

# Innovation in



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2017 Annual Report

## Oncology Inpatient Nursing Care Plans

With the patient being at the core of nursing practice, the nurse utilizes the nursing process to establish a nursing care plan that meets the patient's needs. The nurse uses an organized approach to collect data about each patient and formulates a nursing diagnosis. This diagnosis is the nurse's clinical judgment about the patient's response to his or her current health situation. Based on the nursing assessment and nursing diagnosis, the nurse establishes specific goals for the patient focusing on outcomes. The assessment, diagnosis and goals are the basis of the nursing care plan that, in turn, is implemented and evaluated. The nursing care plan is continuously evaluated and revised as the patient's status changes. Creating an individualized nursing care plan helps to improve patient outcomes.

With cancer patients, the nurse should address the patient's specific needs along with any issues surrounding chemotherapy and/or radiation. The nursing care plan helps to provide direction and promote continuity of care among caregivers.

It was noted in 2016 that only 48.25 percent of the nursing care plans for hospitalized oncology patients were specific and relevant to the needs of the cancer patient.

### Criteria Used in the Study

- The nursing care plan for oncology patients admitted to the second floor was reviewed by the nursing manager to determine if the patient's specific and relevant needs were being addressed.

- Each nursing care plan was evaluated based on whether the assessment, analyzing/nursing diagnosis and planning were appropriate.
- The assessment portion was evaluated to determine if the subjective and objective data were present to support the nursing diagnosis. Items reviewed were the patient's history, physical assessment, laboratory findings and any other pertinent data.
- The analyzing/nursing diagnosis portion was evaluated to determine if the nursing diagnosis was supported by clearly stated subjective and objective data along with the patient's problems.
- The planning portion was evaluated to determine if the interventions documented were derived from the problem statement of the nursing diagnosis. The patient's goals were to be clearly stated, measurable and realistic. In addition, the goals were to be supported by data and the nursing diagnosis. Also, patient education was to be addressed along with referring the patient to social work or the chaplain as appropriate.

### Findings

- The baseline for 2016 was 48.25 percent, which revealed more than half of the oncology patients did not have a nursing care plan that was specific and relevant to their needs.

- The concurrent review revealed that from January–July 2017, the percentage was 0 percent and 50 percent respectively. During this period, the clinical manager diligently educated the nursing team regarding how to formulate a very specific nursing care plan for an oncology patient. Examples of oncology specific nursing care plans were reviewed with the staff. The staff was instructed to consider the physical and emotional impact cancer has on patients. The manager provided the nursing team with information on the role of the social worker, chaplain and navigator in caring for oncology patients. If the patient could benefit from those referrals, it should be included in the nursing care plan.
- There was a drastic increase in the percentage of oncology patients having a very specific care plan in August 2017, reaching 100 percent.
- The study did show this improvement was sustained over the next two months, September–October 2017, with 100 percent of nursing care plans being very specific for oncology patients.

### National Benchmark

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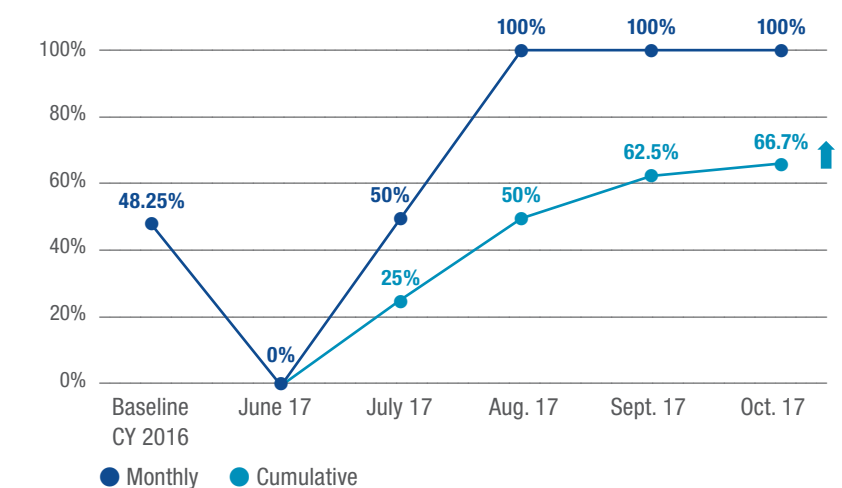
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### Percentage of Appropriate Care Plans



### Strategies offered for future implementation:

- Orientation for new nursing team members joining the second floor will include factors to consider when devising a nursing care plan for an oncology patient.
- Orientation for new nursing team members joining the second floor will include education on the effects of chemotherapy and radiation therapy on patient and family.
- Annual oncology nursing competencies will include a review on development and implementation of the oncology specific patient nursing care plan.

