to the format of the JCAH Standards for Special Care Units. Ten concepts were selected in organizing the Guidelines. Those concepts were: planning, space requirements, admission, plans of treatment, services, organization of services, staff orientation and education of staff, certification and evaluation.

After the Guidelines were developed, a Self-Assessment Tool was created to permit individual units to identify their strengths and weaknesses in relation to the Guidelines. The items on the Self-Assessment Tool correspond to the items on the Guidelines. Each question represents a specific guideline, and can be answered "Yes", "No", or "not applicable".

The second set of data for this investigation came from the 42 surveys submitted by participants in the National Conference on Oncology Units. These data were used to compare the current practice of cancer

care on the selected units with the practice recommended by the Guidelines to direct that care. The comparison was accomplished through transcribing the survey data for each unit onto the Self-Assessment form. It should be noted that the survey form was constructed before the consensus meeting and therefore failed to request information on all areas subsequently addressed in the Guidelines. Hence, only partial assessments could be made.

CHAPTER III

RESULTS AND DISCUSSION

Guidelines for the Oncology Unit

The participants in the National Conference for Oncology Units at Portland, Oregon, in 1981 submitted their recommendations regarding the planning and operation of oncology units in the form of a 51-page narrative report to the Oregon Comprehensive Cancer Program. The first purpose of this study was to convert the narrative record into a set of Guidelines following the format adopted by the Joint Commission for Accreditation of Hospitals for Standards for Special Care Units. Indeed, one of the Conference work groups had stated: "In order to provide the quality of care necessary for oncology patients, we recommend that the unit be designated as a special care area/unit following JCAH Standards" (OCCP, 1981, Group III, p. 1). This format facilitates planning in that the important components of oncology units are easily identified. The format also facilitates evaluation of existing units, in that the extent to which units accord with, or deviate from, recommended procedures may readily be determined.

The Conference dealt with key aspects of planning and developing an oncology unit. These aspects were quite similar to those covered by the JCAH Standards. However, some aspects of special-care units addressed by the Standards were not considered by the Conference, such as safety precautions, infection control, and special equipment needs (e.g., adjustable beds, number of electrical outlets, etc.). On the other hand, the Conference did make recommendations regarding total care of the cancer patient and family, and regarding psycho-social issues not usually covered by the JCAH Standards.

In converting the narrative account to the JCAH format, statements were transcribed verbatim, whenever possible. If the same issue had been addressed by more than one task group at the Conference, their statements were combined and paraphrased. In Appendix B the source of each guideline in the narrative account of the Conference is referenced. Occasionally, no recommendation was found for a topic which nevertheless appeared to be important, either because it had been so considered in the literature, or because it is usually considered in the Standards for other special-care units. These items have been included as notes in the Guidelines.

In accord with the JCAH format, a Self-Assessment tool has been prepared for use along with the Guidelines. This tool provides an easy means for the staff of any unit to determine the extent to which the unit is in accord with the standards or recommendations developed. The instrument, consisting of the Guidelines and the Self-Assessment Tool, is presented in the following pages.

CRITERIA	GUIDELINE
ESTABLISHED AS APPROPRIATE	Oncology units, should be established for cancer patients because they require extraordinary care on a concentrated and continuous basis. The development of an oncology unit should be based on the following guidelines.
DEFINITION	In the context of these guidelines and recommendations, the definition of an oncology unit is: "A designated hospital area which facilitates the team approach to comprehensive cancer care by bringing into close proximity those personnel and facilities necessary for such care. The unit must provide not only for the physical needs of the cancer patient, but also for the ongoing emotional, social, and spiritual support of the patient and his/her family."
PLANNING Needs Assessment	GUIDELINE: Development of an oncology unit should occur only if there is a population to utilize services. This determination will be made through analysis of data from: - American Cancer Society and American College of Surgeons statistics and studies - Epidemiologic data from state departments of health - Data from regulatory bodies (HSA's & AHA) - Hospital tumor registry data - Medical records data - Quality assurance programs - The presence or absence of similar units in neighboring hospitals should be noted.

CRITERIA	GUIDELINE
PLANNING (cont.) Needs (cont.)	NOTE: It is believed that a minimum of 15% of total medical/surgical admissions for cancer is required to justify establishing an oncology unit.
Prerequisite	GUIDELINE: An oncology unit should arise from a pre-existing cancer program. The components of a cancer program include: - an active cancer committee - tumor registry - tumor board - multi-disciplinary consultative services for cancer patients - educational programs related to cancer NOTE: It is strongly recommended that the cancer program be approved by the American College of Surgeons Commission on Cancer
Written Philosophy	GUIDELINE: An oncology unit should be developed according to a specific philosophical base. The philosophical statement should address: - specialized needs of acutely and chronically ill cancer patients - realistic achievement of optimal care recognizing physical, social, and spiritual needs - priorities for service, education, education of health care professionals and patients/families, and research activities
Hospice	GUIDELINE: Needs of the terminally ill cancer patient and his family should be addressed by some component of the total cancer program. Incorporation of the hospice philosophy of care may or may not be a component of the oncology unit.

CRITERIA	GUIDELINE
PLANNING (cont.) Hospice (cont.)	NOTE: Hospice is a term describing a philosophical approach to care, and does not refer to a place or environment.
Planning Group	GUIDELINE: Planning for the development and implementation of an oncology unit should be a multi-disciplinary effort. The planning committee should be composed of representatives from: - medical oncology - radiation oncology - surgical oncology (or general surgery) - oncology nursing - hospital administration - pharmacy - tumor registry - dietary - rehabilitation services (PT, OT, etc.) NOTE: Representatives from other areas or groups may be included depending on individual hospital needs. Maintaining a multi-disciplinary approach is the prime consideration.
SPACE REQUIREMENTS Patient and Family	GUIDELINE: A hospital with an oncology program shall provide adequate physical space to meet the needs of cancer patients and their families. The physical space shall provide: - privacy for the individual (private versus semi-private rooms), if desired - family living space (facilities for overnight stays and access to the kitchen), if desired
Staff	GUIDELINE: Staff needs for meeting space and lounge shall be included in the planning of physical space for an oncology unit.

CRITERIA	GUIDELINE
SPACE (cont.) Staff (cont.)	In addition, the physical space provided shall promote good traffic flow within the oncology unit.
Radioactive implants	GUIDELINE: Space for patients with radioactive implants shall be provided on the perimeter or at the end of the oncology unit.
Outpatient care	GUIDELINE: Out-patient facilities shall be provided as part of the oncology unit or in close proximity.
ADMISSION Priorities	GUIDELINE: Priorities for admission should be predetermined but in all cases will acknowledge priority status for those receiving chemotherapy and/or radiation therapy and those who would benefit most from the expert oncology nursing care. Other cancer patients will also be admitted in accordance with the policy to admit cancer patients to the same unit for care to promote continuity of care.
Options	All cancer patients should be informed of their option to receive treatment on the oncology unit, or when feasible, possibility of receiving treatment through an alternate program in the community should also be offered.
Non-Oncology Patient	GUIDELINE: Admission of non-oncology patients to the unit should take place only if the space is not needed by oncology patients.

CRITERIA	GUIDELINE
ADMISSION (cont.) Ability to Pay	GUIDELINE: The decision to admit a cancer patient to the oncology unit will be made irrespective of ability to pay. No one will be denied admission to the oncology unit due to insufficient funds. NOTE: This statement was made by the author and does not necessarily reflect the sentiments of the consensus group. This specific issue was not addressed at the conference.
PLANS OF TREATMENT Individual	GUIDELINE: Each hospital should have an identified plan of treatment for each cancer patient recognizing his/her specialized needs. This individual plan of care should be based on the resources available in the community, in addition to those of the hospital.
Unit	GUIDELINE: Patient care guidelines and procedures should be developed to direct the care of a cancer patient receiving services on the oncology unit.
SERVICES Terminal care	GUIDELINE: The oncology unit should provide services for terminally ill cancer patients requiring comprehensive care on the oncology unit. This care may or may not be based on the hospice philosophy.
Rehabilitation	NOTE: Patients requiring long-term care or rehabilitation may be transferred to another unit, care facility, or home.

CRITERIA	GUIDELINE

SERVICES (cont.)
Acute Care
	GUIDELINE:
	Most oncology units should provide acute care services including:
	- diagnostic procedures
	- staging procedures
	- active cancer therapy
	  - surgery
	  - radiation
	  - chemotherapy
	  - immunotherapy
	- post surgical care
	- treatment for complications
	- terminal care

Multiple Treatment Modalities	GUIDELINE: Most oncology units will provide an integrated treatment approach to cancer care that will incorporate all the treatment modalities of surgery, radiation, chemotherapy and immunotherapy.
Support Services	GUIDELINE: The following additional services should be available for oncology patients: - diagnostic radiology, including CT scans - IV therapy - tumor registry - dietary services - rehabilitative services (PT, OT, etc.) - respiratory care - social services - pastoral care - home care - hospice care
Discharge Planning	GUIDELINE: Discharge planning for each patient will be initiated at the time of admission to the oncology unit. This planning will include a multi-disciplinary approach with patient and family or significant other, participation.

