Article Provides Excellent Review of Chemotherapy Safety

I am an associate degree RN working full-time on an inpatient medical/oncology unit. What a great article your journal published in the August 2009 issue. “Safe Handling of Hazardous Drugs: Are You Protected?” (Nixon & Schulmeister, 2009) was an excellent review of the gold standards for safe chemotherapy handling. Initially, chemotherapy was given in an acute-care setting. Currently, the outpatient setting is the typical venue to deliver antineoplastic agents. Still, some chemotherapy is given as an inpatient procedure, but infrequency is the issue. This article did an excellent job defining what drugs are considered hazardous, guidelines for handling said drugs, and risks surrounding exposure to cytotoxic agents; it concluded with ideas for staff training and education.

It is easy to feel comfortable giving hazardous drugs if a nurse’s job is administering these day after day. That comfort leads to a relaxation of the safety guidelines. On the other hand, antineoplastic agents are not given on a routine basis, noncompliance may not be due to comfort, but rather overlooked because of the infrequency of the task. Guidelines regarding administration of these drugs may be forgotten by nursing or not readily available. This article is exceptional, not only for the information provided, but for the format as well. Each of the figures can be enlarged, laminated, and displayed in a prominent area of the medication room, thus allowing staff to review standards for safety prior to administering chemotherapy.

I found it disturbing that measurable levels of hazardous drugs were detected on the counters of nursing stations, on infusion pumps, and in the urine samples of oncology nurses, indicating that safety precautions were not being followed. Eisenberg (2009) stated that because no acceptable level of exposure exists for any antineoplastic agent, prevention and minimal contamination should be the goals of all healthcare workers.

Compliance appears to be the pivotal issue in regard to safe handling of medications. In addition to the suggestions made in the article by Nixon and Schulmeister (2009) to bolster compliance, Eisenberg (2009) added suggestions, such as keeping personal protective equipment (PPE) in a convenient location, providing an adequate supply of PPE, and educating nurses that putting on PPE is worth the extra time and effort. Communication and education are two key elements in keeping healthcare workers safe when handling hazardous drugs.

I have already shared the information from this article with my peers and received positive feedback. I want to thank you for sharing this important information with the nursing community.

Darlynn Venne, RN RN to BSN student Saint Anthony College of Nursing Rockford, IL

Evidence Does Not Support the Use of a Neutropenic Diet

In recent years, several excellent articles have illustrated the use of research to guide evidence-based practice. Guided by such exemplars, we have successfully implemented a change in our practice by eliminating the use of the neutropenic diet on an inpatient hematology/oncology unit. The nursing unit primarily administers induction and consolidation therapies in a nonrestrictive environment for adults with refractory or relapsed leukemia or lymphoma.

Nutrition is a vital component to immune functioning and quality of life for patients with cancer. Historically, most oncology centers have used neutropenic guidelines, which incorporate stringent dietary restrictions thought to minimize patients’ exposure to infectious agents. Accordingly, our medical and nursing staffs have educated patients regarding these neutropenic dietary restrictions. However, there has been recent attention to these standards in terms of their basis in research. Therefore, in an effort to implement the use of evidence-based practices into our oncology center, a committee of nursing staff was formed to review the literature regarding the efficacy of the neutropenic diet.

Using the search terms neutropenic diet, oncology dietary restrictions, and low microbial diet in the PubMed and CINAHL® databases, we found and reviewed 12 relevant journal articles concerning the use of neutropenic diets in settings similar to ours. We learned that the introduction of neutropenic dietary

References

restrictions began with irradiated and autoclaved foods in the 1960s as an effort to reduce the introduction of bacteria into the gastrointestinal tract of neutropenic patients. However, this clinical practice initiative had no scientific basis (Restau & Clark, 2008). Of particular interest was the finding that 78% of 120 acute-care facilities surveyed stated that they used some form of dietary restriction with neutropenic patients (Restau & Clark). Seventy percent of those facilities also educated patients regarding dietary restriction at discharge. Across all articles was a lack of standardization for dietary restrictions in acute-care facilities (DeMille, Deming, Lupinacci, & Jacobs, 2006; Nirenberg et al., 2006; Smith & Besser, 2000; Wilson, 2002).

Therefore, based on the findings and recommendations, the committee proposed the implementation of a non-neutropenic diet for our patient population. The proposal was unanimously accepted by the unit dietitian and hematology/oncology attending medical staff. Following, nursing and food service staff received education regarding implementation of the change, and a date was set for initiation. Additionally, patient education materials were developed for instruction on safe food handling, preparation, and storage. This change in practice was communicated throughout the inpatient and outpatient settings to ensure consistency in practice.

Since the implementation of the non-neutropenic diet in December 2008, standard monitoring of monthly infection rates continues, with no change noted. As expected, the Press Ganey scores for patient satisfaction regarding meal choices increased from 42.9% to a high of 75%. With a nine-month average of 61.5%, the increase in patient satisfaction with meals has resulted in an average increase of 20%. Interdisciplinary staff feedback regarding implementation of the change has remained positive.

