NCCP Oncology Medication Safety Review Report

Implementation Status Report

Hospital reporting period:
March-July 2014

Published: December 2014

National Cancer Control Programme
Feidhmeannacht na Seirbhíse Sláinte Health Service Executive
Tús Áite do Shábháilteacht Othar Patient Safety First

Contents:

1. Introduction

The National Cancer Control Programme (NCCP)'s *Oncology Medication Safety Review* was published in January 2014.

The report presented the findings of the review which was conducted across the 26 hospitals in Ireland involved in the administration of systemic cancer therapy in adults and children. The aim of the review was to assess the oncology medication policies and practices in day units nationally, from a patient safety perspective. The report made a total of 93 recommendations.

An Implementation Steering Group is in place to oversee the implementation of the report.

An action plan for the implementation of the recommendations was developed. This covered the recommendations which were for immediate implementation at hospital level and recommendations for implementation at national level. The action plan was circulated to all relevant hospitals.

The review report and action plan are available on the NCCP website at www.hse.ie/nccponcsafetyreview.

In order to obtain a baseline of implementation of individual recommendations, each relevant hospital was asked to complete a baseline implementation status report. This involved completing a checklist of the status of each recommendation of the report, stating in each case whether the recommendation was implemented, underway, not started or not relevant.

Hospitals were asked to confirm the status of each recommendation as at the end of March 2014. All 26 chemotherapy hospitals responded over the period April to July 2014. There was a 100% response rate from the hospitals. Queries in relation to responses from individual hospitals were discussed with the hospitals liaison contacts, with particular focus on those recommendations returned as "not relevant".

This document sets out the first analysis of the implementation of the recommendations since the publication of the report in January 2014. It reflects, in some cases, progress in implementation over a very short period. This implementation status report is the first step in assuring the execution of the patient quality and safety recommendations set out the report. It is important to note that financial and resource constraints can impact the implementation of some recommendations. It is hoped that developments, particularly those relating to information technology, will facilitate appropriate change.

Hospitals are required to provide updates on implementation every 6 months for those recommendations which have not been implemented and every 12 months for those recommendations that have been implemented. Progress on the implementation of recommendations will be tracked on an ongoing basis and hospitals will be supported, where possible, by the NCCP, particularly with the exchange of learning and sharing of good practice across hospital sites.

2. Implementation Status Report (As reported by hospitals April-Jult2014)

Part A: Recommendations for immediate implementation at hospital level

A total of 27 responses were received, from the 26 chemotherapy hospitals including one hospital which has separate oncology and haematology services and therefore made two submissions.

Overall, approximately 55% of the recommendations contained in the report have been implemented by the hospitals (n=81), 26% are underway, 12% have not been started and 6% are not relevant[1]. Implementation in individual hospitals ranged from 37% to 84%.

In many cases, hospitals indicated that policies / procedures were in place in relation to certain areas which required updating. Some hospitals raised issues with staffing, space and other resources as reasons for certain recommendations not being progressed.

The national implementation status of each of the recommendations for implementation at hospital level is provided at Appendix A.

Part B: Recommendations for implementation at national level

A number of the recommendations of the report required the establishment of national representative groups to develop national guidelines and policies.

Two particular areas were identified by the Implementation Steering Group as being priority recommendations:

(i) The development of national policies on intrathecal chemotherapy.

(ii) A national guideline on the management for the prescribing and dispensing of oral chemotherapy.

Overall, 85% of the national recommendations (n=13) are underway and the remaining 15% are scheduled to commence in 2015. This is partially due to delays with the finalisation of group membership and formal establishment of groups. However it is expected that significant progress will be made over the coming months.

The national implementation status of each of the national recommendations is provided at Appendix B.

[1] A recommendation may not be relevant to hospital if, for example, a particular service is not provided by that hospital e.g. intrathecal chemotherapy services.

