The Creation of a Chemo Council

Michele E. Gaguski, MSN, RN, AOCN®, CHPN, APN-C

Given the ever-changing and growing complexity of chemotherapy regimens, oncology nurses are called upon to be active participants and patient advocates in administering, monitoring, and safely handling chemotherapy. They are required to possess knowledge and demonstrate clinical expertise in all aspects of caring for patients receiving chemotherapy. Forming a chemo council exceeds the basic requirements in nursing chemotherapy competency. In addition, nurses are empowered to influence clinical practice and policy development, provide peer support and education to novice oncology nurses, and collaborate with other disciplines (e.g., pharmacy, patient and family education councils) to ensure safe and best practices for patients. This article will describe one institution’s experience in creating a chemo council.

Shared Governance

Shared governance is a major component of the philosophy of Ocean Medical Center in Brick, NJ, because it is a Magnet® accredited community hospital. The inpatient oncology unit has various shared governance project teams that collaborate to implement best practices for patients with cancer and their families. Porter-O’Grady (2005, p. vii) suggested that “nurses need to create a forum for discussion and establish mechanisms that will facilitate the profession’s response to whatever demands emerge.” Through a shared governance model, oncology nurses have a conduit in which to articulate their concerns, voice areas for change and improvement, and play a role in the solution. The concept of shared governance has remained an elusive concept but implies “the allocation of control, power, or authority (governance) among mutually (shared) interested and vested parties” (Stichler, 2005, p. 9). The vested parties in nursing are those who practice nursing by providing direct patient care or work in management or administrative settings where clinical nursing care is provided. Both share a common goal of quality nursing care for patients (Stichler). In today’s high-tech oncology environment, quality and safety are paramount to achieving positive patient outcomes, and at the center of success is the oncology staff nurse.

Development

The concept to build a chemo council developed when nursing staff voiced concerns during a staff meeting over delays in chemotherapy delivery and unfamiliarity with certain dose-intensive therapy regimens. The oncology clinical nurse specialist (CNS) suggested that a council be formed to openly discuss and seek solutions. The nursing staff readily agreed.

Following the staff meeting, the CNS posted an invitation on the unit announcing the first meeting date. The meeting was to be held at two times to accommodate day- and night-shift staff interested in becoming part of the council. Understanding that the role of the pharmacy is critical to the chemotherapy process, the CNS took the opportunity to invite the pharmacy manager to attend.

Several staff nurses, the pharmacy manager, and the CNS participated in the first meeting. The CNS served as the facilitator and recorded meeting minutes. The meeting started with brainstorming to set goals and identify barriers. Nursing staff spoke freely about the challenges they face in the clinical area regarding chemotherapy. As the CNS listened to their concerns, she recorded ideas on a flip chart. The CNS then asked the pharmacy manager’s view on chemotherapy practice and added the comments to the flip chart. The activity allowed both disciplines to listen to each other and visualize the barriers, areas for improvement, and positive aspects not requiring change at the time. After the dialogue, the team set forth prioritizing and setting goals.

The next step entailed discussion of the roles and responsibilities of being a member of the council (see Figure 1). Questions included: Who will arrange meetings? Can staff conference call in? How often should we meet? Which topic should be worked on first? How will other staff be informed of our progress? Under a shared governance model, staff is encouraged to be part of the decision-making process as well as play an integral part in the implementation of the team’s work.

Initiatives

The council decided that any oncology staff nurse could join the team as well as other allied healthcare disciplines involved with influencing best practices of chemotherapy (e.g., dietary, pharmacy). Based on the brainstorming feedback, the top priorities identified by the council after the first meeting were (a) developing a chemotherapy nursing flowchart; (b) obtaining, streamlining, and enhancing access to current patient and family education regarding chemotherapy and the diagnosis of cancer; and (c) strengthening the...
collaboration with pharmacy through clinical policy development for chemotherapy. Other initiatives discussed included developing a chemo topic of the month for regimens rarely seen on the inpatient unit and addressing the late admission times of patients that resulted in administration of chemotherapy on the night shift. Those and other goals are still a work in progress for the council.