CRITERIA	GUIDELINE
SERVICES (cont.) Discharge Planning (cont.)	NOTE: This statement was made by the author and does not necessarily reflect the sentiments of the consensus group. This specific issue was not addressed at the conference.
Education	GUIDELINE: Education for patients and families is a mandatory service of an oncology unit. Patient education process should begin at the time of diagnosis and continue throughout the disease process. Education should include information regarding therapeutic options for care.
ORGANIZATION OF SERVICES Relation to Hospital	GUIDELINE: Each oncology unit should be well organized and integrated with other units and departments of the hospital. The specialized needs of the cancer patient and family require additional planning and considerations with other departments within an institution. Cooperation with the laboratory, dietary, and the x-ray department for example are important for the overall treatment of the cancer patient. The relationship of the oncology unit to other units and departments of the hospital should be specified within the overall hospital organizational plan.
Administrative Support	GUIDELINE: Proper support from hospital administration, medical staff, and nursing administration should be provided to the oncology unit.
Marketing	GUIDELINE: Administration should market the oncology unit in the community.

CRITERIA	GUIDELINE
ORGANIZATION OF SERVICES (cont.)	
Cancer Committee	GUIDELINE: The cancer committee should provide to the oncology unit, overall guidance for goal setting, program planning, and program implementation. Direct supervision of the medical care given on the oncology unit should be the responsibility of the medical director.
STAFF	
Communication	GUIDELINE: There should be special mechanisms that foster and promote good communication among all members of the interdisciplinary team. Weekly team conferences dealing with patient care issues and monthly meetings discussing operational issues are recommended. Team members' communication in an informal manner on a daily basis is encouraged.
Staffing	GUIDELINE: The oncology unit should be properly staffed according to the nature of anticipated needs of the oncology patient and the scope of services offered by the unit. Staff roles, tasks, and functions should be carefully delineated in the oncology unit and planning for this should take place early.
Medical Director	GUIDELINE: The medical director of the oncology unit should have an active interest in treating cancer patients, personal/professional commitment to community where he/she practices and an understanding of the hospital political climate.

CRITERIA	GUIDELINE
STAFF (cont.) Medical Director (cont.)	NOTE: Payment for the services of the medical director should be consistent with the hospital policy for similar positions.
Nurse Manager	GUIDELINE: A head nurse or nurse manager will assume 24-hour responsibility for supervision of nursing care on the oncology unit. He or she should have education, experience and training in oncology.
Primary or Team Nursing	GUIDELINE: Each oncology unit should decide whether primary or team nursing will be used, depending upon the patient and staff needs in the individual units.
RN/Pt Ratio	GUIDELINE: Nurse/patient ratio should take into account: - unit size - patient acuity - RN/LPN and RN/aide ratios - type of nursing (primary vs. other) - staff responsibilities (total care including IV's and chemotherapy) NOTE: A minimum of 7.0 nursing care (all nursing staff, RN, LPN, aides, etc.) hours per patient day is recommended.
Nursing Staff	GUIDELINE: Nursing staff should have an acknowledged dedication to the care and treatment of cancer patient and his/her family and - previous background in medical-surgical nursing - an interest in expanding a knowledge base with some commitment for self-development - self-support systems and outside interests

CRITERIA	GUIDELINE
STAFF (cont.) Nursing Staff (cont.)	NOTE: Other personal qualifications including self-confidence, sound concept of self and good communication skills were felt to be important. However, it was not determined how these attributes could be measured.
Screening Interview	GUIDELINE: Oncology nurses should be involved in discussions on the following issues during the screening for hire interview: - the philosophy that cancer is a chronic rather than terminal illness - the intellectual base required for effective cancer management needs constant updating - identification of stressors relating to the care of dying patients and their families - identification of the unique demands on the oncology nurse - identification of the unique rewards of oncology nursing
Compensation	GUIDELINE: Consideration for compensating the oncology nurse by providing support and nurturance should include: - financial compensation over and above regular staff nursing salary - mental health time off - rotation to other parts of the oncology program - flexible scheduling of work hours
ORIENTATION & EDUCATION OF STAFF Medical Continuing Education	GUIDELINE: Medical staff members, and house staff, who provide patient care on the oncology unit should participate in relevant education programs or activities on a regular basis.

CRITERIA	GUIDELINE
ORIENTATION & EDUCATION OF STAFF (cont.) Medical Continuing Education	NOTE: This statement was made by the author and does not necessarily reflect the sentiments of the consensus group. This issue was addressed,but no statement was included in the report.
Orientation of Nursing Staff	GUIDELINE: All nursing personnel should be prepared for their responsibilities on the oncology unit through appropriate orientation. The orientation program should be flexible enough to ensure that the individual needs of the orientee will be recognized.
Orientation Program Content	GUIDELINE: The orientation program should include the following topics: - pathophysiology of cancer and its complications - pharmacology and administration techniques for chemotherapy administration - radiation safety and management - instruction in special nursing techniques (e.g., venous and arterial lines) - psycho-social support of the cancer patient and family - principles of self-care, e.g. prevention of burnout - introduction to the roles of ancillary staff - lists of oncology resources, personnel/material
On-going Nursing Education	GUIDELINE: All nursing personnel should participate in ongoing, continuing education.
Administrative Support for Nursing Education	GUIDELINE: Hospital administration should provide reasonable opportunities and funding for oncology staff to attend oncology programs given in locations other than in the hospital.

CRITERIA	GUIDELINE
ORIENTATION & EDUCATION OF STAFF (cont.)	
Nurse Instructors/ Nurse Preceptors	GUIDELINE: Each oncology unit should determine whether staff nurses, head nurses or clinical specialists will provide individualized instruction to new nurses on the unit. In addition, each new oncology nurse should have a designated preceptor.
Continuing Education for Nurses	GUIDELINE: All oncology unit nursing personnel should participate in relevant in-service education programs based on a review of the cancer nursing literature and a survey of nursing staff needs for continuing education. Some programs should result in long-term planning.
Interdisciplinary Team Input	GUIDELINE: The interdisciplinary team should be involved in suggesting topics for continuing education for the nursing staff.
CERTIFICATION	GUIDELINE: Oncology units should support the National Oncology Nursing Society in its efforts to develop a certification process that would be standardized and recognized on a national level. NOTE: No guidelines were developed regarding the board certification for medical staff.
EVALUATION	
Quality of Care	GUIDELINE: Quality of care on the oncology unit should be routinely assessed and the oncology unit should participate in hospital-wide audits.

CRITERIA	GUIDELINE
EVALUATION (cont.) Utilization	GUIDELINE: Utilization on the oncology unit should include a study of: - physician referral patterns to unit occupancy rates - lengths of stay - utilization of specific services - staff satisfaction with program effectiveness NOTE: Patient and family satisfaction with care on the oncology unit was not addressed by the consensus meeting; however, it remains an important concern.

SELF-ASSESSMENT ITEMS	Y	N	NA	NOTES/COMMENTS
1. Was your oncology unit established to care for cancer patients based on their need for extraordinary care on a concentrated and continuous basis?				
2. Is your unit defined in writing?				
Was the development of your oncology unit based on data analysis from:				
3. ACS and ACoS statistics				
4. data from state health dept.				
5. data from HSA's and AHA				
6. hospital tumor registry data				
7. medical records data				
8. quality assurance data				
9. presence or absence of similar units in neighboring hospitals				
Does your hospital have:				
10. an active cancer committee				
11. tumor registry				
12. tumor board				
13. multi-disciplinary consultative services				
14. educational programs				
15. Does your hospital have a cancer program approved by the American College of Surgeons Commission on Cancer?				

SELF-ASSESSMENT ITEMS	Y	N	NA	NOTES/COMMENTS
16. Does your oncology unit have a philosophical statement?				
Does your philosophical statement include:				
17. recognition of the special needs of the cancer patient (acute or chronic)				
18. realistic achievement of optimal care recognizing the physical, social, and spiritual needs of cancer patients				
19. are your priorities for service, education, and research activities on the unit in keeping with those of the hospital				
20. education of health care professionals				
21. participation in research				
22. Are the needs of the terminally ill cancer patient and his family addressed by some component of the cancer program?				
23. Do, or did, you have a multi-disciplinary planning committee?				
Does your committee include representatives from:				
24. medical oncology				
25. radiation oncology				
26. surgical oncology (or gen surgery)				
27. oncology nursing				
28. hospital administration				
29. pharmacy				
30. tumor registry				
31. dietary				
32. rehabilitation services (PT, OT, etc.)				
33. Does your hospital maintain a multi-disciplinary approach?				