Appendix A

Status report on the implementation of the NCCP "Oncology Medication Safety Review Report (January 2014)"

Part A: Recommendations for implementation at hospital level

Period: **Baseline March 2014**

(submissions received from hospitals March - July 2014)

Number & Percentage of hospitals that have implemented the recommendation listed

NCCP Rec	Recommendation details	HIQA	Implemented		Underway		Not started		Not relevant	
			#	%	#	%	#	%	#	%
Rec. 1	All HSE hospitals providing elective chemotherapy services should ensure that they have an **appropriate leadership team** in place. The lead of the service could be from any of the professional groups, a consultant oncologist/haematologist, a nurse, or a pharmacist.	5.1 5.2	16	59%	7	26%	4	15%	0	0%
Rec. 2	The specified lead of the chemotherapy service, in association with hospital drugs and therapeutics committees, should be explicitly charged with ensuring that the required **hospital policies/guidelines are in place and adhered to**.	5.1 5.2	9	33%	11	41%	6	22%	0	0%
Rec. 3	The responsibility of different staff in relation to safe **chemotherapy ordering and prescribing, administration and handling of hazardous drugs** should be outlined in a written policy and disseminated to all staff involved in these activities.	5.2	13	48%	13	48%	1	4%	0	0%
Rec. 4	Hospitals should collaborate, within the new hospitals group structure, to share good practice pertaining to systemic cancer therapy provision and to work towards the **standardisation of oncology medication policies and practices.**	2.3 5.5 5.6	5	19%	11	41%	11	41%	0	0%
Rec. 5	In line with national policy, all units are encouraged to have a written policy in place on **incident reporting** (HSE, 2008) and open disclosure (HSE, 2013). Services are encouraged to continue with routine reporting of all medication safety incidents, including near misses.	3.2 3.3	23	85%	3	11%	1	4%	0	0%
Rec. 6	The medical oncology and haematology services should actively engage with hospital **risk management and quality improvement**. Consideration should be given to regular scheduled multidisciplinary meetings, with risk management and supported by senior management, to discuss medication safety reports, review recurring trends and identify areas for improvement.	3.2 3.3 3.6 3.7	12	44%	7	26%	8	30%	0	0%
Rec. 7	Issues which are considered to potentially compromise the safe delivery of systemic cancer therapy should be included on the department or hospital **risk register** and reviewed annually using the HSE risk assessment tool and guidance (HSE, 2011). Processes should be in place to review recurring trends and there should be clear guidance on when incidents need to be addressed nationally.	3.1 3.2 3.6	13	48%	11	41%	3	11%	0	0%
Rec. 8	**Chemotherapy administration should be commenced during normal working hours** wherever possible, when support services and expert advice are available. When chemotherapy continues outside normal working hours, staff skilled in chemotherapy administration and access to expert medical advice must be available.	3.1	27	100%	0	0%	0	0%	1	4%
Rec. 10	If restructuring of the hospital **built environment** is planned, consideration should be given to co-locating the oncology day ward and the preparation area for oncology drugs/pharmacy aseptic units, particularly where the pharmacist(s) involved in the service are shared between the clinical oncology service and drug compounding.	2.7	1	4%	2	7%	5	19%	19	70%
Rec. 11	Day wards and outpatient clinics should facilitate appropriate **desk/office space** for a clinical pharmacy service.	2.7	9	33%	5	19%	12	44%	0	0%
Rec. 12	A **risk-based approach** should be taken locally to ensure that the environment is appropriate for carrying out clinical activities and undertaking manual handling operations, while maintaining a good standard of infection control.	2.7	19	70%	5	19%	3	11%	0	0%
Rec. 13	Day wards/units should have within them, or adjacent to them, a **separate and identified area for the temporary storage of chemotherapy agents** which have been dispensed from pharmacy, and for additional tasks involved in preparation and delivery of treatment. Note: These tasks refer to the preparation of treatment which the local service has deemed safe to prepare at ward level and which does not need to be carried out in pharmacy or outsourced.	2.7	22	78%	2	7%	3	11%	0	0%
Rec. 14	Patients, if appropriate, should be offered a **two day treatment model**, whereby patient assessments and/or blood tests are conducted on the day prior to treatment to improve patient flow and decrease wait times.	2.6 1.1	15	56%	6	22%	6	22%	0	0%
Rec. 20	**Competency should be assessed** at a minimum annually or in line with relevant national or professional guidelines for all disciplines. Staff must be deemed competent before undertaking their assigned roles and responsibilities. In the absence of national policies, local guidelines should be agreed on competencies.	6.3	3	11%	17	63%	7	26%	0	0%
Rec. 22	**Induction training** in the delivery of systemic cancer therapies should be mandatory for doctors, nurses and pharmacists. (Also see Rec. 90 All personnel handling, preparing, transport or administering cytotoxics require training in the relevant areas).	6.3 6.4	10	37%	13	48%	4	15%	0	0%
Rec. 23	**Onsite training** in relation to chemotherapy prescribing should be provided for doctors and nurses working in oncology, with appropriate supervision and competency assessment. (Note:A mandatory chemotherapy prescribing module for medical oncology and haematology SpRs is planned by the RCPI.)	6.3	6	22%	11	41%	10	37%	0	0%
Rec. 24	**Medical Council requirements** in relation to prescriber documentation and to continuing professional development should be implemented in all sites.	5.10 6.3	12	44%	6	22%	7	26%	0	0%

