T 021 944 3750 E info@iconsa.co.za W iconsa.co.za
2nd Floor, Madison Square Park, 4 Howick Close
Tygerfalls, 7530

STANDARD AUDIT OF ONCOLOGY DEPARTMENTS

Contents

The use and origin of this document

This checklist is for use for Icon accreditation and as part of a continuous improvement program.
Icon aims to be helpful with this program. It is based on the National Core Standards of the Dept. of Health with additional Oncology measures.

The document is used for self-assessment, which takes place every 3 years. This will be followed by a site visit and follow up contacts via phone and email.

The document is endorsed by the SA Society of Clinical and Radiation Oncology

Instructions

There are 4 SECTIONS with checklist items which are organised per areas within the practice. These are to be completed by the responsible manager.

Section 4 contains a supplement specifically for Medical Physics. This is managed by Medical Physics and is completed annually

The checklist items must please be scored in the last column as either:
C – Compliant
WIP - Work in Progress
NC - Non-Compliant
NA: - Not Applicable.

Please contact Belinda Bailey at belinda.bailey@iconsa.co.za with any queries on Sections 1 to 3 and Yogi Govender ygovender@iconsa.co.za with any queries on Section 4.

28 APRIL 2015 REVISED FEB 2016, DEC 2016, 8 FEB 2018, JAN 2020, FEB 2021

1. Practice Manager / Administrator

	Practice Admin Area with Records of Standard Operating Procedures (SOPs)	
1	A security and access policy. This policy should assist in minimising the clinical impact of down time caused by theft and vandalism of/ or the unauthorised tampering with – machines and equipment.	
2	Register of incident reports- in conjunction with clinical area: The practice encourages the reporting of errors and near-misses and has a formal process for evaluating the data, at least semi-annually.	
3	Actions are taken on all Continuous Quality Improvement needs and their implementation is monitored (e.g. responsible person/committee)	
4	A policy dealing with patient's death in your practice – in conjunction with clinical area	
5	No smoking policy	
6	The practice has a procedure for documentation and follow-up for patients who miss and cancel scheduled visits and/or chemotherapy treatment	

	Human Resource Records	
7	New staff orientation process –- in conjunction with clinical area; Orientation should include an introduction of new employees to all departments, service providers, and functions that affect patient care	
8	Policy on Competency assessment of ***new*** staff members – in conjunction with clinical area; Deficiencies in new employee training and experience must be **identified** and **remedied** before they can assume patient-care responsibilities	
9	Practice should establish policies and procedures ensuring that personnel who prepare, dispense and administer chemotherapy and monitor patients are competent to perform these functions. Staff performance is assessed annually for continuing demonstrated competency	
10	Evidence of qualifications and current registration with professional body for all professional staff members	
11	Healthcare professionals who intend to dispense medicine, should be in possession of a Dispensing License, according to the Medicines and Related Substances Control Act (Act 101 of 1965 Section 22C(2)	
12	Confidentiality policies: Confidentiality clause in service agreement, signed by all staff members	
13	Staff are easily identifiable; Staff must wear name badges and distinguishes devises always	
14	An appropriate insurance or other cover for medico-legal incidents and damages claims	
15	At least one clinical staff member trained in Basic Life Support is present during chemotherapy administration. BLS training is every 2 years.	
16	Job descriptions and task lists and Organogram	

17	An oncologist/medical officer is immediately available to staff who administer chemotherapy. Lines of communication to contact the appropriate emergency medical staff should be known to all involved and clearly displayed in the chemotherapy area	

	Occupational Health & Safety Records	
18	There is health and safety committee and representative (where applicable). Minutes of meetings should be kept.	
19	A policy exists regarding the management of OHS within your facility	
20	A medical surveillance plan (physical examination) is in place for at-risk staff, based on health risk assessments – in conjunction with the clinical area	
21	Procedures must be in place to address worker contamination. Protocols for appropriate medical attention must be developed.	

