Commission on Cancer

A multidisciplinary program of the American College of Surgeons

Quality Improvement Best Practices
In CoC-Approved Cancer Programs

Quality Improvement: Development of a lymphedema support group.
Implementation Date: 2006

The physical therapy department identified the need for improved education and psychosocial support for patients suffering from lymphedema. This issue was presented by the representative from physical therapy and discussed at the December 2005 cancer committee meeting. The committee recommended that a lymphedema support group should be formed to address the needs of lymphedema patients. On March 15, 2006 a physical therapist certified in lymphedema screening and treatment facilitated the first lymphedema support group meeting with 30 patients in attendance.

Quality Improvement: Purchase and use of a PET scan.
Implementation Date: 2005

The physicians at our facility identified a need for improved imaging of tumors. On January 5, 2002, the representative from diagnostic radiology presented this issue to the cancer committee. The committee decided that a new scanning machine such as a PET scan was needed to improve imaging techniques. On 10/01/2005, a PET scan was purchased and installed. On 12/15/06, the first patient was scanned.

Quality Improvement: Opening an Infusion Center.
Implementation Date: 2006
Many patients were complaining of long wait times to be seen for infusion. It was determined that there were too many patients for the number of infusion rooms currently available. The representative from nursing presented this issue to the cancer committee on September 15, 2002. The members of the cancer committee agreed that this issue needed to be addressed and forwarded to administration. Administration agreed that additional infusion rooms were needed. On January 30, 2003, an infusion center was opened to the public. This increased the number of infusion rooms from 10 to 30 and decreased patient wait times by 1 hour.

Quality Improvement: Implement software system to manage Radiation Oncology Services.
Implementation Date: 2004
Selected, purchased and a system to manage scheduling, billing and statistical reports for Radiation Oncology. The system runs the accelerators, sets the initial parameters of treatment (size of area to be treated, orientation of machine), and drives the multi-leaf collimators. The System benefits patients by functioning as a second check for treatment parameters resulting in a decreased margin of error in treatment protocols. It eliminates the use of individual treatment discs, reduces errors in billing, can interface with the hospital billing system and supports IMRT as a new treatment modality.

Quality Improvement: Medication delivery/Chemotherapy administration.
Implementation Date: 2005

1) Deletion of current documentation system.
2) Development and implementation of "template" or standard orders for chemotherapy, sickle cell, pain
   management, antibiotic, etc.
3) Defined "paper system" for documentation of chemotherapy including time line following administration and responsible person at each step in process.
4) Initiated development of "quick reference" material for care givers on the unit.
5) Incorporated this education with each new employee orientation and annual competency days.
   Outcome: 0.09 percent medication error rate (national is 0.1 percent)

Quality Improvement: Pain/Pain Standards.
Implementation Date: 2005

In 2005, a review of policies/procedures, education materials, and tools for pain management were completed. After a thorough review of the literature in 2001, a pain tool/scale for children, infants, and confused patients was adopted, and the general pain scale was updated from 0-5 to 0-10. Several pain protocols were condensed to one. Policies/procedures were updated to reflect national guidelines/literature review. House-wide education to professional staff on the misconceptions of pain and pain assessment took place in March-April 2001. Patient satisfaction of pain management continues to be monitored.

Quality Improvement: Site-specific cancer conference.
Implementation Date: 2006

Prostate and bladder are two of five most frequent sites of cancer seen at this facility. Established a genitourinary cancer conference where these cases can be presented to a multi-disciplinary group of oncology specialists for treatment planning.

The first GU Cancer Conference was held in September, 2001 and is held twice a month.

Quality Improvement: Keep in touch.
Implementation Date: 2006

Web-based initiative began with regular e-mail newsletters to community subscribers regarding cancer news, cancer screening, and educational programs.

Quality Improvement: Assessing patient satisfaction for Oncology Unit and Radiation Oncology.
Implementation Date: 2004

Observation: Need tool to monitor and track satisfaction with delivery of care from patient perspective.

Implementation: Utilize facility-wide patient satisfaction survey for every patient discharged from service. Returned surveys processed by Outcomes Measurement Department and sent to respective areas for review.

Outcome: Included in Oncology Dashboard (scorecard) for reporting to cancer committee at quarterly meetings. Ongoing process.

Quality Improvement: Chemotherapy infusion complications.
Implementation Date: 2004

Ambulatory home 22-hour chemotherapy infusions had multiple complications requiring calls at night, return visits to the clinic, and inaccurate delivery of chemotherapy. A checklist was developed that required two RNs to verify the pump settings and to assure that the pump has cycled prior to the patient's discharge. Staff education was done as well as the development of a patient instruction sheet, which is given to every patient. Since using of the checklist, the complications have decreased from 45 percent to < 5 percent. This checklist is now used on 100 percent of the pump infusions and is a permanent part of the patient's chart.

Quality Improvement: Standardized use of anti-emetics.
Implementation Date: 2005

Standardized use of anti-emetics with all six physicians in the cancer center. The physicians and RNs developed standardized protocols for anti-emetics based on literature review and ASCO and NCCN guidelines. Educational efforts were done with the staff and patient and instructional sheets were developed for home anti-emetics post-chemotherapy. Thirty charts were audited monthly on use of these standardized order sheets. Compliance over the year showed an increase from 73 percent during the first quarter of 2001 to 95 percent during the last quarter of 2001. Patient’s nausea/vomiting remains controlled by patient’s self-reports or follow-up phone calls at 24 hours post-treatment.