NCCP Rec	Recommendation details	HIQA	Implemented		Underway		Not started		Not relevant	
			#	%	#	%	#	%	#	%
Rec. 25	**Training and CPD records** should be maintained by staff in line with the recommendations of their professional and/or regulatory bodies.	6.3	14	52%	11	41%	2	7%	0	0%
Rec. 26	Sharing of **educational sessions on a multidisciplinary basis** should be promoted between centres and learning opportunities maximised by using technologies such as video linkage, webinars and e-learning.	6.3	15	56%	7	26%	5	19%	0	0%
Rec. 27	All units involved in the prescribing/ordering and administration of systemic anticancer therapy must have **guidelines/policies** in place covering the essential areas as detailed in Appendix 4 of the Review Report.	3.1	4	15%	22	81%	1	4%	0	0%
Rec. 28	Relevant national policy recommendations and NCCP recommendations should be included in **local policies and practices**.	2.1	2	7%	20	74%	4	15%	0	0%
Rec. 29	All units should have **patient information** on cancer e.g. cancer treatment, local support groups and support services.	1.4	27	100%	0	0%	0	0%	0	0%
Rec. 30	Decisions to treat a patient with chemotherapy should involve the patient and carer on an **informed choice** basis.	1.4	25	93%	2	7%	0	0%	0	0%
Rec. 31	**Written information** should be available for patients and carers for each treatment protocol on the hospital's agreed list.	1.4	25	93%	2	7%	0	0%	0	0%
Rec. 32	There should be **written information for patients and carers** covering the action they should take, whom they should contact for advice, and the symptoms that should prompt this, with regard to treatment related side-effects of systemic cancer therapy.	1.4	25	93%	2	7%	0	0%	0	0%
Rec. 33	All units should have written policies in place on information for patients on **safe handling of cytotoxic drugs in the community** including: - Spillage information - Disposal information - Safe storage information Also see Rec. 93 regarding supply of spill kits to patients on home parenteral chemotherapy.	3.1	7	26%	6	22%	13	48%	1	4%
Rec. 34	The patient's **treatment plan** should include the following information at a minimum: Diagnosis and staging according to an internationally recognised staging system Performance status and co-morbidities Treatment intent Treatment protocol Pre-treatment investigations where required Planned numbers of cycles Frequency and method of assessment if appropriate Any deviation from protocol and rationale for deviation	8.1	19	70%	8	30%	0	0%	0	0%
Rec. 35	There should be detailed documentation of the patient's systemic cancer therapy in the **patient's treatment record**, fulfilling the minimum criteria as detailed in Appendix 5 of the review report for each patient: Prior to the start of a course of chemotherapy Prior to the administration of each cycle After the final cycle is given in a course	8.1	16	59%	9	33%	1	4%	0	0%
Rec. 36	**Patient consent** or understanding of adverse events should be documented.	1.5	18	67%	7	26%	2	7%	0	0%
Rec. 37	The **consent form**, signed prior to starting a course of chemotherapy, should contain the minimum criteria as specified in the NCCP Template Patient Consent Form for Systemic Therapy Treatment.	1.5	10	37%	11	41%	6	22%	0	0%
Rec. 38	**Reassessment** is required before the start of any subsequent cycle of treatment. Assessment requirements should be detailed in the treatment protocols and should, at a minimum: • Document any serious toxicity (e.g. grade 3 or 4 toxicities) • Indicate appropriate blood tests and other tests, as required • Outline circumstances and details of dose modifications when required • Document response to treatment at appropriate intervals	8.3	21	78%	5	19%	1	4%	0	0%
Rec. 39	Each unit should have a written policy on: • The **maximum time period** acceptable between pre-treatment tests, including patient weight, and chemotherapy administration • **Patient assessment** using validated tools such as Early Warning Score and Common Criteria Toxicity Scale	2.2	5	19%	16	59%	6	22%	0	0%
Rec. 40	**Pre-treatment tests** should be undertaken a maximum of three days prior to Day 1 of each cancer medicines cycle (excluding cycle 1) and at intervals designated in the treatment plan. Local arrangements may need to be made to consider bank holiday weekends.	2.2	24	89%	2	7%	1	4%	0	0%
Rec. 41	Each unit should have access to an agreed list of **chemotherapy protocols**. This list should be updated at a minimum every two years.	2.5	13	48%	11	41%	2	7%	0	0%
Rec. 42	Each protocol should contain the **minimum protocol specific information** as detailed in Appendix 3 of the Review Report. Each protocol should be reviewed at a minimum every two years.	2.5	9	33%	17	63%	1	4%	0	0%
Rec. 43	**Protocols should be readily available** to multiple users. At a minimum there should be hard copies of the local protocols in all wards (including day wards, and out-patient clinics) where oncology/haematology patients are admitted or reviewed. The unit should have a policy in place designed to ensure that the hard copies of the local protocols are kept up to date and versions are controlled. Master copies should be signed by the approving consultant. If the local protocols are maintained in electronic form on the unit's intranet or computerised physician order entry system, there should be a method designed to ensure that these documents are kept up to date as displayed on the electronic system. Note: An electronic form of the protocols does not preclude the requirement for hard copies as above.	2.5 8.1 8.2	12	44%	11	41%	3	11%	1	4%