SELF-ASSESSMENT ITEMS	Y	N	NA	NOTES/COMMENTS
Did the planning of physical space include provision for:				
34. privacy for the individual (private versus semi-private rooms), if desired				
35. family living space (facilities for overnight stays and access to the kitchen), if desired				
36. Were staff needs for meeting space and lounge included in the planning of physical space?				
37. Was space for patients with radioactive implants provided on the perimeter or end of the oncology unit?				
38. Were out-patient facilities provided either within or in close proximity to the oncology unit?				
39. Does your unit have pre-determined admission criteria?				
Are all cancer patients informed of their option to receive treatment:				
40. on the oncology unit				
41. from an alternate program in the community				
42. Does your unit give admission priority to those who will benefit the most from the expert nursing care provided?				
Is priority for admission given to those receiving treatment with:				
43. chemotherapy				
44. radiation therapy				

SELF-ASSESSMENT ITEMS	Y	N	NA	NOTES/COMMENTS
45. Does your unit provide services for terminally ill cancer patients requiring comprehensive care?				
46. Are non-oncology patients admitted to the oncology unit on a space available basis?				
47. Are patients admitted to the oncology unit regardless of ability to pay?				
48. Does each cancer patient have an identified plan of care recognizing their specialized needs?				
49. Can patients requiring long-term care or rehabilitation be transferred to another unit, care facility, or home?				
50. Is this plan of care based on the resources of the community in addition to those of the hospital?				
Does your oncology unit provide acute care services including:				
51. diagnostic procedures				
52. staging procedures				
active cancer therapy:				
53. surgery				
54. radiation				
55. chemotherapy				
56. immunotherapy				
57. post surgical care				
58. treatment for complications				
59. terminal care				

SELF-ASSESSMENT ITEMS	Y	N	NA	NOTES/COMMENTS
Are the following additional services available for cancer patients:				
60. diagnostic radiology, including CT scans				
61. IV therapy				
62. tumor registry				
63. dietary services				
64. rehabilitative services (PT, OT, etc)				
65. respiratory care				
66. social services				
67. pastoral care				
68. home care				
69. hospice care				
70. Does discharge planning begin at the time of the cancer patient's admission to the oncology unit?				
71. Is discharge planning a multidisciplinary process?				
72. Is patient and family education considered a mandatory service provided by the oncology unit?				
Does patient education:				
73. begin at the time of diagnosis and continue throughout the disease process				
74. include information regarding therapeutic options for care				
75. Is your oncology unit well organized?				
76. Is your oncology unit integrated with other units and departments of the hospital?				
77. Are the relationships of the oncology unit and other depts. of the hospital specified within the overall hospital organizational plan?				

SELF-ASSESSMENT ITEMS	Y	N	NA	NOTES/COMMENTS
Does your oncology unit have support from:				
78. hospital administration				
79. medical staff				
80. nursing administration				
81. Does your hospital administration accept the responsibility for marketing the oncology unit in the community?				
Does your cancer committee provide overall guidance for:				
82. goal setting				
83. program planning				
84. program implementation				
85. Does the medical director of the oncology unit provide direct supervision for the medical care provided?				
Is interdisciplinary team communication supported through:				
86. weekly team conferences dealing with patient care issues				
87. monthly meetings discussing operational issues				
88. Does your oncology unit have a head nurse or nurse manager that assumes 24-hour responsibility for supervision of nursing care on the unit?				
89. Are staff roles, tasks, and functions carefully delineated?				
90. Is your unit considered to be properly staffed according to the nature of the anticipated needs of the oncology patient and the scope of services offered by the unit?				

SELF-ASSESSMENT ITEMS	Y	N	NA	NOTES/COMMENTS
Does the medical director of the oncology unit have:				
91. an active interest in treating cancer patients				
92. personal/professional commitment to the community where he/she practices				
93. an understanding of the hospital political climate				
Does the nurse manager of the oncology unit have:				
94. education				
95. training				
96. experience in the area of oncology				
(No specific recommendation was made regarding the kind of nursing care delivery system to be used. That decision will be based on individual need.)				
Does the staffing of your oncology unit reflect consideration for:				
97. individual unit size				
98. patient care needs (acute versus chronic)				
99. available staff (RN vs RN/LPN vs RN/LPN/PA)				
100. staff responsibilities (total care including IV and chemotherapy)				
In addition to acknowledged dedication to the care and treatment of the cancer patient and his/her family, does the nursing staff on your unit have:				
101. previous background in medical-surgical nursing				
102. an interest in expanding a knowledge base with some committment for self-development				
103. self-support systems and outside interests				

SELF-ASSESSMENT ITEMS	Y	N	NA	NOTES/COMMENTS
Does compensation for the oncology nurse include:				
104. financial compensation over and above regular staff nursing salary				
105. mental health time off				
106. rotation to other parts of the oncology program				
107. flexible scheduling of work hours				
108. Do the staff members (medical, house staff, and nursing) who provide patient care on the oncology unit participate in relevant education programs or activities on a regular basis?				
Are all personnel prepared for their responsibilities on the oncology unit through:				
109. appropriate orientation				
110. in-service training				
111. continuing education programs				
Does the orientation program include:				
112. pathophysiology of cancer and its complications				
113. pharmacology and administration techniques for chemotherapy				
114. radiation safety and management				
115. instruction in special nursing techniques (e.g. venous and arterial lines)				
116. psycho-social support of the cancer patient and family				
117. principles of self-care (e.g. prevention of burn-out)				
118. introduction to the roles of ancillary staff				

SELF-ASSESSMENT ITEMS	Y	N	NA	NOTES/COMMENTS
119. lists of oncology resources, personnel/material				
120. Does your hospital administration provide reasonable opportunities and funding for oncology unit staff to attend oncology programs given in locations other than the hospital?				
Does the screening interview for oncology nurses include discussions regarding:				
121. the philosophy that cancer is a chronic rather than terminal illness				
122. the intellectual base required for effective cancer management needs constant updating identification of stressors relating to the care of dying patients and their families				
123. identification of the unique demands on the oncology nurse				
124. identification of the unique rewards of oncology nursing				

SELF-ASSESSMENT ITEMS	Y	N	NA	NOTES/COMMENTS
(Each oncology unit will determine for themselves whether staff nurses head nurses, or clinical specialists will provide individualized instruction to the new nurses on the unit).				
125. Does each new oncology nurse have a designated preceptor?				
Does your oncology unit nursing personnel participate in relevant in-service education programs based on:				
126. cancer nursing literature				
127. survey of nursing staff needs for continuing education				
128. Is your interdisciplinary team involved in setting priorities for continuing education for the nursing staff?				
129. Does your oncology unit provide continuing education programs that result in the development of patient care guidelines and patient care procedures?				
130. Does any of your continuing education programming for nursing personnel result in long range planning?				
131. Does your oncology unit support the Oncology Nursing Society in their efforts to develop a certification process on the national level?				
132. Is quality of care on the oncology unit routinely assessed?				
133. Does your oncology unit participate in hospital-wide audits?				

SELF-ASSESSMENT ITEMS	Y	N	NA	NOTES/COMMENTS
Does the evaluation of the oncology unit include a study of:				
134. referral patterns (Are physicians referring new cases to the hospital as the result of the unit's existence?)				
135. the level of utilization of the oncology unit				
136. expenditure patterns				
137. revenue patterns				
138. staff satisfaction with program effectiveness				

Existing Oncology Units: Characteristics and Development

The second purpose of this study was to describe existing oncology units and determine the extent to which they had been planned and organized in accord with the recommendations adopted by the Conference. Prior to the Conference deliberations, descriptive data about their oncology unit had been gathered from 42 hospitals, ranging in size from 95 to 1103 beds. The oncology units varied in size from 10 to 48 beds, with a mean of 22.8 beds. Occupancy rates of these units ranged from 25% to 100% with a mean of 80.4%. The data from the survey permit a limited description of the units and some determination of the degree of their correspondence to the specifications of the Guideline. These data may serve as baseline data for future investigations of oncology units, after the recommendations have been more widely circulated. The data may also prove useful in identifying particularly problematic or difficult aspects of planning and developing oncology units.

Planning

The Guidelines state that the need for an oncology unit should be documented with data derived from a number of sources. In this way the size of the pool of potential patients may be estimated. It appears that many units had not planned their units carefully on this basis. Two-thirds of the units had relied on medical records for documentation of need. About 46% had used hospital Tumor Registry data. Only 33% had used data from HSA's and the American Hospital Association. Only 26% took into account, in their planning, the absence or presence of similar units in neighboring hospitals. (See Table 1).

Table 1

Documentation of Need for Existing Oncology Units

Nature of Documentation Obtained	Need Documented Before Planning Unit			
	Yes		No	
	Number	Per Cent	Number	Per Cent
HSA's and AHA	13	33.3%	26	66.7%
Hospital Tumor Registry	18	46.2	21	58.3
Medical Records	26	66.7	13	33.3
Presence or Absence of Similar Units in Neighboring Hospitals	10	26.3	28	73.7

According to the Guidelines, an ongoing cancer program is a prerequisite for a successful oncology unit. Table 2 indicates that over 97% of the responding hospitals stated they had a Tumor Registry, 95% a Tumor Board, and 93% a Cancer Committee. Multidisciplinary consultative services were available in 70% of the hospitals, and all had educational programs. In short, the vast majority of units did follow the Guidelines in respect to this prerequisite planning. Finally, it might be mentioned that the cancer programs were approved by the American College of Surgeons, Commission on Cancer, in about 83% of the hospitals.

Once the need for an oncology unit has been established, and a cancer program is in place, then it is recommended that a planning committee be formed of representatives from many disciplines. Survey respondents were asked to identify the disciplines represented on their planning committees. From Table 3 it may be noted that physicians and hospital administrators were the professionals most frequently named (by 83% and 73% of the units, respectively.) Oncology nurses were included on 58% of the committees. Other participants included radiation therapists (on 40% of the committees), surgical oncologists or general surgeons (28%), pharmacists (25%), and tumor registrar (20%). The number of different disciplines represented varied from 1 to 9, with an average of 4. Most of the institutions included at least some of the members of the cancer health care team in the committees which planned the oncology units.

