**The Problem**
Each oncology disease group works a little differently, including the way patient notes are written. Not having a standard format creates difficulty for cross covering nurses and for the physicians looking for specific treatment information and toxicities. What information is pertinent and where should it be within the note?

Problem:
- Varied information provided in notes
- Challenges cross-covering
- Timeliness of note completion
- Difficulty finding the specific treatment related information and toxicities
- Notes affect all members of research staff

**Aim/Goal**
- Develop a standardized format for both screening/eligibility and follow up visits that would be easily used by the research team to ensure improved documentation
- Create a format to clearly locate specific treatment related information for all staff
- Standardization would improve efficiency with cross-coverage; assist the Clinical Research Coordinator and monitors with the collection and review of patient data

**The Interventions**

**Progress to Date/Feedback**
- The roll out began January of 2016
- How to improve formatting of AE list with dates and attributions
- Potential to add back the use of an asterisk for changes in AE

**Lessons Learned**
As with any change, there is resistance; however making the macro easy to use and providing training and education will improve quality of information, efficiency in note completion, ease of finding pertinent information, and improved quality of data collection.

**Next Steps/What Should Happen Next**
- Continue to provide training and education of current staff and new staff
- Thinking ahead for other systems to improve quality of documentation and data collection
- Begin to reformat existing notes as patients are seen

**Acknowledgements**
Thank you to Joanna Kemp, CCTO Nursing Director, Christine Conley, Assistant Manager, CCTO- Susan Gotthardt, RN, Phase I Clinical Trials- Carol Delaney, BSN, Mary Ellen Bowers, BSN, Neuro-Oncology for providing their input.

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