Flowchart: Development of a chemotherapy nursing flowchart (see Figure 2) was undertaken by the council to provide a quick reference tool for novice nursing staff involved with chemotherapy. The tool also was used as a “hand-off” form during the nurses’ shift-to-shift report. The use of the flowchart allowed the receiving nurse to be aware of which steps in the chemotherapy process had been completed by the previous nurse. Standardizing hand-off communication is a national patient safety goal set forth by the Joint Commission. The Joint Commission (2009) standard emphasized that organizations must define, communicate to staff, and implement a process in which information about patient, client, and resident care is communicated in a consistent manner. The flowchart was developed over several months and based upon the Oncology Nursing Society’s (ONS’s) (Polovich, White, & Kelleher, 2009) Chemotherapy and Biotherapy Guidelines and Recommendations for Practice. Final approval for use of the form was provided by the oncology nurse manager. The council members took the lead on educating their peers on the value and use of the flowchart. The flowchart also was laminated and placed in the medication room on the bulletin board as a reference for all nursing staff. The chemotherapy nursing flowchart supplements the independent double-check process for chemotherapy orders while serving as a communication tool between nurses to ensure safety standards occurred at all steps during the process. The flowchart has been well received by the oncology nursing staff according to verbal and written feedback.

Patient and family education: The next priority set by the council was to establish a designated area for patient and family education. The council reviewed the current patient and family educational materials for accuracy, reading level, and currency of the data presented. They also reviewed pamphlets, books, and drug information sheets; discarded outdated materials; composed a list of needed information by categories (e.g., symptom management, types of cancer, support resources); and divided categories among the members. Each member had the responsibility of obtaining new teaching material. The revision took approximately three to four months to complete, which included finding reputable sites for patient education, cost (most new materials were free of charge from many organizations, such as the American Cancer Society, Cancer Care, and the National Cancer Institute), ordering, delivery, and determining location and space allocation for the new supplies.

When all of the new materials arrived, the council members organized the education materials. One of the members donated a used filing cabinet where the most frequently ordered chemotherapy drug information sheets from the Lexicomp® database at the hospital were alphabetized and organized. The council ordered pamphlet holders and shelf organizers for the two five-tier bookshelves in the conference room on the unit. The organization occurred during monthly meetings. When the new area was completed, the council decided that staff and other disciplines should be made aware of the patient and family education area. The council members named the area “The Oncology Resource Corner” and developed a flier to market the opening for oncology staff as well as other disciplines throughout the hospital. This was important because patients with cancer are sometimes admitted to nononcology units (e.g., telemetry) and staff may need to find current information about cancer care in a timely manner.

The opening included refreshments provided by the council members and was held in the evening. Other highlights included a ribbon-cutting ceremony, a tour of the new layout of patient education material (e.g., ONS Putting Evidence Into Practice cards, viewing of a family educational DVD on hospice care, pre-made chemotherapy folders for patients receiving their first cycle). The opening even included a tour for members of the hospital’s Patient and Family Education Committee.

Pharmacy: The council’s ongoing commitment is to collaborate with pharmacy to ensure best practices during the chemotherapy administration process. Pharmacy attends the meetings quarterly, and an open discussion is held surrounding any concerns. Items of discussion have included a review of chemotherapy agents requiring a filter, retrospective chart reviews of patients who have received chemotherapy to identify adherence to hospital policy, and active participation in revision of the hospital-based parenteral chemotherapy practice policy with ONS guidelines.

In the early stages of policy development, the chemo council members brainstormed for areas that could benefit from improvement. The practice policy has been approved and incorporated into nursing and pharmacy clinical care. The next project for the council will be to contribute to the development of an oral chemotherapy administration and management policy for oncology and nononcology settings.

