Chemotherapy-related toxicities are common and often undertreated, and can decrease patients’ quality of life (Groopman & Itri, 1999; Hassett, O’Malley, Pakes, Newhouse, & Earle, 2006; Lindley et al., 1999; Lyman & Kuderer, 2002; Patrick et al., 2002). A review of data on 12,239 women with breast cancer treated with chemotherapy found that serious adverse events requiring emergency care or hospitalization occurred in 16% of patients—higher than the average rate typically reported for a large clinical trial (Hassett et al.). Common causes of hospitalization included infection and fever (8%); neutropenia or thrombocytopenia (5.5%); electrolyte disorders, such as dehydration (2.5%) and nausea or diarrhea (2.4%); fatigue, dizziness, and related conditions (2%); deep venous thrombosis or pulmonary embolism (1.2%); and malnutrition (0.9%).

Quality improvement programs can be used to improve management of chemotherapy-related toxicities before they become serious enough to require hospitalization (Davis, Thomson, Oxman, & Haynes, 1995). Studies show that effective quality improvement strategies, such as sending reminders and increasing outreach visits, have been implemented by physicians (Davis et al.; Tu & Davis, 2002). Few programs, however, (Fortner, Okon, Ashley, et al., 2003; Malin et al., 2006; Rosenbaum et al., 2004; Smith & Hillner, 2001) have tapped into nurses’ potential to become involved in and focused on implementing quality improvement programs in community oncology practices, where more than 80% of patients with cancer are treated (Herzlinger, 2002). Successful quality improvement programs included interventions with multiple educational strategies that require engaging activities across different levels of professional practice and extend over time with iterative feedback (Davis & Taylor-Vaisey, 1997). Program evaluations included measures of the implemented processes, patient health, and professional practice outcomes.

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