

THERE MUST
BE A BETTER
WAY!



An Inpatient and Outpatient Nursing Collaborative Improves the Patient Experience

SwedishAmerican Health System is a division of UW Health of Madison, Wisconsin. SwedishAmerican Hospital is a 333-bed acute care facility located in Rockford, Ill., serving a population of approximately 300,000. In 2012, SwedishAmerican Regional Cancer Center opened its doors, providing outpatient radiation and chemotherapy treatment in a state-of-the-art facility that serves north central Illinois, south central Wisconsin, and the surrounding regions. The new Regional Cancer Center merged two medical oncology practices, bringing eight medical oncology and two radiation oncology providers together into one location. Along with the opportunity for SwedishAmerican Regional Cancer Center to offer new oncology services to our community came great responsibility to deliver excellent quality care.

A Sea Change in Care Setting

In the United States today, most cancer care is provided in the outpatient setting. SwedishAmerican Regional Cancer Center provides only about 20 percent of cancer care and less than 10 percent of chemotherapy administration in the inpatient setting. Despite this shift toward cancer care in the outpatient setting, as healthcare professionals we need to understand and continuously advocate for quality patient care by not losing focus on the importance of inpatient oncology—even when it occurs infrequently.

In fiscal year 2012, SwedishAmerican Regional Cancer Center began looking at ways to incorporate the American Society of Clinical Oncology Quality Oncology Practice Initiative (QOPI) data into its newly formed patient care model. It soon found that though QOPI works well for the outpatient oncology setting, it does not translate as well to the inpatient setting. Using QOPI standards in clinical decision making, the Regional Cancer Center

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documented strong performance in its annual quality report within the outpatient setting, but it was unable to quantify performance in inpatient oncology.

At SwedishAmerican, we saw this challenge as an opportunity. How could we measure and build our inpatient oncology department to provide high-quality, patient-centered care from a highly competent and a highly skilled nursing staff? How could we keep our nursing and support staff competent and skilled in chemotherapy administration when chemotherapy is given so infrequently? How should leadership prepare and respond for attrition and burnout of our inpatient nursing and support staff when oncology is only part of what we do? And most of all, did our patients see inpatient and outpatient care as two parts of one larger team or as two separate entities?

Identifying Issues and Areas for Improvement

In 2015 I began working at the Regional Cancer Center as the medical oncology supervisor. As part of my responsibilities, I represented nursing on the Continuous Quality Improvement Committee. This committee team helped me to understand QOPI measures and how our team could work together to improve quality measures as a health system. From a departmental perspective, nurses from both the inpatient and outpatient settings shared several concerns with the quality of education provided to oncology patients, including the following:

Lack of Patient Education Resources for Inpatient Nursing Staff. During a time when information is the most meaningful for our cancer patients—often at first diagnosis—inpatient nurses lacked access to appropriate educational resources. At SwedishAmerican, inpatient education was driven by the discharge process and the information needed for discharge. Though our discharge planners would say that the discharge process begins on the day of admission, no one could clearly identify what information was given to oncology inpatients before or after diagnosis. Although we had star performers in our system who went above and beyond to assist in any way they could, patient education was not standardized or quantifiable. Therefore, compliance in measuring education was nonexistent, which our Continuous Quality Improvement scorecard confirmed.

At this point in the care continuum, when patients and families needed information, inpatient nurses scrambled to assemble a packet of information printed from the Internet or from materials found on someone's desk or in a filing cabinet. These well-intentioned attempts to provide patients with information took nurses away from the bedside when minutes were precious. Nursing staff felt strongly that having a source of meaningful, easy-to-understand information for patients at the time of diagnosis was very important. Though some patients would use the information right away, others might prefer to review the information later, but they would have everything in one place.

No Hand-off Process from the Inpatient to the Outpatient Setting. Lacking a connection to these newly diagnosed patients, outpatient nurses often did not know when these patients would be coming for their outpatient treatment. Without a clear handoff process, our outpatient nurses felt that they were sometimes scrambling to prepare patients at the last minute—in terms of both patient education and required prior authorization. Although our chemo coordinators prepared each day for next-day chemotherapy patients, despite everyone's best efforts, patients sometimes fell through the cracks.

Inconsistent Predischarge Resources for Patients. In addition to the lack of patient education available in the inpatient setting, outpatient nurses reported that patients were not always given all of the resources needed prior to discharge. Nursing staff understood that patients needed to stay as healthy as possible

prior to their next treatment, but the process was not there to ensure that this was occurring. All nurses agreed that patients needed to have a basic understanding of why it was important to stay hydrated and combat nausea and vomiting with an antiemetic, yet patients were frequently discharged without any oncology prescriptions in hand. Patients needed to know how to use pain medication appropriately or why a prescription for a simple antibiotic is necessary when their white blood cell counts were low.

