The Creation of a Chemo Council

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Given the ever-changing and growing complexity of chemotherapy regimens, oncology nurses are called upon to be active participants and patient advocates in administering, monitoring, and safely handling chemotherapy. They are required to possess knowledge and demonstrate clinical expertise in all aspects of caring for patients receiving chemotherapy. Forming a chemo council exceeds the basic requirements in nursing chemotherapy competency. In addition, nurses are empowered to influence clinical practice and policy development, provide peer support and education to novice oncology nurses, and collaborate with other disciplines (e.g., pharmacy, patient and family education councils) to ensure safe and best practices for patients. This article will describe one institution’s experience and best practices for patients with chemotherapy competency with certain dose-intensive therapy regimens. The oncology clinical nurse specialist (CNS) suggested that a council be formed to openly discuss and seek solutions. The nursing staff readily agreed.

Development

The concept to build a chemo council developed when nursing staff voiced concerns during a staff meeting over delays in chemotherapy delivery and unfamiliarity with certain dose-intensive therapy regimens. The oncology clinical nurse specialist (CNS) suggested that a council be formed to openly discuss and seek solutions. The nursing staff readily agreed.

Following the staff meeting, the CNS posted an invitation on the unit announcing the first meeting date. The meeting was to be held at two times to accommodate day- and night-shift staff interested in becoming part of the council. Understanding that the role of the pharmacy is critical to the chemotherapy process, the CNS took the opportunity to invite the pharmacy manager to attend.

Several staff nurses, the pharmacy manager, and the CNS participated in the first meeting. The CNS served as the facilitator and recorded meeting minutes. The meeting started with brainstorming facilitator and recorded meeting minutes. The CNS then asked the pharmacy manager’s view on chemotherapy practice and added the comments to the flip chart. The activity allowed both disciplines to listen to each other and visualize the barriers, areas for improvement, and positive aspects not requiring change at the time. After the dialogue, the team set forth prioritizing and setting goals.

The next step entailed discussion of the roles and responsibilities of being a member of the council (see Figure 1). Questions included: Who will arrange meetings? Can staff conference call in? How often should we meet? Which topic should be worked on first? How will other staff be informed of our progress? Under a shared governance model, staff is encouraged to be part of the decision-making process as well as play an integral part in the implementation of the team’s work.

Initiatives

The council decided that any oncology staff nurse could join the team as well as other allied healthcare disciplines involved with influencing best practices of chemotherapy (e.g., dietary, pharmacy). Based on the brainstorming feedback, the top priorities identified by the council after the first meeting were (a) developing a chemotherapy nursing flowchart; (b) obtaining, streamlining, and enhancing access to current patient and family education regarding chemotherapy and the diagnosis of cancer; and (c) strengthening the

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