# Reducing the Average Number of Days from Treatment Plan Agreement to Chemotherapy

A new cancer diagnosis can be confusing and overwhelming to the patient and family. This is compounded by the patient beginning a new treatment regimen that is unfamiliar. Waiting to begin treatment can increase the patient’s anxiety and can hinder the patient’s recovery process.

It was noted that it took a prolonged number of days between when an oncology patient started his or her chemotherapy and when he or she agreed on the treatment plan. The average number of days noted from October through December 2016 was 7.7 days but increased to 12.7 in January 2017. The goal was to decrease the average number of days to 5 by October 2017.

An oncology nurse navigator served as a resource to both the nursing team and to the patient to begin chemotherapy as soon as possible and to help with overcoming barriers to care. With appropriate identification of obstacles to beginning timely chemotherapy, the nurse navigator could work with appropriate members of the treatment team to expedite the patient’s care.

## Action Taken

This project included a Plan/Do/Check/Act (PDCA) plan to improve the average number of days from when the patient agreed upon the treatment plan to the start of chemotherapy.

Initial plans included mapping the current process to identify barriers to beginning chemotherapy in a timely manner. Many of the delays were attributed to the oncologist not consistently placing the “intent to treat” orders, which impacted insurance verification. Without insurance verification, the initiation of chemotherapy could be delayed. In addition, it was identified that the port-a-caths (port) were not being placed timely by interventional radiology (IR).

PDCA Cycle #1	
<b>Plan</b>	To improve the oncologist completing the “intent to treat” order.
<b>Do</b>	Nurse navigator to daily monitor new patients and remind oncologist to complete all “intent to treat” orders by the end of the day.
<b>Check</b>	February: Average number of days decreased to 11.4 from 12.7 in January.
<b>Act</b>	Nurse navigator to continue to remind the oncologist to enter “intent to treat” orders by the end of each day and meet with interventional radiology.

PDCA Cycle #2	
<b>Plan</b>	It was also noted that some delays were related to getting the patient’s port placed. IR was not always receiving the required documentation (progress note and order) in a timely manner.
<b>Do</b>	Improve timeliness of patients getting their port placed: <ul style="list-style-type: none"> <li>■ Nurse navigator met with IR to understand their workflow.</li> <li>■ IR required the oncologist’s progress note stating the need for the port along with the order.</li> <li>■ Nurse navigator to obtain required documentation and fax to IR by the end of the day for all new chemotherapy patients.</li> <li>■ Nurse navigator to call IR to ensure required documentation is received and port placement is scheduled.</li> </ul>
<b>Check</b>	March and April: Average number of days decreased to 7 and 7.7 respectively.
<b>Act</b>	Nurse navigator to provide IR with the required documentation by the end of each day. Include “pending” chemotherapy patients in weekly chart rounds.

PDCA Cycle #3	
<b>Plan</b>	It was discovered that even though the patient had received insurance verification and his or her port was placed, there was not always an open slot to begin administration of chemotherapy in the infusion center.
<b>Do</b>	Beginning in June, the nurse navigator began including “pending” patients, those who were to begin chemotherapy, in weekly chart rounds. This allowed the infusion center to tentatively add those patients to the chemotherapy schedule.
<b>Check</b>	The last five months, June–October, the average number of days have ranged from 3 to 4.8 days, meeting the goal of decreasing the average number of days to 5 by October 2017.
<b>Act</b>	Continue with current process.

## Outcomes and Takeaways

Interdisciplinary communication is vital to improving the care for our patients. By working with the oncologist to enter “intent to treat” orders in a timely manner for insurance verification, working with interventional radiology to get ports placed in a timely manner, and including “pending” patients in weekly rounds, we were able to begin chemotherapy in less than 5 days once the treatment plan was agreed upon.

Utilizing the nurse navigator to facilitate the various steps necessary for initiation of chemotherapy is a critical factor in expediting treatment.