Bottom line: We needed to establish processes and improve communication between inpatient and outpatient nursing.

Another challenge identified in the discharge process was that at times inexperienced nurses were working with the hospitalists or primary care physicians responsible for oncology patient discharges.

Establishing the Oncology Collaboration Committee

SwedishAmerican Hospital and the Regional Cancer Center became a Magnet-designated facility in 2015, bringing with it a strong, nursing-led structure of shared governance. With a focus on this new shared governance, management from the inpatient and outpatient oncology departments formed the first Oncology Collaboration Committee with representation of nursing staff from both settings. As drivers for quality, this team used a foundation of American Society of Clinical Oncology and Oncology Nursing Society guidelines, as well as Press Ganey scores for measurements of care delivery and patient education. The Oncology Collaboration Committee had two initial goals:

1. To standardize patient information and education across the continuum of care, regardless of entry point.
2. To ensure that nursing staff along the oncology care continuum had an adequate foundation of knowledge and skills to deliver safe, patient-centered, high-quality care.

Breaking Down Communication Barriers

The Oncology Collaboration Committee identified two transition issues with the potential to make a big impact. The first was identified by our outpatient physician assistant. During her new oncology patient appointments, which were set aside for patient education, she found that new patients lacked medication resources after discharge from the inpatient unit. She confirmed that our

newly diagnosed oncology patients who had been recently hospitalized were not discharged with pain, antiemetic, or antibiotic prescriptions. During a discussion at our new monthly Oncology Collaboration Committee meeting, inpatient nurses quickly identified the issue. All inpatient discharges are the responsibility of the hospitalist or the primary care physician—not the specialty physicians. The hospitalists were unfamiliar with the small details and potential needs of oncology patients prior to their first outpatient appointment. Another challenge identified in the discharge process was that at times inexperienced nurses were working with the hospitalists or primary care physicians responsible for oncology patient discharges.

After a brief discussion, the committee arrived at a simple solution: laminated reminders on computers in the nursing station. These helped ensure that inpatient nurses obtained prescriptions for an antiemetics, pain medication, or antibiotics when patients' white blood cell counts were low prior to discharge, providing relief for patients prior to their first appointment at the outpatient clinic. This simple yet effective tool has greatly improved care coordination for our oncology patients. Additionally, the Oncology Collaboration Committee identified a need for better education for patients and inpatient nurses. The committee worked with the inpatient management team to provide necessary education for staff, ensuring that patients not only received their prescriptions but also understood when to take them. The next step was to provide instructions to patients regarding when they should notify their oncologist of potential issues.

The second challenge the committee tackled was the transition from inpatient to outpatient care and what that looked like from the patient's perspective. We clearly had logistical issues because the outpatient clinic and the hospital are 8 miles away from each other, but the bigger concern was how to overcome communication issues. The hospital and the outpatient clinic use different electronic health records, making communication a challenge. The hospital was slated to move to the same electronic health record as the outpatient clinic but not until the summer of 2018. For a variety of reasons, our clinic providers did not have an easily identifiable way to "report out" to nurses any new patient consults that occurred after hours or on weekends and holidays. Additionally, with staff turnover from shift to shift, inpatient nurses did not have an easy way to communicate with outpatient nurses.

To address these transition challenges, the Oncology Collaboration Committee developed the Situation, Background, Assessment, and Recommendation (SBAR) Tool (Figure 1, right). The committee decided that the inpatient nurse would fill out the SBAR tool after the patient's last inpatient chemotherapy treatment, signifying the transition to the outpatient setting. The SBAR form needed to be brief enough to ensure compliance from the inpatient nurse but long enough to include vital information needed by outpatient nurses. The committee settled on information such as chemotherapy consent, the date chemo education was completed, the patient's tolerance to chemotherapy, and an open-ended question for the inpatient nurse to share additional relevant

Figure 1. Chemo Collaboration Project: Chemo SBAR Tool

Patient: _____
DOB: _____
Was this patient's first treatment? (Circle) YES / NO
Do you have a chemo consent? (Circle) YES / NO
Who did their chemo teach? _____
Did patient receive binder? (Circle) YES / NO
Type of treatment given: _____
Number of treatments given inpatient: _____
How did patient tolerate treatment: _____
Symptom management: _____
Prescriptions nurse is sending home with patient: _____
Any other significant information: _____ _____
Fax SBAR and Chemo Consent to Attention of Dr. _____
Nurse _____

information. At the bottom of the form are clear instructions that completed forms should be faxed directly to the outpatient clinic nurse's station for evaluation.