NCCP Rec	Recommendation details	HIQA	Implemented		Underway		Not started		Not relevant	
			#	%	#	%	#	%	#	%
Rec. 44	Each unit should have a **written policy for preventing regular use of protocols not on the accepted list**. The policy should state: • The exceptional circumstances under which such a regimen could be used. • The procedure which is then required to authorise it.	5.2	0	0%	12	44%	14	52%	1	4%
Rec. 45	**Requests to use a non-approved protocol** should be made to hospital pharmacy by a medical consultant and accompanied by supporting references and a completed proforma request. A record should be kept of all such requests which result in off-protocol treatment. Annual audits should be conducted to examine the reasons why such off-protocol treatments were necessary.	5.2	6	22%	9	33%	12	44%	0	0%
Rec. 46	There should be regular **multidisciplinary team meetings** (e.g. weekly) to discuss patients' treatment, including chemotherapy treatment.	2.3	20	74%	4	15%	3	11%	0	0%
Rec. 47	The **first cycle of a course of systemic cancer therapy** must be written by a consultant medical oncologist or haematologist, SpR or Registrar based on the consultant's written treatment plan. Subsequent cycles may be written by a Consultant, Specialist Registrar (SpR) or Registrar.	5.1 5.2	25	93%	2	7%	0	0%	0	0%
Rec. 48	All units should maintain a list and **signature bank*** of those staff deemed competent to prescribe/order, check, dispense and administer systemic cancer therapy. The list and signature bank should be updated annually. *A signature bank is not required for those functions where electronic systems have replaced paper processes.	5.1 5.2	9	33%	12	44%	6	22%	0	0%
Rec. 49	**Approved drug names** should be used when prescribing/ordering chemotherapy. Trade names should only be utilised where the use of an approved name may result in an error.	3.1	22	81%	3	11%	1	4%	0	0%
Rec. 50	**Prescriptions/orders for all parenteral or oral chemotherapy must be written** and should not be given as verbal or telephone orders. If a prescription/order is amended, the changes must be signed and dated on all copies of the prescription/order by the physician before the treatment is administered or supplied by the Pharmacy Department. Electronic orders must be clearly attributed to the prescriber and all changes to the order must be maintained in an audit log.	3.1	21	78%	6	22%	0	0%	0	0%
Rec. 51	Writing of **chemotherapy orders in advance of day of treatment** should be introduced for a large majority of elective chemotherapy treatments. This does not remove the need for patient assessment and sign off (off-hold) prior to administration.	3.1	24	89%	2	7%	1	4%	0	0%
Rec. 52	Chemotherapy orders must be signed "**off-hold**" by the prescriber or the policy authorised person prior to administration of chemotherapy to the patient.	3.1	11	41%	6	22%	8	30%	2	7%
Rec. 53	A copy of the chemotherapy order and/or prescription must be kept in the **patient's medical record**.	3.1	26	96%	1	4%	0	0%	0	0%
Rec. 54	In the absence of electronic ordering systems, chemotherapy should be ordered on **designated order forms**. Ideally these should be pre-printed and regimen specific. A standardised blank order form should be available to cater for situations where non approved protocols are utilised and where pre-printed order forms are not yet available for infrequently used protocols. The minimum data required are detailed in Appendix 9 of the Review Report.	3.1	20	74%	7	26%	0	0%	0	0%
Rec. 55	A rigorous **validation process for electronic ordering** is required pre-implementation of electronic ordering to ensure accuracy of calculated doses. These systems must have on-going maintenance and have suitable arrangements for supervision of their use by appropriately qualified staff.	3.1	2	7%	3	11%	5	19%	17	63%
Rec. 57	Hospitals using computerised physician order entry systems should ensure that these systems are fully validated and, as for paper based prescribing/ordering, a clinical pharmacy check is required to authorise the prescription. This needs to be auditable. In addition there should be clear medical, pharmacy and nursing checks of the electronic ordering template for each chemotherapy regimen	3.1	3	11%	1	4%	4	15%	19	70%
Rec. 58	Hospitals should ensure that their **chemotherapy prescription checking and administration policy** includes: • Both oral and parenteral chemotherapy • A description of the integrated multidisciplinary checking process and details of each team member's responsibility in this process. An example is included in Appendix 8 of the Review Report. • The pharmacy verification practice where different levels of verification are in place.	3.1	5	19%	16	59%	6	22%	0	0%
Rec. 59	All **chemotherapy prescriptions** should be checked by a pharmacist, who has demonstrated their appropriate competence and is locally authorised/accredited for the task. Minimum recommended pharmacy checks are detailed in Appendix 6 of the Review Report.	3.1 5.2	15	56%	10	37%	2	7%	0	0%
Rec. 60	All patient treatment, assessment and prescription checking areas should have access to the most recent relevant **laboratory test results**.	2.5	26	96%	0	0%	1	4%	0	0%
Rec. 61	All units should have a policy in place that defines the **persons authorised to give approval** to proceed with treatment (off-hold).	5.1	8	30%	11	41%	8	30%	0	0%