The Guidelines state that every oncology unit should develop a written philosophy to give purpose and focus to the unit. The

Table 2

Existing Oncology Units Planned on the Basis of a Pre-existing Cancer Program

Cancer Program Components	Units Planned on Basis of Pre-existing Cancer Program Components			
	Yes		No	
	Number	Per Cent	Number	Per Cent
An Active Cancer Committee	38	92.7%	3	7.3%
Tumor Registry	40	97.6	1	2.4
Tumor Board	39	95.1	2	4.9
Multidisciplinary Consultative Services	28	70.0	12	30.0
Educational Programs	40	100.0	0	0.0

Table 3

Multidisciplinary Planning of an Oncology Unit as Reflected in Representation of Various Health Care Providers on Committee

Health Care Providers	Representation on Planning Committee			
	Yes		No	
	Number	Per Cent	Number	Per Cent
Medical Oncologist	33	82.5%	7	17.5%
Radiation Oncologist	16	40.0	24	60.0
Surgical Oncologist	11	27.5	29	72.5
Nurse Oncologist	23	57.5	17	42.5
Hospital Administrator	29	72.5	11	27.5
Pharmacist	10	25.0	30	75.0
Tumor Registrar	8	20.0	32	80.0
Dietitian	4	10.0	36	90.0
Other	33	82.5	7	17.5

Note: Total number of health care providers per institution ranged from 1 to 9, with a mean of 4.

philosophy should recognize that optimal care for acutely and chronically ill cancer patients can be achieved only through recognition of their special physical, psychological, social, and spiritual needs. The philosophy should identify service, education and research as priorities. The survey did not yield any information regarding philosophies of individual units. However, respondents were requested to bring copies of their philosophical statements with them to the Conference. Only 12 units submitted such copies. All of these responded positively to the issues of providing specialized care for cancer patients, and all recognized that optimal care required meeting the physical, psychological, social and spiritual needs of the patients. All 12 philosophies stressed service and education, but none mentioned the role of research.

The final area of planning to be considered is that of the hospice. The Guidelines stated that incorporation of a hospice philosophy was not mandatory for an oncology unit. However, some component of the cancer program should provide hospice care. Since the survey did not specifically address the question of hospice care, no information is available regarding the form in which existing oncology units resolved the issue of terminal care.

Space Requirements

The Guidelines indicate that physical space on the unit should be so allocated as to provide for patient privacy, and for family live-in facilities. The availability of private rooms for patients is presumed to provide patient privacy. From the survey it was learned that 83% of the units had private rooms; the exact number is

unknown. Family living space in the form of overnight accommodations on or near the units was available in 70% of the cases. About 60% provided kitchen facilities.

The Guidelines also recommended staff meeting space and staff lounges, special designated areas for patients with radioactive implants, and outpatient facilities near or within the oncology unit. No data were available from the surveys by which to estimate the extent to which existing units made such provisions.

Admissions

At the Conference, it was agreed that all oncology units should establish priorities for admissions. It was also agreed that patients should be involved in the decision as to whether they would receive cancer treatment on the oncology unit, or elsewhere in the hospital. The survey provided no information regarding the establishment or incorporation of admission criteria. However, over 73% of the respondents indicated that patients were given an option to receive treatment on the oncology unit or elsewhere within the hospital.

The issue of whether or not non-oncology patients might be admitted to the unit was broached on the survey. Over 85% of the units stated they did admit such patients. It is not clear from the responses whether such admissions were standard practice or on a space-available-basis only. It was impossible, then, in this investigation to differentiate between units purposefully mixing oncology and non-oncology patients for philosophical reasons, and units doing so for economic or expediency reasons only.

Finally, it might be mentioned that neither the Conference nor the survey spoke to admission policy in relation to the patient's ability to pay. Yet, a policy adopted in this regard would have deep implications for hospital solvency, for patient quality of care and for the population or community whose needs the hospital purports to serve.

Plan of Treatment

The special needs of the cancer patients are best met through an individualized, identified plan of medical care. Only 37% of the respondents to the survey indicated they used such plans. This deviation from the recommended procedure may be overestimated, in that respondents might have interpreted "plan of medical care" to mean participation in medical research where protocol guidelines are established and strictly adhered to.

Individualized nursing care plans are also recognized as an integral part of cancer patient care. Thus, the JCAH requires that nursing care plans be developed for all patients to meet their individual needs (JCAH, 1979, NS p. 18). The extent to which the oncology units followed this procedure cannot be estimated since no information was gathered on the survey about nursing care plans.

Services

It was the consensus of the Conference that service to the cancer patient should be given high priority (OCCP, 1981, Group VII, p. 1). Specific services include acute care, use of multiple treatment modalities, terminal care, rehabilitation, support services, discharge planning and education. However, it was agreed that the particular

services offered by oncology units might vary considerably, depending on their purpose and philosophy.

Inasmuch as oncology units are housed in the acute care setting, it is assumed they should provide acute care services. Table 4 presents data on the services offered by the units surveyed. All units provided some form of active cancer therapy. Over 95% provided chemotherapy, over 95% provided radiation therapy; 86% provided immunotherapy and 81%, surgical services. The fact that several forms of active cancer therapy were available in over 80% of the units clearly indicates compliance with the Conference's recommendation that multiple treatment modalities should be made available.

Additional services identified as important by Conference participants are postsurgical care and terminal care. Postsurgical care was provided by 83% of the oncology units, and terminal care by 95%. Whether or not terminal care was based on a hospice philosophy is unknown, as stated earlier.

Still other services considered important are diagnostic procedures, intravenous therapy, tumor registry, dietary services, rehabilitation (as physical and occupational therapy), respiratory care, social services, pastoral care, home care, and education for patients and families. Data from the survey were limited to the areas of home care, tumor registry, and education. Home care was provided by 50% of the units. Over 95% reported the existence of a tumor registry. Finally, 87% of the respondents claimed that education was provided patient and family. No information, however, was available regarding the content or timing of this education.

Table 4

Acute Care Services Provided on the Oncology Units

Services	Units Providing Services			
	Number	Per Cent	Number	Per Cent
Active Cancer Therapy				
Surgery	33	80.5%	8	19.5%
Radiation	40	95.5	2	4.5
Chemotherapy	41	97.6	1	2.4
Immunotherapy	36	85.7	6	14.3
Other				
Post Surgical Care	35	83.3	7	16.7
Terminal Care	40	95.2	2	4.8

The Guidelines specify, in these respects, that the educational process should begin at time of diagnosis and continue throughout treatment and that it should include information regarding therapeutic options.

The issue of discharge planning was not discussed at the Conference. Nevertheless, a guideline has been written about the need to provide such service on a multidisciplinary basis. In the survey, respondents were queried regarding the participants in this process. The results are presented in Table 5. In over 95% of the units, the registered nurse was a participant in the process, in 91%, the social worker participated, and in 83%, the physician. In 52% of the units, a "discharge planner" was involved. The professional affiliation of this individual is unknown. The medical director and other individuals were also sometimes listed as participants in the discharge planning process.

Organization of Services

The Guidelines address the relationship of the oncology unit to the rest of the hospital, to the administration, and to the Cancer Committee, emphasizing integration, mutual support and communication. The concept of marketing through administration was also addressed. No information on these aspects or relationships is available from the survey.

Staffing

Several work groups at the Conference deliberated on the issue of staffing an oncology unit. They considered the role of the medical director, but for the most part made their recommendations about nursing staff -- their qualifications and responsibilities, mode of

Table 5

Health Care Providers Involved in Discharge Planning

Health Care Providers	Participation by Health Care Providers			
	Yes		No	
	Number	Per Cent	Number	Per Cent
"Discharge Planner"	22	52.4%	20	47.6%
Social Worker	38	90.5	4	9.5
M.D.	35	83.3	7	16.7
R.N.	40	95.2	2	4.8
Medical Director	8	19.0	34	81.0
Other	19	46.3	22	56.7

nursing care delivery, the RN/patient ratio, the interviewing process to be used in hiring, and the compensation given nurses.

Table 6 indicates that primary nursing was the nursing care mode most commonly employed, by 46% of the units. The decision regarding mode of nursing care delivery is often based on the RN/patient ratio. The Conference estimated that 7.0 nursing care hours per patient was the minimum level acceptable. For the 13 units for which information exists, the actual number of nursing care hours ranged from 4.7 to 7.5 hours, with a mean of 6.1, thus falling short of the acceptable minimum.

Information was obtained from 12 units on the number of nursing care hours budgeted. In 6 of these units, nursing care hours equaled those budgeted, in 5 units the actual number of hours exceeded the number budgeted, and in the last unit the hours were less than budgeted. Mean hours budgeted was 6.8, and the range was from 4.1 to 15.0. Perhaps the wide variability in budgeted hours was the result of differences in the manner in which nursing care hours were calculated (i.e., including or excluding head nurses, clinical specialists, etc. in the count).