This simple yet highly effective tool has helped tremendously to bridge care across the continuum. In addition to basic patient information and treatment scheduling, we could now communicate how the patient tolerated treatment. If inpatient nurses believed that special considerations or accommodations should be shared, those items could be included on the SBAR. With this tool in place, inpatient nurses could now "hand off" their patients knowing that both patient and nurse concerns would be addressed; outpatient nurses gained respect for the care their patients received on the inpatient unit. This small victory gave us momentum to tackle the additional challenges ahead.

Improving Patient and Staff Education

The Oncology Collaboration Committee focused next on our goal of improving education for oncology patients and nursing staff. For oncology patients, the committee was challenged with providing standardized, customizable, easy-to-understand education. Prior to these efforts, outpatient oncology education consisted of a purchased information packet that was not specific to patient diagnosis or to our organization. As stated previously, on the inpatient unit, oncology patients received only the standard hospital discharge information and whatever information the discharge nurse had time to print out for them.

As the committee identified additional concerns, the team felt strongly that standardizing oncology and chemotherapy administration education for nursing should be a high priority. At that time, chemotherapy education for staff was not standardized or developed by the hospital or clinical education teams. Instead, this education was occurring as a “passed-down” form of orientation that left many potential education gaps and exposure to staff attrition. Additionally, the annual skills for inpatient nursing and support staff did not include oncology or chemotherapy updates or competencies. For these reasons, the team expanded the target to not only standardize but also to improve staff education. By investing in our staff, the Oncology Collaboration Committee felt confident that we could provide sustainability to the entire program. Committee members were all familiar with the health system’s current practice of printing and reviewing the After-Visit Summary and the Inpatient Discharge Summary with patients. The Oncology Collaboration Committee brought these forms (and the process for how they are filled out and how information is provided to patients) to the Regional Cancer Center’s Patient and Family Advisory Council, a group of patients and/or family members of former patients dedicated to improving the oncology patient experience.

This group’s unanimous recommendation: refine our patient education and make it more meaningful and understandable. As examples, several members of the advisory council shared valuable information that had been provided to them, such as beautiful brochures that were never used because they did not understand the content or significance or did not understand how to prioritize the information. Council members also explained how overwhelmed they had been by the volume of information they received and how they were unsure how to organize it. With these recommendations in mind, the Oncology Collaboration Committee identified three opportunities for improvement:

1. Create one source of patient education for inpatient and outpatient settings by consolidating information.
2. Standardize nursing staff education that overlapped into both inpatient and outpatient settings.
3. Identify educational opportunities that could be accomplished by inpatient and outpatient nurses in partnership, including new staff orientation and annual skills and competencies.

By focusing on these three goals, the Oncology Collaboration Committee envisioned a delivery of seamless care for the oncology

patient across the continuum that would be sustainable over time and adaptable to ever-present changes.

Developing a Patient Education Binder

Our first step to standardize and consolidate patient education was to develop an oncology patient education binder, representing all departments and including information on nutrition, symptom management, a section for keeping labs organized, and a personal journal section for jotting down notes for the provider or personal reflections. The Patient and Family Advisory Council advised us to keep the standard oncology binder simple. We decided to start the binder with generic information that any oncology patient would need, such as commonly used telephone numbers and a glossary of oncology terms. We also included a triage section with information on when a patient needed to be seen immediately by the provider, when he or she should call to notify the provider of an issue, and when he or she could wait until his or her next provider visit to discuss. Next, additional material specific to the patient’s diagnosis would be included in the binder.

Our team reviewed those areas that we felt represented the “minimum” or “basic” understanding of oncology care for a new patient. We decided that all binders would include information from both the inpatient and outpatient perspectives, because our patients often experience care in both settings. For the section on Symptom Management, we included common information about reactions or concerns specific to a patient’s condition, allowing for additional materials as needed. As holistic caregivers who treat mind, body, and soul, our binder also provides information on how to optimize physical health postdiagnosis with simple exercises such as meditation and relaxation. In the process, we focused on balancing information for immediate and future use; for example, including information on exercise for when patients are feeling well and on energy conservation for when they are not. Because concurrent therapy is not used for all diagnoses, we chose not to include information on radiation therapy in the basic oncology binder. More in-depth information can be added by radiation oncology staff, tailored to the patient’s diagnosis and treatment plan.