NCCP Rec	Recommendation details	HIQA	Implemented		Underway		Not started		Not relevant	
			#	%	#	%	#	%	#	%
Rec. 62	Each unit should have a written policy on: • Management of **skin penetrating injuries** with cytotoxic drug exposure • The **prevention, recognition and management of treatment related side effects** such as: o Neutropenia/neutropenic sepsis o Cytotoxic-induced emesis o Cytotoxic extravasation o Allergic reactions including anaphylaxis o Stomatitis, other mucositis and diarrhoea • The use of **mechanical drug delivery devices** used by the unit, such as infusion pumps etc. • The **use of devices to prevent alopecia**, if used by the unit. • The **care of aids to venous access** for use in the unit (e.g. Hickman lines, PICC lines).	2.1	6	22%	20	74%	1	4%	0	0%
Rec. 63	Prescription drugs to be administered must be checked by two chemotherapy competent nurses prior to administration. Minimum recommended verification information is included in Appendix 7 of the Review Report.	3.1	24	89%	2	7%	0	0%	0	0%
Rec. 64	Each unit should have a **written policy on the management of unscheduled care** including: • Emergency department policies e.g neutropenic sepsis, cytotoxic induced emesis, extravasation etc. • Inter hospital patient transfers • Telephone triage • Acute admission of patients from other hospitals • Data requests from other hospitals	2.3 2.5	3	11%	18	67%	6	22%	0	0%
Rec. 65	**Telephone triage protocols**, using evidence based scoring/assessment, should be utilised to facilitate accurate and standardised patient assessments.	2.3	4	15%	8	30%	15	56%	0	0%
Rec. 66	Chemotherapy should be written by a consultant medical oncologist/haematologist in the event of it being required as an emergency outside of normal working hours. A record of the number of times that this procedure has taken place outside normal hours should be maintained. Preparation of hazardous drugs out-of-hours should be in accordance with local arrangements and local policy.	5.1	9	33%	7	26%	1	4%	10	37%
Rec. 67	**Guidelines/polices on the management of symptoms pertaining to treatment and oncology emergencies** should be accessible to general physicians/ED staff, if there is no direct access to oncology services out-of-hours.	6.3 6.4	7	26%	6	22%	5	19%	8	30%
Rec. 68	All hospitals administering **intrathecal chemotherapy** should have the following policies in place: • A policy for the prescribing, preparation, delivery, storage and administration of intrathecal chemotherapy • A policy on the dilution of vinca alkaloids, including the minimum recommendations of WHO (2007)	3.1	11	41%	6	22%	0	0%	10	37%
Rec. 69	**Intrathecal chemotherapy** should always be stored in a different area to intravenous chemotherapy.	3.1	14	52%	1	4%	0	0%	12	44%
Rec. 70	**Intravenous chemotherapy** should always be given at a different time to intrathecal chemotherapy.	3.1	16	59%	0	0%	0	0%	11	41%
Rec. 72	Each unit should have a written policy in place on **drug preparation** including labelling and packaging (see Appendix 10 of the Review Report for minimum recommendations on labelling).	3.1	19	70%	6	22%	1	4%	1	4%
Rec. 73	Pharmacy departments should maintain: • Structured **pharmaceutical care plans**, either electronically or on paper, for each patient • A **patient history** for each patient that allows the verification of cumulative and maximum patient doses.	8.3	12	44%	8	30%	7	26%	0	0%
Rec. 74	All hospital pharmacy departments should have a dedicated area reserved for the **preparation/ dispensing/supply of hazardous drugs**, both oral and parenteral.	2.7	23	85%	2	7%	2	7%	0	0%
Rec. 75	All hospital pharmacy departments should utilise a **specialised computer system** for the preparation and/or dispensing or issuing of cancer medicines to enable batch tracking, cumulative dose monitoring, and a complete electronic patient history.	2.5	23	85%	1	4%	3	11%	0	0%
Rec. 76	**Labels** should comply with all statutory and professional requirements, and should include the minimum information as detailed in Appendix 10 of the Review Report.	5.11	21	78%	6	22%	0	0%	0	0%
Rec. 77	**Outsourced products should be overlabelled** where the label does not comply with the minimum requirements as detailed in Appendix 10 of the Review Report.	3.1	16	59%	4	15%	3	11%	3	11%
Rec. 78	Hospitals **outsourcing the production of parenteral chemotherapy** should ensure that the chosen suppliers comply with best practice and/or any statutory/regulatory requirements.	5.11	22	81%	3	11%	0	0%	1	4%
Rec. 81	**Monitoring of adherence to oral chemotherapy** by medical/nursing personnel is recommended while patients are on their treatment.	3.1	20	74%	6	22%	1	4%	0	0%
Rec. 82	**Structured education** is required for patients and their carers in relation to safe handling, administration and the identification and management of side-effects pertaining to their oral chemotherapy medications. A pre-treatment education checklist should be developed for patients on each oral chemotherapy agent.	3.1	14	52%	13	48%	0	0%	0	0%
Rec. 83	Patients on oral chemotherapy should have **24hr access to appropriately trained medical oncology staff**.	2.3	26	96%	1	4%	0	0%	0	0%