In summary, through implementation of evidenced-based practice guidelines, we have successfully eliminated neutropenic dietary restrictions and replaced them with patient education regarding food hygiene and safe food handling.

Sarah Tarr, BSN, RN, OCN®
Deborah H. Allen, MSN, CNS, FNP-BC, AOCNP®
Duke University Medical Center
Durham, NC

References

My Visit With Big Tobacco
In May of this year, I found myself in a very unlikely place: I attended the shareholders meeting for Reynolds American Inc., the manufacturer of Camel and Natural American Spirit cigarettes and Grizzly chewing tobacco. As a member of Nightingales Nurses (www.nightingalesnurses.org), I was representing the thousands of oncology nurses and patients with cancer affected by tobacco use. Nightingales Nurses are a group of nurse activists who work to focus public attention on the behavior of the tobacco industry and its contribution to the preventable epidemic of tobacco-caused disease and death.

I arrived in Winston-Salem, NC, late the night before the meeting. Two other Nightingales picked me up and drove me around town. We drove past the Winston Café, the Camel Pawn Shop, and the Salem Funeral Home and Crematory. The Reynolds American buildings were tall with large, red, neon letters at the top. Heavy fog had rolled in and gave the buildings an ominous look, as if Disney had designed the city as a set. Barricades were already in place to control traffic and any protesters. The levels of well-orchestrated intimidation had already started.

Arriving at the building the next morning, we were met by uniformed police on the sidewalk; this was the first of five security checkpoints we had to pass to enter the meeting. The chairperson started the meeting by going through a list of accomplishments the company had experienced, the growth of certain cigarette lines, and the growth in certain markets. It was at this moment that I realized what a surreal experience I was having. Here I sat as an oncology nurse who had cancer myself, a daughter whose parents both had lung cancer, a daughter who held her mother as she died from lung cancer. For a minute, I did not hear the speaker.

I listened to a Franciscan clergyman introduce a resolution on the issue of social justice in not marketing to the poor. A group of college students asked for action on Green Tobacco Sickness in farm workers. One of the Nightingales submitted a resolution for a commitment to not add nicotine or addictive additives to future products. I wondered whether I had anything to offer or whether I could make any difference. I reached into my purse and pulled out the picture I had brought of my parents and remembered why I was there—to honor their lives and the lives of the hundreds of people with cancer for whom I have cared. I got up and walked to the microphone. As it turned out, the time allotted for questions and answers ended before it was my turn to speak. The chairperson did not recommend voting for any of the resolutions presented, and none was passed, but the number of votes for support increased from the previous year.

Even though I did not get the chance to speak at the microphone, I spoke just by being there. My presence as a nurse was known to big tobacco, and I bore witness to the suffering and death that these products have brought upon so many families, including my own. I plan on attending this meeting again, and next time, I will be better equipped to express my message, and I will take the picture with me again. It is my hope that, over time, hundreds of other nurses will join me there. Someday, when as a profession we are finally able to see the scale of this preventable disease epidemic and its corporate sources, we will be glad to have been among those who stood up against it.

Janice Ross, RN, MSN, OCN®, CBCN®
Manager
Olcott Center For Cancer Education
Bloomington, IN
Study on Veterans and End of Life May Reveal Gender Differences

I appreciated the well-done study and your reporting of the data in “Nebraska Veterans’ Preferences for End-of-Life Care” (Freeman & Berger, 2009). I’m sorry for the low response rate. However, I believe very strongly in your comment in the summary that the “results may have been influenced more by gender . . . than by veteran status.” Perhaps putting all of the men (veterans and non-veterans) in one group and all the women (veterans and non-veterans) in another group and comparing the two would result in another valuable set of observations.

In my 30 years of experience in medical and radiation oncology and 15 in medical ethics, I find that men are less verbal about fear of dying, are less likely to discuss it (except possibly with the spouse), are less likely to have an advanced directive or living will, and have greater hope that a doctor would be open to frank discussions than a spouse or other about all end-of-life issues.

It is interesting that the differences you note are not terribly different in each of your categories (although statistically they are). But one could not prejudge anyone based on their military status alone.

C. Ronald Koons, MD, FACP
Clinical Professor of Medicine
Member, Ethics Committee
University of California, Irvine
Mission Viejo, CA

Reference

The Author Responds

I sincerely appreciate Dr. Koon’s insightful response to the information presented in the article. The total 2006 survey respondents were 60% female and 40% male. The suggestion to conduct further analysis to determine differences in the responses based on gender is an excellent one, and I will forward it to the Nebraska Hospice and Palliative Care Partnership. I also thank you for your comment and reinforce the message that health professionals should not prejudge someone based on military status alone. Our role is to ensure honest, open, and truthful communication with each patient and family regarding end-of-life care planning.

Shanna L. Freeman, MSN, APRN-NP, CCRN
RN
Veterans Affairs Medical Center
Omaha, NE