With respect to the qualifications of nurses employed on oncology units, the Guidelines specify the desirability of previous experience in medical-surgical nursing, an interest in continuous updating of knowledge, and presence of a support group. In the hiring interview, emphasis should be placed on the philosophy that cancer is a chronic, not terminal, disease, on the importance of updating knowledge, on the stressors of the job, and on the unique demands and rewards of

Table 6

Types of Nursing Care Provided on Oncology Units

Types of Care	Units That Provide Specific Types of Nursing Care	
	Number	Per Cent
Team	8	20.5%
Primary	18	46.2
Comprehensive	5	12.8
Modular	1	2.6
Primary and Team	4	10.3
Other	3	7.7

Note: 3 respondents did not answer

oncology nursing. Finally, compensation for the oncology nurse should include time off for mental health reasons, rotation to other segments of the cancer program, and flexible work hours. None of these issues were addressed by the survey. Therefore, no conclusions may be drawn regarding the congruence of unit practices with the Guidelines.

Orientation and Education of Staff

According to the Guidelines, orientation and continuing education of unit staff are essential. Orientation for nursing staff should be individualized and under tutelage of a preceptor. Orientation content should cover the pathophysiology of cancer, cancer complications, pharmacology and chemotherapy techniques, radiation safety and management, instruction in special nursing techniques as venous and arterial lines, psychosocial support, principles of self-care for staff, the roles of the ancillary staff, and identification of resources. All but one of the units reported that they provided orientation, but no information is available regarding its content or individualized nature. Staff were instructed in principles of self-care to prevent burnout in 40 units. What these measures were, and whether or not instruction occurred during the orientation process are unknown.

In-service training and continuing programs were available in 40 units. Administrative support in funding these educational endeavors was common, with 92% of the units reporting administration assumed the costs of sending nurses to meetings outside the hospital. Whether the input to the educational programs was multidisciplinary, as recommended by the Conference, is unknown.

Certification

In the Guidelines it is stated that individual oncology units should support the efforts of the National Oncology Nursing Society to obtain certification for oncology nurses. Although at present no certification process exists, 29% of the respondents claimed their nurses were certified. This claim is difficult to interpret.

Evaluation

The Guidelines call for routine assessment of quality of care and participation by the oncology unit in hospital audits. Over 85% of the respondents affirmed that their units were regularly assessed. The Guidelines also call for evaluation of such aspects of the unit's operation as physician referral patterns, occupancy rates, length of stay of patients, and staff satisfaction with program effectiveness. Although no mention was made at the Conference of assessing consumer satisfaction it would still appear to be an important component of any comprehensive evaluation of services. No data are available to determine whether or not existing oncology units adhere to these recommendations of the Conference.

CHAPTER IV

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The specialization of both medical and nursing care has contributed to the growth and development of oncology units designed to provide comprehensive care to cancer patients and their families. There has been, however, little research to date to assist in the planning and development of such units. Neither has there been research into the effectiveness of such units or the relative contribution of the many aspects and components of the units to high quality cancer patient care. The present study was undertaken to help fill this gap.

The first purpose of this study was to convert the narrative reports or recommendations of the National Conference on Oncology Units: A Consensus Meeting into a concise set of Guidelines. The format chosen was that utilized by the Joint Commission on Accreditation of Hospitals to set standards of care for Special Care Units. Using this format, key concepts were identified and Guidelines were developed from the information provided by the National Conference. In addition, following the usual practice of the JCAH, a checklist (Self-Assessment Tool) was developed corresponding to the Guidelines so that individual units might readily compare their procedures and services with those specified in the Guidelines. The Guidelines related to ten different areas. They were planning, space requirements, admission, plans of treatment, services, organization of services, staff, orientation and education of staff, certification, and evaluation.

The second purpose of this study was to evaluate the planning, implementation and functioning of selected oncology units against the

Guidelines. To accomplish this purpose, data were analyzed from a survey administered to participants of the National Conference on Oncology Units. The surveys were completed prior to the Conference and therefore did not completely reflect the areas of importance as identified by the Consensus Meeting. Many of the items on the Guidelines were not addressed in the survey, which limited the comparisons that could be made. However, the survey provides baseline data which may prove useful to future investigators for identifying trends and documenting changes.

When the 42 units were evaluated against the Guidelines with respect to those aspects of planning and implementation addressed in the survey, the following results were obtained. With respect to planning, the surveys revealed that a majority of oncology units were developed on the basis of a strong cancer program, e.g. most of the institutions had cancer programs approved by the American College of Surgeons, Commission on Cancer. Pre-planning information, although identified by all respondents, generally consisted of obtaining information from one or two sources only. In addition, the planning did reflect a multidisciplinary nature; however, most of the institutions did not incorporate as many team members as the Guidelines identified. The few philosophical statements that were reviewed did correspond to the Guidelines, and the concept of hospice was not addressed. With reference to space requirements, the units appeared to provide for patient privacy through private rooms. However, unless the specific number of private rooms is known on a per unit basis it is not possible to determine whether the positive response accurately reflects the

unit's provision for privacy. The Guidelines stressed the importance of including the family in services provided by an oncology unit and yet only 70% of units provided family accommodations through living space or kitchen facilities. With reference to admissions; most units provided the option of admission to the unit or elsewhere and most did admit non-oncology patients. Since medical plans of treatment were recommended for all patients, and only approximately one third of the respondents stated they had them, this is another area of conflict or deficiency related to the Guidelines.

Services provided by the units were in accord with the Guidelines in the areas of terminal care, acute care services, and education provided for the cancer patient and family. Multidisciplinary planning was recommended strongly in the Guidelines; however, this apparently had not occurred. Organization of services was not addressed by the survey and therefore no comparisons can be made. In response to staffing, the surveys indicated that most of the units did have a medical director and that primary nursing care was provided most frequently. There was a wide range of responses regarding the type of nursing care provided. The RN/patient care ratio was generally below the acceptable minimum established by the Guidelines. Orientation and education of the staff were issues addressed by the respondents in keeping with the Guideline recommendations. Almost all of the units provided staff orientation, attempted to prevent burnout, and provided monies for staff education outside the institution. The issue of national certification could not be evaluated in relation to the Guidelines because the mechanism for certification does not exist. No

comparisons could be made regarding evaluation of issues since survey data were insufficient.

The findings indicate that although a cancer program may be in existence prior to the development of an oncology unit, that does not necessarily assure that an optimal oncology unit will be planned. Many units indicated areas of deficiencies in planning, multidisciplinary participation, provision of privacy for patient and care for family, and RN/patient care staffing ratios. Strengths of these selected units included their emphasis on education for staff and patients. Lack of data collection on many issues makes further analyses and comparisons impossible at this time.

The limitations of this study are numerous. First, it must be recognized that the consensus statements were in essence compromise statements, with all the weaknesses implied thereby. Second, the sample may not have been representative. Findings were based on data from only 42 units, 20% of the total oncology units identified as of that date. Third, the lack of correspondence between the topics addressed by the survey and the topics addressed by the Guidelines resulted in incomplete knowledge concerning adherence of units to the recommended procedures and practices. Finally, even should the present findings accurately reflect services available to cancer patients and their families on the units in 1981, they may not reflect the care available in 1983. The National Consensus Conference may have induced changes, through the distribution of the narrative reports which served as the basis for the present Guidelines. Even so, the survey information gathered and analyzed here may serve as baseline data for

identifying and evaluating those changes.

Recommendations for Further Study

The next logical step in this project should be to revise and refine the Guidelines and the Self-Assessment Tool. This revision might be accomplished through use of the Delphi technique. The expert panel might consist of the chairpersons and co-chairpersons of the consensus groups at the National Conference, since those individuals were originally chosen on the basis of their recognized expertise in the area of oncology units. Other consultants might be drawn from the Association of the Community Cancer Centers and Community Hospital Oncology Programs sponsored by the National Cancer Institute.

These consultants should consider the advisability of expanding the Guidelines to cover aspects of oncology care not discussed at the 1981 Conference. For example, the Conference failed to list social workers and chaplains as necessary members of the planning committees for oncology units. In view of the emphasis on an interdisciplinary approach to the cancer patient and family, it would seem important to correct that omission. Examples of other issues which might be addressed include: the role of the medical director on the unit; location of the unit within the institution; isolation procedures; admission policies, procedures and any restrictions by age; provision for conjugal visits; fund-raising activities, or acceptance of philanthropic gifts; provision of outpatient services; educational qualifications for nursing staff; continuing education requirements for staff; acceptability of employing float or agency nurses; and criteria for evaluating unit effectiveness.

After the Guidelines and Tool appear satisfactory to cancer leaders, then they might be submitted to the JCAH for further evaluation and possible inclusion in their manual for hospital procedures. It is also suggested that a broad survey be conducted of existing oncology units. Units in addition to the 42 surveyed in 1981 might be identified through the National Oncology Nursing Society and the American Society of Clinical Oncologists. Still other units might be located through the Association of Community Cancer Centers. The data obtained from such a survey should provide an up-to-date report on the nature and functioning of oncology units, and their compliance with the recommended practices and procedures. Still further studies might examine the relation between compliance and optimal patient care. In this manner, knowledge may gradually accumulate to answer the difficult questions of whether cancer care provided in special oncology units differs from and is superior to cancer care provided in institutions without oncology units; and whether oncology units which comply with the Guidelines provide better care than oncology units which do not. The assumption underlying the Consensus Conference and this study has been that oncology units improve cancer patient care. That assumption needs careful testing.

In conclusion, this study has attempted to contribute to the body of knowledge related to cancer patient care, specifically in the area of oncology units. It is anticipated that the Guidelines and Self-Assessment Tool will be refined further and may be of use to hospital staffs in desiring to open special units for the purpose of meeting the needs of cancer patients and their families.