NCCP Rec	Recommendation details	HIQA	Implemented		Underway		Not started		Not relevant	
			#	%	#	%	#	%	#	%
Rec. 85	All hospitals should have **clear protocols/guidelines to reduce the occupational exposure of staff** to cytotoxics and should have written policies on the safe handling of cytotoxic agents including: • Segregated storage • Spill management of cytotoxic agents • Transportation of cytotoxics • Disposal of cytotoxic waste • Needle stick injuries • Preparation of cytotoxics	3.1	18	67%	8	30%	1	4%	0	0%
Rec. 86	All hospitals should maintain a **list of hazardous drugs** in line with the hospital's waste policy, relevant legislation and best practice.	5.10.	14	52%	6	22%	6	22%	0	0%
Rec. 87	**Hazardous drugs** should be stored separately from other drugs. Access to hazardous drug storage areas on wards or day units should be limited to authorised staff. Storage should be designed in a manner that will prevent containers of hazardous drugs from falling or being punctured. Such storage areas should be clearly labelled with cytotoxic warning labels. High-risk drugs, such as intrathecal chemotherapy, should be stored in a segregated manner in line with local hospital policy, best practice and relevant legislation	3.1	16	59%	8	30%	2	7%	0	0%
Rec. 88	**Refrigerators** used for the storage of chemotherapy doses should be monitored according to hospital policy.	3.1	23	85%	4	15%	0	0%	0	0%
Rec. 89	Containers of prepared cytotoxic agents should be transported in appropriately labelled, sturdy and leak-proof transport boxes or bags. They should be clearly labelled as 'Cytotoxic - handle with care'. Intrathecal chemotherapy should be transported separately to all other medication. Pneumatic tubes should not be used for transporting any non-solid cytotoxic agents, including creams and ointments.	3.1	21	78%	5	19%	0	0%	0	0%
Rec. 90	All personnel **handling, preparing, transporting or administering cytotoxics** require training in the relevant areas.	6.3	16	59%	8	30%	2	7%	0	0%
Rec. 91	A member of staff should receive the hazardous drug in the transit bag/box at its destination. Bags/boxes must not be left unattended or with untrained staff on arrival.	3.1 6.3	25	93%	2	7%	0	0%	0	0%
Rec. 92	**Disposal of cytotoxic waste** should comply with the hospital's waste policy, relevant legislation and best practice.	3.1	27	100%	0	0%	0	0%	0	0%
Rec. 93	Hospitals should supply **spill kits** to patients who are on home parenteral chemotherapy.	3.1	8	30%	7	26%	9	33%	2	7%

