A collaborative interprofessional team of healthcare providers from a regional comprehensive community cancer program established standardized chemotherapy and immunotherapy preadministration documentation in the electronic health record. This quality improvement project facilitated adherence to administration considerations defined within Oncology Nursing Society chemotherapy and immunotherapy guidelines and established organizational accreditation goals. The goal was to foster safe and seamless patient-centered care.

**AT A GLANCE**
- Interprofessional healthcare providers can utilize teamwork and collaboration to create standardized, evidence-based processes to optimize chemotherapy and immunotherapy documentation.
- A centralized location in the electronic health record to document treatment plan and schedule, diagnosis, laboratory work within administration needs to include the following components:
  - Diagnosis
  - Drugs, including accurate dosing
  - Protocol, with or without deviation
  - Correct route
  - Treatment plan and schedule
  - Signed consent
  - Accurate height and weight or body surface area (BSA)
  - Laboratory work within administration parameters
  - Completed patient education
  - IV access device and site assessment for patency and condition

Adherence to the dual verification process minimizes professional liability and maximizes patient safety.

**Opportunity for Improvement**
The interprofessional improvement team at PRMCE observed variation in medication preadministration practices on their 34-bed inpatient medical oncology unit. Lack of comprehensive documentation and adherence to the Oncology Nursing Society (ONS) recommendations and guidelines for chemotherapy and immunotherapy administration generated safety and liability concerns (LeFebvre & Smith, 2019). Informal prechecks were completed on paper and not integrated as part of the electronic health record (EHR). Patient-specific information related to treatment tolerance, protocol deviations, and dose adjustments were not consistently communicated verbally or documented electronically across all stages of care and clinical settings. Without a centralized location in the EHR, this lack of documentation provided a significant opportunity for improvement (Bakshi & Trivedi, 2018).

The quality improvement project goals included (a) standardization of preadministration documentation with dual provider verification and (b) centralization of relevant information in the EHR. This project was implemented during a 13-month period with a primary aim of developing a reliable mechanism for tracking individual patient tolerance, side effects, and complications.

**Project Interventions**
An interprofessional team was formed to implement a standardized process using evidence-based interventions for chemotherapy and immunotherapy documentation (Cantril et al., 2019). The EHR