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APPENDIX A

Survey of Oncology Units

OREGON COMPREHENSIVE CANCER PROGRAM

SURVEY ON ONCOLOGY UNITS

Items to Bring and to Know for May 14 & 15, 1981

Name_____ Position/Title_____

Name of Hospital_____No. of Beds_____

I. YOUR UNIT

1. Describe the services that apply to your unit. (Please mark the boxes that apply to your unit.)

   Multi-disciplinary care (physicians representing various disciplines of oncology) . . . . . /_/

   Inter-disciplinary team (physicians representing various disciplines of oncology plus allied health professionals). . /_/

   24-hour services available for out-patients . . . . . /_/

   In-patient radiation therapy . . . . . /_/

   In-patient chemotherapy . . . . . /_/

   Out-patient radiation therapy . . . . . /_/

   Out-patient chemotherapy . . . . . /_/

   Home-Care Program . . . . . /_/

2. Please check the style of care that is currently used by your oncology unit:

   Primary nursing . . . . . /_/

   Comprehensive nursing . . . . . /_/

   Team nursing . . . . . /_/

   District . . . . . /_/

   Other _____

3. Is staff satisfied with the present type of nursing care?
   Yes /_/ No /_/

   How was level of satisfaction determined?_____

   _____

4. Some oncology units specialize in the types of cancer they treat. Would you please check the box that describes your unit.

   All forms of cancer . . . . . /_/
   Solid tumors only . . . . . /_/
   Hematology only . . . . . /_/
   Comment_____

5. Does your unit have the capability of providing for:

Surgical patients	Yes /_/	No /_/
Radiology patients	Yes /_/	No /_/
Medical Oncology patients	Yes /_/	No /_/
Immunotherapy patients	Yes /_/	No /_/

6. Are Phase III Clinical protocols utilized on your unit?
   Yes /_/ No /_/
   If "yes", what percentage of the unit's patients are on protocols? _____

7. Are other site specific patient care "guidelines" utilized?
   Yes /_/ No /_/
   If "yes", please list sites _____

8. Is isolation available for patients on your unit? Yes /_/ No /_/

Staff

1. We would like to know about your oncology unit staff (composition). Please fill in FTE's. If an individual is shared throughout the hospital, estimate percentage of time he/she is available to your unit?

Medical oncologists	/_/	LVN/LPNs	/_/
Radiation therapists	/_/	Oncology nurses	/_/
Social workers(s)	/_/	Nursing aides	/_/
Occupation therapists	/_/	Chaplain(s)	/_/
Volunteers	/_/	Dieticians	/_/
Surgical oncologists	/_/	Rehabilitation therapists	/_/
		Physical therapists	/_/

   Other_____

2. Do you have a medical director? . . . . . Yes /_/ No /_/

   What percent of his/her time is reimbursed for service in the unit? _____

   How was he/she chosen? _____

   What is the role/impact of the unit medical director? _____

   _____

3. Please specify your oncology unit patient staff ratio (i.e. how many nursing hours per patient per 24 hours are assigned to the unit).

	Day Shift	Evening Shift	Night Shift
RN			
LVN/LPN			
Nurse Aid Attendant			

4. What is the number of nursing hours budgeted for?_____

5. If occasional additional nursing staff is needed, which of the following do you use?

   Float pool . . . . . /_/

   On call . . . . . /_/

   Other nursing units . . . . . /_/

   Temporary agency nurses . . . . . /_/

6. Is there initial screening of applicants? . . . Yes /_/ No /_/

   How is it done?_____

   _____

7. Is there initial staff orientation? . . . . . Yes /_/ No /_/

   Is this a formal process? . . . . . Yes /_/ No /_/

   How many hours are required to complete orientation?_____

   Please bring any orientation material.

8. How is staff supported to prevent burn-out?_____

   _____

9. Please bring any written copy of the philosophy of your unit and/or hospital.

10. Please bring a copy of any form, such as a questionnaire, used to evaluate the "success" (e.g. patient satisfaction, financial) of the unit. Also bring any forms used to evaluate nurse, physician, or administration satisfaction.

11. Do you use volunteers? . . . . . Yes /_/ No /_/

How are volunteers used? (give examples) _____

_____

Policy

The following section has been designed to identify oncology unit policies.

1. Who determines the admission policy for your unit?

Nurse supervisor of oncology unit . . . . . /_/

Head nurse of oncology unit . . . . . /_/

Medical director of oncology unit . . . . . /_/

Admission Committee . . . . . /_/

Other_____

Please bring any admission protocol.

2. Do you have a minimum age limitation for patients?
Yes /_/ No /_/

If "yes", what is the limitation? _____

3. Are patients given the choice of being admitted to the oncology unit or elsewhere in the hospital? . . . . . Yes /_/ No /_/

4. Who admits the patient? (Please mark the box that applies.)

Nurse manager of oncology unit . . . . . /_/

Medical Director of oncology unit . . . . . /_/

Any staff physician . . . . . /_/

Admissions officer . . . . . /_/

Please bring any data regarding oncology patients <u>not</u> admitted to unit.

5. Who participates in discharge planning and communicating with the home care services.

Discharge Planner . . . . . /_/

Social worker . . . . . /_/

Physician in charge . . . . . /_/

Nurse . . . . . /_/

Medical Director . . . . . /_/

Other_____

6. Please bring any standard of care guidelines and/or specific policies regarding drug administration on your unit.

7. Who employs and terminates the staff for the oncology unit?

   Head nurse . . . . . /_/

   Supervisor . . . . . /_/

   Assistant Director of Nursing . . . . . /_/

   Director of Nursing Services . . . . . /_/

   Other _____

8. Are patients other than cancer patients ever admited to your unit? . . . . . Yes /_/ No /_/

   What is the average percentage of non-cancer patients in your unit? . . . . . /_/

9. Which of the following types of cancer patients are cared for in your oncology unit?

   Newly diagnosed patients (e.g. requiring further workup or psychosocial support) . . . . . /_/

   Patients in cure-or/control-oriented therapies . . . . . /_/

   Post-surgery cancer patients . . . . . /_/

   Terminal patients . . . . . /_/

   Terminal patients previously cared for on the unit . . . . /_/

Education/Training

1. Is there a specific oncology degree or certification required of nursing staff? . . . . . Yes /_/ No /_/

   If "yes", please describe_____

2. Of you OCU staff, how many have: MN____ BSN_____Diploma _____ Associate Degree_____

3. Is on-going education/training offered for the staff of your unit? . . . . . Yes /_/ No /_/

   If "yes", is it: Inservice___ Specialty Workshops___ Conferences___

   Approximately how many hours per year are provided for:

   Inservice education_____ Conference_____

   Workshops_____

   Please bring any curriculum.

4. How is staff education/training which is provided outside the hospital paid for?

   Individual's responsibility____ Please indicate % of total_____

   Hospital's responsibility_____ Please indicate % of total_____

5. Is the education process multidisciplinary? Yes /_/ No /_/
   interdisciplinary? Yes /_/ No /_/

6. Is there a nursing audit process? . . . . . Yes /_/ No /_/

   If "yes", by whom?_____ How often?_____

Facilities

1. How was the location of your oncology unit determined? Check all of the following that apply:

   Closeness to lab . . . . . /_/

   Closeness to radiation therapy . . . . . /_/

   Access to outside space . . . . . /_/

   Proximity to outside entrance . . . . . /_/

   Proximity to ambulatory service . . . . . /_/

   Within mainstream of hospital . . . . . /_/

   Other_____

   Review minutes of the unit formation discussion to determine what the primary considerations were.

2. How many beds did your unit originally include? . . . . ./___/

3. How many beds do you presently have? . . . . . ./___/

4. If there has been an increase in the number of beds, what was the occupancy rate at the time of the increase (use a 6-month average)_____

5. What is your present occupancy rate (use average of last 6 months)_____

6. Do you have both private and semi-private rooms? Yes /_/ No /_/

   If "yes", how many private rooms? . . . . . ./___/

7. Please check the appropriate box(es) if your unit contains any of the following?

   Examination room . . . . . /_/
   Private guest space . . . . . /_/
   Lounge (only for oncology unit patients, families and visitors). . . . . /_/
   Kitchen facilities (for use by families and/or patients) . /_/
   Library and conference room . . . . . /_/
   Quiet room/screaming room . . . . . /_/
   Overnight accommodations for a family member on unit . . . /_/
   Overnight accommodations for a family nearby . . . . . /_/
   Other_____

8. What services/equipment in the oncology unit are duplicated elsewhere in the hospital?_____

9. Please bring a sketch of your floor plan.

Patient Support Services

1. Please mark the boxes below that describe those patient support options offered by your unit.

   On-going education for patient and family . . . . . /_/
   Who does it?_____
   Out-patient passes for patient . . . . . /_/
   Conjugal visits . . . . . /_/
   Counseling groups for patients and families . . . . . /_/
   Who does it?_____
   Is patient/family education hospital based? . . Yes /_/ No /_/

2. Are community resources (e.g., ACS, Make Today Count, etc.) utilized for patient/family education? . . . . . Yes /_/ No /_/

   Which ones are utilized?_____

Costs

1. Has reimbursement presented any problems? . . . Yes /_/ No /_/

   If "yes", please explain_____

   _____

2. Does reimbursement meet the total costs of the unit?
   Yes /_/ No /_/

   Please bring financial data, if it has been analyzed.