The Oncology Collaboration Committee reached out to each department for information to add to the binder and reviewed all submissions to keep the material simple and appropriate for all diagnoses. Looking back, we would recommend that your team develop these guidelines in the beginning; starting this project with all departments simultaneously was an opportunity to build strong communications that we missed.

The final version of the patient education binder was presented to the Patient and Family Advisory Committee and received an enthusiastic “thumbs-up.” We initially piloted the binder to 10 patients and were able to follow up with 9 of them. All 9 patients found the binder easy to understand and helpful to their care. Based on those findings, the patient education binder went into production and was assembled by volunteers at the cancer center.

Standardizing Staff Education, Reducing Attrition

Oncology Collaboration Committee staff were often asked to be preceptors or to sit on committees that developed education for current staff and new staff orientation. The first issue our team identified was that the current method of educating new staff in the inpatient setting left us at great risk of staff attrition. As nurses left our organization, fewer nurses were being prepared for inpatient oncology care. In addition, the team was not certain that all areas of education were being met. In other words, inpatient nurses were left to wait for the hospitalization of oncology patients to gain skills from treating them.

Thus, we prioritized standardizing our approach to educate our inpatient nurses. The outpatient clinic was realizing great success with onboarding new nursing staff by leveraging our affiliate partnership at the UW Carbone Cancer Center in Madison, Wisconsin. The UW Carbone Cancer Center offered a three-day chemotherapy administration course four times a year that included a competency exam and a mock chemotherapy administration practicum. As a UW affiliate, this course is available to our inpatient and outpatient clinic nurses at no cost, resulting in a strong foundation for nurses new to chemotherapy administration. The committee decided that oncology education for both inpatient and outpatient nursing staff should begin with this course.

After nurses successfully completed the course, observation and return demonstration of chemotherapy administration would be conducted at the outpatient Regional Cancer Center. This process allows inpatient nurses an opportunity to immediately follow up on their education and complete their competency. As part of the process, nurses complete a check-off sheet to ensure that all information was understood and a proper return demonstration was completed.

At the same time, inpatient nurses complete a tour of the outpatient cancer center to gain a better understanding of the care process from the oncology patient's perspective. This visit gives inpatient nurses an opportunity to meet outpatient clinic nurses, helping to build ties as we work together. The experience prepares nurses to assist patients in understanding changes that happen when moving from the inpatient to the outpatient care setting, as well as what remains the same regardless of where care is delivered. Our experience is like a bedside nurse giving a nurse-to-nurse report when one goes off duty. This improved communication allows nurses the opportunity to praise nursing staff in both care settings. "Don't worry, Mr. Jones, you will be in excellent hands at the Regional Cancer Center. You will meet Kate, Kristin, and many of the other nurses, and I know they will take great care of you." These types of conversations are a great comfort to patients as they transition into the next phase of their care journey.

Looking Ahead

Eighteen months after establishing the Oncology Collaboration Committee, we have seen improvement on our Continuous Quality Improvement scorecard. We now provide consistent patient education through the oncology education binder and quantify the education provided to our inpatient oncology patients. Through implementation of the SBAR tool, we are now able to track our inpatients, providing a hand-off process for patients moving from the inpatient setting to the outpatient clinic setting. We have also sent more inpatient nurses to UW Health in Madison for training and to the Regional Cancer Center for follow-up training. The cancer center has seen a progressive climb in its Press Ganey scores, especially regarding how patients feel about their oncology education.

Nurses must act as bridges—building strong, healthy, collaborative teams that work together in delivering excellent patient-centered care.

As the Oncology Collaboration Committee looks to next steps, we will seek to widen our scope to all care areas that oncology patients may encounter. We are actively working with several areas and departments within our health system, such as interventional radiology, pharmacy, and surgery. We want the patient education binder to encompass every touchpoint in the hospital, as well as the outpatient clinic, to help patients understand their purpose. In staff education, we want to ensure that chemo handling is safe and up to date in all hospital departments.

Leadership needs to be diligent in hiring inpatient nurses who are interested in becoming part of a core group of oncology nurses, supporting nursing staff obtaining certification and providing guidance to the entire team. Nurses must be excellent collaborators across all care settings and departments. We need to first help others understand how we are connected by our patients and why good communication is imperative to high-quality, patient-centered care. We need ongoing evaluation of the effectiveness of our communication to be strong patient advocates. Developing new quality improvement processes on our own care islands will not work. Nurses must act as bridges—building strong, healthy, collaborative teams that work together in delivering excellent patient-centered care. 🗨️

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