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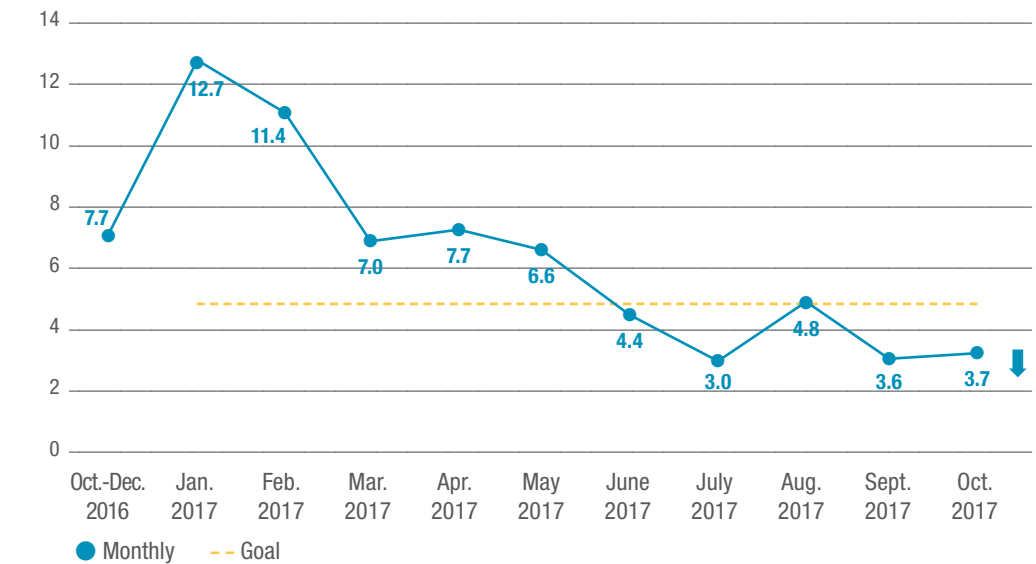
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Average Number of Days Between Treatment Plan Agreement and Start of Chemotherapy



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# Reduction of Red Blood Cell Transfusions

The American Association of Blood Banks (AABB) published guidelines in 2012 and included clear recommendations to minimize transfusions and that a restrictive hemoglobin pattern seems to improve outcomes in most patients. Blood transfusions that do not meet AABB guidelines may expose patients to potential infections and noninfectious risks and healthcare costs.

A Study of Quality was conducted in 2016 and the reduction of red blood cells (RBCs) administered without AABB guidelines was at an average of 36 percent (12/33) for the year. Monthly compliance ranged from 100 percent in February to 0 percent for the last three months of the year. The purpose of this project is to continue with process improvement to support sustainability of reducing the percentage of packed red blood cell (RBC) transfusions, where more than one unit is given without AABB guidelines, to an average of less than 25 percent by September 2017.

A task force was created to look at the percentage of cancer patients receiving more than one unit of packed red blood cells without AABB guidelines. The team evaluated the obstacles and prioritized improvements with greatest impact to reduce routine administration of RBCs out of AABB guidelines in stable patients, with Hb >7g/dl (8g/dl for patients with significant cardiac issues).



## Evaluation

An overall reduction in transfusing red blood cells to cancer patients decreased by 69 percent from the prior year. The total number of red blood cell transfusions in 2016 was 33 units, and in 2017 it had decreased to only 16 units. The average number of units administered without AABB guidelines decreased to 25 percent for 2017, meeting the established goal. It was noted that the prior year, 2016, 36 percent of units were given without AABB guidelines, resulting in a 36 percent decrease for 2017. There were four months where all red blood cell transfusions were given consistent with AABB guidelines.

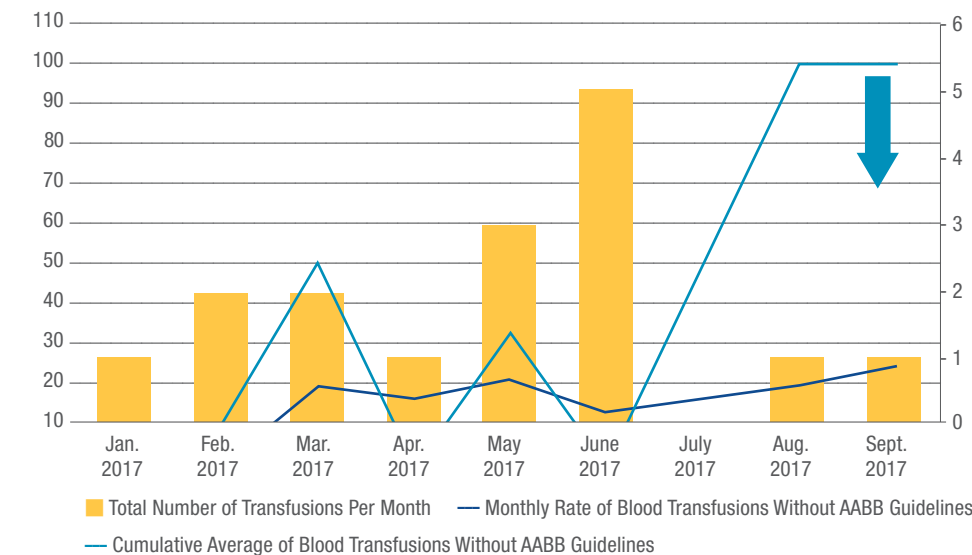
## Discussion

The team acknowledged that with the decreased number of red blood cells being transfused it is important to evaluate any deviations from the criteria as soon as possible.