3. What was the initial cost of starting your unit?_____
(Accuracy is important.)

II. PLANNING

1. By which of the following methods was the group chosen to plan your unit:

   A. Internally . . . . . /_/
   Chosen by cancer committee . . . . . /_/
   Appointed by hospital administration . . . . . /_/

   B. Externally (outside consultant group) . . . . . /_/

   C. Mixture of A & B . . /_/ Indicate percentage of A__ and B__

   D. Other_____

2. Please mark the specialty that described each member of that group. (Review minutes and include only actual participants.)

Medical Oncologist . . . /_/	Radiation Oncologist . . . . /_/
Surgical Oncologist . . /_/	Nurse Oncologist . . . . . /_/
Lay person . . . . . /_/	Administrator . . . . . /_/
Pharmacy . . . . . /_/	Dietary . . . . . /_/
Housekeeping . . . . . /_/	Tumor Registry . . . . . /_/

Other_____

3. What is the composition (as example see above) of the cancer committee? List disciplines of each member_____

_____

_____

4. Is your cancer program approved by the American College of Surgeons? Yes /_/ No /_/

If not, what components of a cancer program do you have?

Tumor Registry /_/ Cancer Committee /_/ Tumor Board /Cancer conference /_/

Need

1. Which of the following describes how the need for the oncology unit was determined in your hospital? (Mark those boxes that apply.)

   Interest of M.D.'s . . . . . /_/

   Tumor registry data . . . . . /_/

   Number of new malignancies per year (excluding skin cancer). /_/

   Types of cancer treatment given . . . . . /_/

   Lack of any other oncology unit in HSA District . . . . . /_/

   Patient census . . . . . /_/

   . . . . . past /_/

   . . . . . .present /_/

   . . . . . .projected /_/

   What else?_____

   _____

2. Please bring the most recent annual report from your tumor registry/cancer committee.

3. Does your unit receive memorial gifts? . . . . . Yes /_/ No /_/

   Other philanthropic support? . . . . . Yes /_/ No /_/

4. Does your unit actively promote soliciting such funds?
   Yes /_/ No /_/

APPENDIX B

Note: Unless otherwise noted all references in this Appendix are from the narrative report published by the Oregon Comprehensive Cancer Program following the National Conference on Oncology Units: A Consensus Meeting.

CRITERIA	GUIDELINE
ESTABLISHED AS APPROPRIATE	Oncology units, should be established for cancer patients because they require extraordinary care on a concentrated and continuous basis. The development of an oncology unit should be based on the following guidelines. JCAH, 1979, SCU 2
DEFINITION	In the context of these guidelines and recommendations, the definition of an oncology unit is: "A designated hospital area which facilitates the team approach to comprehensive cancer care by bringing into close proximity those personnel and facilities necessary for such care. The unit must provide not only for the physical needs of the cancer patient, but also for the ongoing emotional, social, and spiritual support of the patient and his/her family." Group III, P. 1
PLANNING Needs Assessment	GUIDELINE: Development of an oncology unit should occur only if there is a population to utilize services. This determination will be made through analysis of data from: - American Cancer Society and American College of Surgeons statistics and studies - Epidemiologic data from state departments of health - Data from regulatory bodies (HSA's & AHA) - Hospital tumor registry data - Medical records data - Quality assurance programs Group III, P. 2 - The presence or absence of similar units in neighboring hospitals should be noted. Group IV, P. 1

CRITERIA	GUIDELINE
PLANNING (cont.) Needs (cont.)	NOTE: It is believed that a minimum of 15% of total medical/surgical admissions for cancer is required to justify establishing an oncology unit. Group III, P. 3
Prerequisite	GUIDELINE: An oncology unit should arise from a pre-existing cancer program. The components of a cancer program include: - an active cancer committee - tumor registry - tumor board - multi-disciplinary consultative services for cancer patients - educational programs related to cancer NOTE: It is strongly recommended that the cancer program be approved by the American College of Surgeons Commission on Cancer Group III, P. 1
Written Philosophy	GUIDELINE: An oncology unit should be developed according to a specific philosophical base. The philosophical statement should address: - specialized needs of acutely and chronically ill cancer patients - realistic achievement of optimal care recognizing physical, social, and spiritual needs - priorities for service, education, education of health care professionals and patients/families, and research activities Group I, P. 1 Group VII, P. 1
Hospice	GUIDELINE: Needs of the terminally ill cancer patient and his family should be addressed by some component of the total cancer program. Incorporation of the hospice philosophy of care may or may not be a component of the oncology unit.

CRITERIA	GUIDELINE
PLANNING (cont.) Hospice (cont.)	NOTE: Hospice is a term describing a philosophical approach to care, and does not refer to a place or environment. Group VII, P. 7
Planning Group	GUIDELINE: Planning for the development and implementation of an oncology unit should be a multi-disciplinary effort. The planning committee should be composed of representatives from: - medical oncology - radiation oncology - surgical oncology (or general surgery) - oncology nursing - hospital administration - pharmacy - tumor registry - dietary - rehabilitation services (PT, OT, etc.) Group VII, P. 5 NOTE: Representatives from other areas or groups may be included depending on individual hospital needs. Maintaining a multi-disciplinary approach is the prime consideration. Group VII, P. 5
SPACE REQUIREMENTS Patient and Family	GUIDELINE: A hospital with an oncology program shall provide adequate physical space to meet the needs of cancer patients and their families. The physical space shall provide: - privacy for the individual (private versus semi-private rooms), if desired - family living space (facilities for overnight stays and access to the kitchen), if desired Group III, P. 3 Group IV, P. 3 & 4
Staff	GUIDELINE: Staff needs for meeting space and lounge shall be included in the planning of physical space for an oncology unit.

CRITERIA	GUIDELINE
SPACE (cont.) Staff (cont.)	In addition, the physical space provided shall promote good traffic flow within the oncology unit. Group III, P. 3 Group IV, P. 3 & 4
Radioactive implants	GUIDELINE: Space for patients with radioactive implants shall be provided on the perimeter or at the end of the oncology unit. Group IV, P. 3 "e"
Outpatient care	GUIDELINE: Out-patient facilities shall be provided as part of the oncology unit or in close proximity. Group IV, P. 3 "f"
ADMISSION Priorities	GUIDELINE: Priorities for admission should be predetermined but in all cases will acknowledge priority status for those receiving chemotherapy and/or radiation therapy and those who would benefit most from the expert oncology nursing care. Other cancer patients will also be admitted in accordance with the policy to admit cancer patients to the same unit for care to promote continuity of care. Group II, P. 1 & 2 Group VII, P. 6
Options	All cancer patients should be informed of their option to receive treatment on the oncology unit, or when feasible, receive treatment provided by an alternate program in the community. Group II, P. 2
Non-Oncology Patient	GUIDELINE: Admission of non-oncology patients to the unit should take place only if the space is not needed by oncology patients. Group II, P. 2

CRITERIA	GUIDELINE
ADMISSION (cont.) Ability to Pay	GUIDELINE: The decision to admit a cancer patient to the oncology unit will be made irrespective of ability to pay. No one will be denied admission to the oncology unit due to insufficient funds. NOTE: This statement was made by the author and does not necessarily reflect the sentiments of the consensus group. This specific issue was not addressed at the conference.
PLANS OF TREATMENT Individual	GUIDELINE: Each hospital should have an identified plan of treatment for each cancer patient recognizing their specialized needs. This individual plan of care should be based on the resources available in the community, in addition to those of the hospital. Group VII, P. 3
Unit	GUIDELINE: Patient care guidelines and procedures should be developed to direct the care of a cancer patient receiving services on the oncology unit. Group VI, P. 4
SERVICES Terminal care	GUIDELINE: The oncology unit should provide services for terminally ill cancer patients requiring comprehensive care on the oncology unit. This care may or may not be based on the hospice philosophy. Group II, P. 3
Rehabilitation	NOTE: Patients requiring long-term care or rehabilitation may be transferred to another unit, care facility, or home. Group II, P. 4

CRITERIA	GUIDELINE

SERVICES (cont.)
Acute Care
	GUIDELINE:
	Most oncology units should provide acute care services including:
	- diagnostic procedures
	- staging procedures
	- active cancer therapy
	  - surgery
	  - radiation
	  - chemotherapy
	  - immunotherapy
	- post surgical care
	- treatment for complications
	- terminal care
	Group II, P. 1

Multiple Treatment Modalities	GUIDELINE: Most oncology units will provide an integrated treatment approach to cancer care that will incorporate all the treatment modalities of surgery, radiation, chemotherapy and immunotherapy. Group II, P. 6
Support Services	GUIDELINE: The following additional services should be available for oncology patients: - diagnostic radiology, including CT scans - IV therapy - tumor registry - dietary services - rehabilitative services (PT, OT, etc.) - respiratory care - social services - pastoral care - home care - hospice care Group III, P. 4, 7 & 8
Discharge Planning	GUIDELINE: Discharge planning for each patient will be initiated at the time of admission to the oncology unit. This planning will include a multi-disciplinary approach with patient and family or significant other, participation. Group III, P. 8, #12