Conclusion

The chemo council serves as a resource to oncology staff regarding cancer care education, evidence-based practice, and practice policy. Staff can turn to the council for concerns and questions and provide suggestions for future projects. A council member reports progress at monthly staff meetings, writes a small article and submits for publication in the unit’s shared governance newsletter entitled The POST-IT (Progress in Oncology Shared Governance Teams: Innovation and Teamwork), and places highlights of the team’s accomplishments on the unit’s shared governance bulletin board. The council is supported in its efforts by the oncology nurse manager who promotes self-scheduling and advocates for participation in shared governance by all nursing staff. Pharmacy colleagues voiced positive feedback regarding their involvement with the council and share
Chemotherapy orders are received.

Step 1
RN reviews order for clarity, completeness, appropriateness, legibility, timing, and contraindications (includes consent).

RN has addressed all areas noted in Step 1.
RN initials: __________

Step 2
RN reviews appropriate diagnostic data for chemotherapy regimen and reports abnormal findings to physician (may include, but not limited to, complete blood count with differential, liver function test, multigated acquisition scan, pulmonary function test, etc.).

RN has addressed all areas noted in Step 2.
RN initials: __________

Step 3
RN reviews each chemotherapy agent in the regimen, dosage parameters, and indications and verifies appropriateness for patient diagnosis and height and weight (i.e., body surface area is correct).

RN has addressed all areas noted in Step 3.
RN initials: __________

Step 4
RN reviews premedications, including antiemetics based on antiemetic potential, hydration, and diagnostic testing (urinalysis, uric acid, etc.) as indicated by the prescribed chemotherapy regimen.

RN has addressed all areas noted in Step 4.
RN initials: __________

Step 5
RN confirms appropriate route of administration for chemotherapy regimen (presence and function of venous access device and appropriate blood return, ability to ingest oral medications).

RN has addressed all areas noted in Step 5.
RN initials: __________

Step 6
RN confirms that patient, family, and significant other education has been completed and documented in medical record. RN confirms that chemotherapy education has been provided to the patient.

RN has addressed all areas noted in Step 6.
RN initials: __________

Step 7
RN confirms correct patient identification with another RN by using two patient identifiers as per institution policy. RN confirms that dosages, indications, and calculations are correct with another chemotherapy-competent RN and verifies on the chemotherapy order form.

RN has addressed all areas noted in Step 7.
RN initials: __________

By initialing in the boxes above, the RN is verifying that all elements in that step of the chemotherapy process have been addressed.

RN signature: ____________________________
RN signature: ____________________________
RN signature: ____________________________

Figure 2. Chemotherapy Administration Algorithm Oncology Nursing Process Flowchart

Note. Courtesy of Ocean Medical Center. Used with permission.
council outcomes at their respective staff meetings. The oncology CNS serves as a catalyst, facilitator, and active participant in the council while motivating council members to reach toward goals that ultimately will enhance patient care on the oncology unit and elevate oncology nurses’ knowledge level and skill in the process. Shared governance allows oncology nurses to feel empowered to create practice changes, challenge the status quo, and build personal leadership qualities for one common goal: ensuring quality cancer care.

The author acknowledges the following members of the chemo council: Tracy Brazetis, RPh, Mary Brandsema, RN, BSN, OCN®, Lani Gernalin, RN, BSN, OCN®, Elizabeth Martinez, RN, BSN, OCN®, and Nicole Strasko, RN.

Author Contact: Michele E. Gaguski, MSN, RN, AOCN®, CHPN, APN-C, can be reached at megcns@comcast.net, with copy to editor at CJONEditor@ons.org.

References

The author takes full responsibility for the content of the article. The author did not receive honoraria for this work. Gaguski has participated on the speakers bureau for ELISA Pharmaceutical and sanofi aventis. The content of this article has been reviewed to ensure that it is balanced, objective, and free from commercial bias. No financial relationships relevant to the content of this article have been disclosed by the author or editorial staff.