	The Entrance, Kitchen, Storage Rooms, Cupboards, Toilet and Waste Disposal Area	
22	Cleanliness and hygiene are maintained on a systematic basis	
23	All service areas including reception and toilets within the facility clearly signposted	

	The Information Areas for Patients – as needed	
24	Information brochure/card with contact details and opening hours, etc.	
25	Standard operating procedure on orientation and education of all new patients, including potential side-effects and management thereof – in conjunction with all areas.	
26	A patients Complaints Procedure should be in place.	
27	Information booklets on side-effects and management of chemotherapy treatment – in conjunction with the chemotherapy nurse manager.	
28	Patient privacy is ensured when examined, counselled, and phoned	

	The Information Areas for Staff	
29	The Treatment Protocols, e.g. ICON Treatment Protocols	
30	DOH Licenses should be displayed (where applicable), as well as Department of Radiation control licences for Radiotherapy services	
31	Roster of on-call duties, with names and contact details (includes Doctors, Physicists & Radiotherapists) – in conjunction clinical areas.	

	Facilities & Equipment	
	a) Linen/Laundry:	
32	Check that al laundry is handled in line with infection control and safety requirements	
33	The storage of linen must be in a separate room with an extractor fan and door vent OR a cupboard with door vents	
	b) Waste management:	
34	A current waste management policy and procedure - refer to DOH (Western Cape Health Care Waste Management Act, 2007)	
35	A contract and service level agreement should be in place with approved and legally compliant waste removal service provider	

	c) Patient waiting area and reception:	
36	Patient waiting area with comfortable seating.	
37	A wheelchair or bed is available for waiting patients	
38	An area allowing private patient discussions.	
	d) Sluice room:	
39	For collection and temporary storage of used equipment and dirty/soiled linen	
	e) Clean room/cupboard:	
40	For storage of sterilized packs, dressings, sterile equipment	
	f) Patient toilets:	
41	The doors from patient ablution and toilet facilities must be equipped with a standard emergency release lock that can be opened from the outside.	
42	Fitted with Grab rails and an emergency call system	
	g) All areas - Disaster Plan information:	
43	Fire Escape accessible and clearly indicated	
44	Emergency plan displayed in all areas	
45	Firefighting equipment, displaying valid service dates	
46	Regular fire-drills, documented	
	h) Medical equipment	
47	All medical equipment (scales, thermometers, medical refrigerators, defibrillators) must be serviced annually. Records of service dates to be kept.	

Completed by: …… Signed: …… Date: .....

2. Oncologist / Nurse Manager

	The Consent Forms in File	
1	There is a practice specific process for obtaining informed consent from patients prior to treatment	
2	A consent form for record keeping of information and sharing information with Health funders is signed by the patient, prior to treatment	

	Patient Records SOPs	
3	Follow-up arrangements are made and documented in-patient records	
4	Toxicity assessment documentation is available for planning subsequent treatment cycles	
5	The practice must have evidence of an efficient filing system.	
6	There is a documented contingency plan for ensuring continuing availability of the patient record in the event of a disaster e.g. fire	
7	There is a protocol for safe keeping of any electronic medical records	
8	There is a protocol for correspondence with the patient's GP and referring doctors both at the time of initial consultation and treatment planning as well as at the time of treatment completion to explain follow up plan.	

	The Available Support Services Include:	
9	Pathology, haematology and biochemistry services	
10	Radiology	
11	Referral process to an Oncology social worker in place	
12	Referral process to Palliative care services in place	
13	Emergency medical service and admission facilities	

Completed by: …… Signed: …… Date: .....

3. Pharmacist/Chemotherapy Nurse Manager

	Pharmacy Admin Area - Records of Standard Operating Policies (SOP) include:	
1	Policy on Receipt, Checking of all drugs prior to administration, e.g. expiry dates, correct quantity, correct drug, etc.	
2	The chemo prescription must be cross-checked and verified by a second staff member	
3	Policy on the Storage and Transport of hazardous drugs	
4	Procedure for the removal of expired, damaged, or contaminated stock	
5	Policy for products requiring special storage/Refrigeration (stored and handled under correct conditions)	
6	Policy on Fridges cleaning (once a month). Policy on Chemotherapy medicine fridges not to be used for other purposes, e.g. food storage	
7	Policy on Decontamination of all appropriate medical equipment, e.g. drip stands, infusion pumps, Biohazard Cabinets, re-usable containers, etc.	
8	Chemotherapy drugs are labelled immediately upon preparation, and labels include the following: Patient's name, a second identifier, full generic drug name, drug dose, route, expiration times (when applicable, e.g., Dacarbazine))	