CRITERIA	GUIDELINE
SERVICES (cont.) Discharge Planning (cont.)	NOTE: This statement was made by the author and does not necessarily reflect the sentiments of the consensus group. This specific issue was not addressed at the conference.
Education	GUIDELINE: Education for patients and families is a mandatory service of an oncology unit. Patient education process should begin at the time of diagnosis and continue throughout the disease process. Education should include information regarding therapeutic options for care. Group I, P. 2 Group II, P. 2 & 3
ORGANIZATION OF SERVICES Relation to Hospital	GUIDELINE: Each oncology unit should be well organized and integrated with other units and departments of the hospital. The specialized needs of the cancer patient and family require additional planning and considerations with other departments within an institution. Cooperation with the laboratory, dietary, and the x-ray department for example are important for the overall treatment of the cancer patient. The relationship of the oncology unit to other units and departments of the hospital should be specified within the overall hospital organizational plan.
Administrative Support	GUIDELINE: Proper support from hospital administration, medical staff, and nursing administration should be provided to the oncology unit. Group III, P. 3, 4 & 7
Marketing	GUIDELINE: Administration should market the oncology unit in the community. Group III, P. 7

CRITERIA	GUIDELINE
ORGANIZATION OF SERVICES (cont.)	
Cancer Committee	GUIDELINE: The cancer committee should provide to the oncology unit, overall guidance for goal setting, program planning, and program implementation. Direct supervision of the medical care given on the oncology unit should be the responsibility of the medical director. Group V, P. 5
STAFF	
Communication	GUIDELINE: There should be special mechanisms that foster and promote good communication among all members of the interdisciplinary team. Weekly team conferences dealing with patient care issues and monthly meetings discussing operational issues are recommended. Team members' communication in an informal manner on a daily basis is encouraged. Group V, P. 4
Staffing	GUIDELINE: The oncology unit should be properly staffed according to the nature of anticipated needs of the oncology patient and the scope of services offered by the unit. Staff roles, tasks, and functions should be carefully delineated in the oncology unit and planning for this should take place early. Group V, P. 2
Medical Director	GUIDELINE: The medical director of the oncology unit should have an active interest in treating cancer patients, personal/professional commitment to community where he/she practices and an understanding of the hospital political climate. Group III, P. 5

CRITERIA	GUIDELINE
STAFF (cont.) Medical Director (cont.)	NOTE: Payment for the services of the medical director should be consistent with the hospital policy for similar positions. Group III, P. 5
Nurse Manager	GUIDELINE: A head nurse or nurse manager will assume 24-hour responsibility for supervision of nursing care on the oncology unit. He or she should have education, experience and training in oncology. Group V, P. 1
Primary or Team Nursing	GUIDELINE: Each oncology unit should decide whether primary or team nursing will be used, depending upon the patient and staff needs in the individual units. Group V, P. 65
RN/Pt Ratio	GUIDELINE: Nurse/patient ratio should take into account: - unit size - patient acuity - RN/LPN and RN/aide ratios - type of nursing (primary vs. other) - staff responsibilities (total care including IV's and chemotherapy) NOTE: A minimum of 7.0 nursing care (all nursing staff, RN, LPN, aides, etc.) hours per patient day is recommended. Group V, P. 66
Nursing Staff	GUIDELINE: Nursing staff should have an acknowledged dedication to the care and treatment of cancer patient and his/her family and - previous background in medical-surgical nursing - an interest in expanding a knowledge base with some commitment for self-development - self-support systems and outside interests

CRITERIA	GUIDELINE
STAFF (cont.) Nursing Staff (cont.)	NOTE: Other personal qualifications including self-confidence, sound concept of self and good communication skills were felt to be important. However, it was not determined how these attributes could be measured. Group V, P. 67
Screening Interview	GUIDELINE: Oncology nurses should be involved in discussions on the following issues during the screening for hire interview: - the philosophy that cancer is a chronic rather than terminal illness - the intellectual base required for effective cancer management needs constant updating - identification of stressors relating to the care of dying patients and their families - identification of the unique demands on the oncology nurse - identification of the unique rewards of oncology nursing Group VI, P. 1
Compensation	GUIDELINE: Consideration for compensating the oncology nurse by providing support and nurturance should include: - financial compensation over and above regular staff nursing salary - mental health time off - rotation to other parts of the oncology program - flexible scheduling of work hours Group V, P. 8-9
ORIENTATION & EDUCATION OF STAFF Medical Continuing Education	GUIDELINE: Medical staff members, and house staff, who provide patient care on the oncology unit should participate in relevant education programs or activities on a regular basis.

CRITERIA	GUIDELINE
ORIENTATION & EDUCATION OF STAFF (cont.) Medical Continuing Education	NOTE: This statement was made by the author and does not necessarily reflect the sentiments of the consensus group. This issue was addressed,but no statement was included in the report.
Orientation of Nursing Staff	GUIDELINE: All nursing personnel should be prepared for their responsibilities on the oncology unit through appropriate orientation. The orientation program should be flexible enough to ensure that the individual needs of the orientee will be recognized. Group VI, P. 1
Orientation Program Content	GUIDELINE: The orientation program should include the following topics: - pathophysiology of cancer and its complications - pharmacology and administration techniques for chemotherapy administration - radiation safety and management - instruction in special nursing techniques (e.g., venous and arterial lines) - psycho-social support of the cancer patient and family - principles of self-care, e.g. prevention of burnout - introduction to the roles of ancillary staff - lists of oncology resources, personnel/material
On-going Nursing Education	GUIDELINE: All nursing personnel should participate in ongoing, continuing education. Group III, P. 6
Administrative Support for Nursing Education	GUIDELINE: Hospital administration should provide reasonable opportunities and funding for oncology staff to attend oncology programs given in locations other than in the hospital. Group VI, P. 5

CRITERIA	GUIDELINE
ORIENTATION & EDUCATION OF STAFF (cont.)	
Nurse Instructors/ Nurse Preceptors	GUIDELINE: Each oncology unit should determine whether staff nurses, head nurses or clinical specialists will provide individualized instruction to new nurses on the unit. In addition, each new oncology nurse should have a designated preceptor. Group VI, P. 2 #2
Continuing Education for Nurses	GUIDELINE: All oncology unit nursing personnel should participate in relevant in-service education programs based on a review of the cancer nursing literature and a survey of nursing staff needs for continuing education. Some programs should result in long-term planning. Group VI, P. 4
Interdisciplinary Team Input	GUIDELINE: The interdisciplinary team should be involved in suggesting topics for continuing education for the nursing staff. Group VI, P. 4
CERTIFICATION	GUIDELINE: Oncology units should support the National Oncology Nursing Society in it's efforts to develop a certification process that would be standardized and recognized on a national level. NOTE: No guidelines were developed regarding the board certification for medical staff. Group VI, P. 7
EVALUATION Quality of Care	GUIDELINE: Quality of care on the oncology unit should be routinely assessed and the oncology unit should participate in hospital-wide audits. Group VI, P. 6

CRITERIA	GUIDELINE
EVALUATION (cont.) Utilization	GUIDELINE: Utilization on the oncology unit should include a study of: - physician referral patterns to unit occupancy rates - lengths of stay - utilization of specific services - staff satisfaction with program effectiveness NOTE: Patient and family satisfaction with care on the oncology unit was not addressed by the consensus meeting, however, it remains an important concern. Group III, P. 9

AN ABSTRACT OF THE THESIS OF JEAN REYNOLDS HOUSE

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TITLE: ONCOLOGY UNIT GUIDELINES AND COMPLIANCE OF SELECTED UNITS

APPROVED: [redacted]

Julia S. Brown, Ph.D., Professor

The creation of oncology units in hospitals across the country is increasing with the specialization of medical and nursing care. Little research has been conducted to date to describe or to analyze the characteristics of these units, their planning, implementation or evaluation. A National Conference on Oncology Units:A Consensus Meeting was held in Portland, Oregon in May, 1981, in an attempt to develop recommendations for the development of oncology units designed to provide comprehensive specialized care for cancer patients and their families.

The recommendations of the seven task groups of the Conference were reported in narrative form. One of the purposes of the present study was to convert these narrative reports into a readily usable and precise set of Guidelines. This was accomplished by adopting the format developed by the Joint Commission on Accreditation of Hospitals for Standards for Special Care Units. In this format key concepts are identified and specific guidelines related to those topics are formulated.

Another purpose of this study was to describe the "state of the art" of medical and nursing practice on oncology units to serve as a

basis for later comparative studies. This purpose was accomplished through analysis of survey material provided by 42 Conference participants regarding components of their units. The characteristics of these units and the process of their development as revealed by the survey data were then compared to the characteristics and process recommended by the Guidelines.

Findings of this study indicate that current practice on oncology units as of May 1981 was generally based on a cancer program recognized by the American College of Surgeons as meeting basic minimums. Major discrepancies between survey data and Guidelines were identified in the areas of planning, multidisciplinary participation in many areas, provision of privacy for patients and care for family, and RN/patient care staffing ratio. Strengths of these selected units were most evident in the area of education for staff and patients. Lack of data collection in several important areas made it impossible to determine the degree of overall congruence of practices and policies of the surveyed units with those recommended in the Guidelines.

This study provides some important baseline information for health care professionals dealing with oncology units in any stage of development. Further tool development and study are recommended to answer many questions that this study has generated.