## Next Steps and Lessons Learned

Any educational opportunities to the medical staff should be conducted in a timely manner.

## Reduction of Red Blood Cell Transfusions



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# Cancer Registry

	CoC Benchmark	CoC State of Texas Performance Rate	My CoC Program Type (CCP)	CoC Census Region (West South Central) Performance Rate	All CoC Programs Performance Rate	Baylor Scott & White – Waxahachie Performance Rate		
	2016 Forward	Diagnosis Year 2015 (CoC)				2014*	2015*	2016**
<b>Breast Cancer</b>								
<b>BCS: Breast Conservation surgery rate</b> for women with AJCC clinical stage 0, I, or II breast cancer (Surveillance Measure)	NA	58.1%	70.3%	59.1%	66.2%	61.8%	57.1%	71.9%
<b>NbX: Image or palpation-guided needle biopsy</b> (core or FNA) is performed for the treatment of breast cancer (Quality Improvement Measure - Released Spring 2014)	80.0%	92.1%	91.3%	91.2%	91.8%	92.7%	89.4%	94.4%
<b>HT: Adjuvant Hormonal Therapy:</b> Tamoxifen or third generation aromatase inhibitor is considered or administered within 1 year (365 days) of diagnosis for women with AJCC T1cNoMo, or Stage II or III hormone receptor positive breast cancer (Accountability Measure - Released Fall 2008)	90%	82.7%	90.8%	84.4%	92.1%	100.0%	100.0%	92.6%
<b>MASTRT: Radiation therapy</b> is considered or administered following any mastectomy within 1 year (365 days) of diagnosis for women with >= 4 positive lymph nodes (Accountability Measure)	90.0%	78.3%	86.1%	79.6%	88.2%	100.0%	100.0%	100.0%
<b>BCRST: Post Breast Conserving Surgery Irradiation:</b> Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 and receiving breast conserving surgery for breast cancer (Accountability Measure - Released Fall 2008)	90.0%	84.9%	89.7%	86.5%	91.7%	94.0%	94.4%	94.1%
<b>MAC: Adjuvant Chemotherapy:</b> Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cNoMo, or Stage II or III hormone receptor negative breast cancer (Accountability Measure - Released Fall 2008)	NA	87.7%	93.1%	89.8%	93.0%	100.0%	100.0%	100.0%
<b>Colorectal Cancer</b>								
<b>ACT: Adjuvant Chemotherapy:</b> Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis to patients under age 80 with AJCC III (lymph node positive) colon cancer (Accountability Measure - Released Fall 2008)	NA	75.3%	88.1%	78.8%	88.2%	100.0%	85.7%	100.0%
<b>12 RLN: Surgical Resection Includes at Least 12 Lymph Nodes:</b> At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer (Quality Improvement - Released Fall 2008)	85%	92.5%	89.4%	91.8%	92.1%	94.1%	100.0%	90.0%
<b>Rectal Cancer</b>								
<b>RECRCT: Pre-operative chemo and radiation</b> are administered for clinical AJCC T3N0, T4N0, or Stage III; or postoperative chemo and radiation are administered within 180 days of diagnosis for clinical AJCC T1-2N0 with pathologic AJCC T3N0, T4N0, or Stage III; or treatment is considered; for patients under the age of 80 receiving resection for rectal cancer (Quality Improvement - Released Spring 2015)	85%	86.8%	88.1%	85.7%	87.7%	No Data Available	No Data Available	50.0%
<b>Gastric</b>								
<b>G15RLN: At least 15 regional lymph nodes</b> are removed and pathologically examined for resected gastric cancer (Quality Improvement - Released Fall 2014)	80%	62.3%	45.1%	60.5%	61.5%	100.0%	No Data Available	No Data Available