	Pharmacy Equipment & Storage Areas Regulations:	
9	Anti-neoplastic mixing area/room is separate from the treatment area: with a separate Clinical hand wash basin and tap, and tiled area behind the taps	
10	''No unauthorised access'' signage displayed on the mixing room door, that should be kept close at all times	
11	Compounding is done by a licensed pharmacist, pharmacy assistant, or registered nurse with documented competency	
12	Floors should not be fitted with a carpet	
13	On-site Medical Refrigerator (for the storage of chemotherapy drugs) with alarm for refrigeration failure that will notify a responsible person in the event of a sudden rise of temperature required	
14	All Medical Refrigerators for the storage of chemotherapy drugs, must be equipped with a back-up system to provide uninterrupted power supply to fridge(s) in the event of an electrical power failure	
15	An accurately calibrated thermometer to record temperatures twice daily. There is a contingency plan to manage inappropriate temp's (room/fridge)	
16	Annual servicing of fridges carried out and documented	
17	BSC (Biological Safety Cabinets): Current service date displayed on cabinet and regular services (minimum annually) must be recorded.	
18	If Generators/UPS are used; regular testing and service. Records of -tests and services available. Diesel spill kit is a recommendation.	
19	Infusion pumps used for the administration of chemotherapy must be serviced annually. Records of service dates to be kept.	

	Drug Storage room:	
20	A safe and secured temperature-controlled area must be provided for the storage of drugs in accordance with manufacturers' instruction or other legal requirements. Only authorised personnel must be granted access.	
21	The temperature of room where medication is kept is constantly in the safe range and is recorded daily, using an accurately calibrated thermometer. Temp log is available. It is recommended that the temp is recorded twice daily	
22	Appropriate security and storage of Schedule 5, 6 & 7 substances. Drug book required for Scheduled drugs on the emergency trolley, e.g. Phenergan and Valium. If not, pharmacist needs to keep drugs in pharmacy. A policy on the management of these medicines in place.	

	Chemotherapy Admin area - Standard Operating Procedures Records:	
23	Record of more than 1 nurse on duty to cross check drugs prior to mixing and prior to administration.	
24	Policy on Chemotherapy Administration Protocol document that is used and applied daily	
25	Policy on Identification of patients based on 3 patient identifiers	
26	Policy on The Spillage of Cytotoxics	
27	Policy on Prevention and Management of extravasations	
28	Policy on Reporting and Management of Anaphylactic reactions and other adverse reactions.	
29	Policy on Management & Reporting of Needle Stick injuries	
30	Policy on the Collection and Disposal of Cytotoxic waste	
31	Policy on Sharps Disposal.	
32	The Policy on Infection Prevention and Control (IPC) is available	

	Chemotherapy Treatment Area contains:	
33	Emergency trolleys appropriately stocked and regularly checked. BLS Algorithm displayed clearly	
34	Chemotherapy is administered by trained & competent staff	
35	Basic equipment requirements including: Defibrillator, Oxygen cylinder with regulator, Portable suction machine, CPR Board, Blood Pressure monitoring, Ambubag.	
36	Suitable chairs made of a washable material.	
37	Patients seating arranged to enable nursing staff to directly observe all patients	
38	Floors not fitted with a carpet.	
39	Clinical hand wash basins with soap and paper towel dispenser, tile area behind the taps. Documented Guidelines on Handwashing	
40	Chemotherapy Spill kit is available	