Appendix B

Status report on the implementation of the NCCP "Oncology Medication Safety Review Report (January 2014)"

Part B: Recommendations for implementation at national level

Period **Baseline March 2014** (as at September 2014)

NCCP Rec	N.	Recommendation details	HIQA	Baseline status: March 2014	
				Status	Comments
9	1	Guidelines should be agreed nationally on the optimum requirements of the **built environment** of a haematology / oncology day ward. Day ward design must consider: • Current and future needs/demands • Infection control recommendations • Health and safety considerations • Patient comfort • An efficient, safe work environment	2.7	Underway	Group is in place and working on recommendations
15	1	The NCCP should develop a **space planning model** to support hospitals in their local service planning with regard to day ward spatial requirements.	2.7	Underway	
16	1	There should be national agreement on the **minimum key personnel** required for an oncology/haematology day unit in relation to scope of service and the essential qualifications/ experience of these key staff.	6.1 6.2 6.3	Underway	Paper for consideration by Steering Group
17	1	The NCCP should develop a **capacity-planning model** to support hospitals in their local service planning with regard to day ward activity and staffing requirements.	6.1 6.2 6.3	Underway	Discussions underway re. access to UK C-PORT tool
18	1	**National competencies** for all disciplines in relation to acute oncology should be developed in collaboration with the relevant colleges and professional bodies.	6.3	Underway	Nursing Group is place. RCPI curricula for medical oncology and haematology (SpR) are comprehensive.
19	1	**Specialist competency training needs** to be developed and implemented for all disciplines working in the areas of clinical oncology and aseptic manufacturing.	6.3	Underway	
21	1	Generic guidance should be developed on **specific oncology training programmes or competency assessments** for all nurses, pharmacists and doctors.	6.3	Not started	Multidisciplinary group to be established 2015
55	1	A rigorous **validation process for electronic ordering** is required pre-implementation of electronic ordering to ensure accuracy of calculated doses. These systems must have on-going maintenance and have suitable arrangements for supervision of their use by appropriately qualified staff.	3.1	Underway	Business case for MOCIS submitted to HSE ICT for Govt CIO.
56	1	A **national computerised physician order entry system** agenda should be developed by the NCCP and HSE IT.	3.1	Underway	
71	1	The NCCP to lead on the development of **national intrathecal polices** to inform the content of these local hospital policies.	3.1	Underway	Group is in place & policy is in development
79	1	The NCCP to lead on the development of **minimum standards for the preparation of parenteral chemotherapy**. This should recognise the requirements of small and large centres.	2.1	Not started	Establishment of group delayed due to industrial action of IMPACT affecting HPAI members
80	1	A national guideline is required for the **management of the prescribing and dispensing of oral chemotherapy**. This guideline should include: • Safe prescribing • Prescription checking • Prescription format • Administration • Service models for dispensing and supply Communication system between primary care and secondary care	2.1 3.1	Underway	Group is in place and developing recommendations
84	1	The NCCP will engage with the PCRS with regard to current design of the **High Tech prescription form**.	2.3	Underway	

Total	13			
Number implemented			0	0%
Number underway			11	85%
Number not started			2	15%
Number not relevant			0	0%