	CoC Benchmark	CoC State of Texas Performance Rate	My CoC Program Type (CCP)	CoC Census Region (West South Central) Performance Rate	All CoC Programs Performance Rate	Baylor Scott & White – Waxahachie Performance Rate		
	2016 Forward	Diagnosis Year 2015 (CoC)				2014*	2015*	2016**
<b>Non-Small Cell Lung</b>								
<b>10RLN: At least 10 regional lymph nodes</b> are removed and pathologically examined for AJCC Stage 1A, 1B, IIA, and IIB resected NSCLC (Surveillance Measure - Released Fall 2014)	NA	47.1%	38.3%	47.4%	47.7%	No Data Available	No Data Available	No Data Available
<b>LNoSurg: Surgery</b> is not first course of treatment for cN2, M0 cases (Quality Improvement)	85%	91.3%	93.8%	92.3%	92.3%	100.0%	No Data Available	No Data Available
<b>LCT: Systemic chemotherapy</b> is considered or administered within 4 months to the day pre-operatively or day of surgery to 6 months postoperatively or surgically resected cases with pathologic lymph node positive (pN1) and (pN2) NSCLC (Quality Improvement - Released Fall 2014)	85%	81.8%	89.0%	84.4%	90.8%	No Data Available	No Data Available	100.0%
<b>Cervix</b>								
<b>CBRR: Use of brachytherapy</b> in patients treated with primary radiation with curative intent in any stage of cervical cancer (Surveillance Measure - Released Spring 2015)	NA	61.2%	55.1%	65.9%	69.7%	No Data Available	No Data Available	No Data Available
<b>CERRT: Radiation therapy</b> completed within 60 days of initiation of radiation among women diagnosed with any stage of cervical cancer (Surveillance Measure - Released Spring 2015)	NA	82.5%	76.8%	80.9%	79.7%	No Data Available	No Data Available	No Data Available
<b>CERCT: Chemotherapy</b> administered to cervical cancer patients who received radiation for Stages IB2-IV cancer (Group 1) or with positive pelvic nodes, positive surgical margin, and/or positive parametrium (Group 2) (Surveillance Measure - Released Spring 2015)	NA	94.9%	93.2%	92.9%	89.7%	No Data Available	100.0%	No Data Available
<b>Endometrium</b>								
<b>ENDLRC:</b> Endoscopic, laparoscopic, or robotic performed for all endometrial cancer (excluding sarcoma and lymphoma), for all stages except Stage IV (Surveillance Measure - Released Fall 2015)	NA	67.1%	68.1%	69.2%	77.2%	No Data Available	No Data Available	0.0%
<b>ENDCTRT:</b> Chemotherapy and/or radiation administered to patients with Stage IIIc or IV endometrial cancer (Surveillance Measure - Released Fall 2015)	NA	71.0%	77.8%	75.1%	83.3%	No Data Available	No Data Available	No Data Available
<b>Ovary</b>								
<b>OVSAL:</b> Salpingo-oophorectomy with omentectomy, debulking/cytoreductive surgery, or pelvic exteneration in Stages I-IIIc ovarian cancer (Surveillance Measure - Released Fall 2015)	NA	62.3%	51.6%	64.0%	70.2%	0.0%	No Data Available	No Data Available
<b>Bladder</b>								
<b>BL2RLN:</b> At least 2 lymph nodes are removed in patients under 80 undergoing partial or radical cystectomy (Surveillance Measure - Released Spring 2016)	NA	91.3%	81.4%	93.5%	92.7%	No Data Available	No Data Available	0.0%
<b>ABLCSTRI:</b> Radical or partial cystectomy; or tri-modality therapy (local tumor destruction/excision with chemotherapy and radiation) for clinical T234N0M0 patients with urothelial carcinoma of the bladder, first treatment within 90 days of diagnosis (Surveillance Measure)	NA	50.3%	45.7%	55.1%	59.5%	No Data Available	0.0%	No Data Available
<b>BLCT:</b> Neo-adjuvant or adjuvant chemotherapy recommended or administered for patients with muscle invasive cancer undergoing radical cystectomy (Surveillance Measure)	NA	57.3%	66.7%	54.8%	66.2%	No Data Available	No Data Available	No Data Available
<b>Kidney</b>								
<b>PD1RLN:</b> At least 1 regional lymph node is removed and pathologically examined for primarily resected unilateral nephroblastoma (Surveillance Measure)	NA	No Data	No Data	No Data	95.2%	No Data Available	No Data Available	No Data Available

\*Data Source: Data results released by the Commission on Cancer National Cancer Data Base

\*\*Data Source: Baylor Scott & White – North Texas Cancer Registry. Data results pending release by the Commission on Cancer National Cancer Data Base.



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