	The Patient's Chemo Admin Records contains:	
41	Chemotherapy Prescription Document containing all the required information, see example Annexure B – ICONs Chemotherapy Prescription Document	
42	Chemotherapy Administration Record containing all the required information, see example Annexure B – ICON 's Chemotherapy Administration record	
43	A nursing record/process, with each entry signed and dated by the responsible nurse.	
44	A patient assessment document for each day of treatment, including Performance status, Vital signs, etc. with appropriate action records	
45	Infusion times (start & stop times) recorded of all drugs administered	
46	Documentation of verification (double checking) when chemotherapy is administered	
47	Documentation of post-chemotherapy instructions, e.g. pre-medication for next treatment session, details of medication taken at home, etc.	
48	Patients are provided with written procedures for handling body secretions and waste at home, where applicable	

Completed by: …… Signed: …… Date: .....

4. RTT Manager

	Radiation Therapy Prescription and Request Forms	
1	Evidence of diagnosis, clinical assessment and preferably, consultation notes, preceding radiation treatment	
2	Radiation prescription containing intent, modality, technique, dose per fraction and fraction number and the relevant clinical information	
3	Radiation prescriptions are filed and stored together with the treatment record	
4	Radiation is prescribed by a Radiation Oncologist	
5	Prescription is signed before commencement of radiation treatment with fraction numbers and total dose, treatment record and weekly treatment checks by RO	

	Treatment Records Before Radiation Therapy	
6	Policy and protocols on handing education brochures to all patients	
7	Policy and protocols on **contouring** organs at risk (OAR) per ICRU/RTOG/ESTRO guidelines	
8	Tumour and Organ at risk (OAR) **reporting** per internationally accepted protocols (e.g. ICRU, RTOG, ESTRO).	
9	Informed Consent signed	

	Treatment Records During Radiation Therapy	
10	Protocols in place for using at least 3 patient identifiers to be recorded in the patient's records	
11	Adherence to protocols for image matching	
12	RT's note weekly progress of patients or patient complaints	
13	Routine treatment checks by RO's/MO's; completions checked	
14	Alerts noted on the treatment record or patient folder and is visible to all staff	
15	Record and Verify systems SOPs are implemented as part of workflow	

	Radiation Treatment Area - Standard Operating Procedures records	
16	The availability and evidence of adherence to the Protocols and procedures on the preparation and delivery of a course of radiation or brachytherapy must be available and includes the following:	
17	Policy and protocol on the consent process preceding a course of radiation and brachytherapy treatment	
18	Protocols on the CT scanning and simulation processes to allow for 2D, 3D and advanced techniques	
19	Protocols on the manufacturing of immobilization devices for accuracy in set up	
20	Protocols on set up procedures to ensure reproducibility for entire treatment courses	
21	Protocols on planning procedures for 2D, 3D and advanced techniques	
22	Protocols on treatment procedures including daily QA with imaging and dosimetry	
23	Imaging protocols for all techniques of radiation therapy	
24	Protocols on the management of waiting lists	
25	Protocols to deal with scheduled and unscheduled breaks in treatment	
26	Comprehensive Quality Assurance Protocol	
27	Reporting structure with regards to adverse events	
28	Evidence of how these events are managed to prevent accidents	
29	Protocols on the re-irradiation of patients, in terms of overlap of fields and doses to organs at risk	
30	Policy and Protocols on source handling in the event of an after-loader source being stuck	

Completed by: …… Signed: ……. Date: .....

Medical Physicist

This section is managed by Medical Physics and is completed annually

Radiation Safety Management area		
	Radiation Monitoring	
1	Evidence of safety precautions in the handling of radioactive sources	
2	Radiation badge management by safety officer	
3	Register of all radiation badges	
4	Register of the dose accrued by all staff members	
5	Evidence of safety measures to prevent exposure accidents	
6	Protocols available on management of over exposures of staff	
7	Evidence of all staff wearing radiation badges when working in the radiation area	
8	Evidence of QC and QA procedures (daily, weekly, and monthly)	

	The Reporting of Complications and/or adverse events arising from Radiotherapy	
9	Adverse event protocol	
10	Register of incident reports and adverse events	
11	Quality improvement plan based on analysis of risk	
12	Reporting structure	
13	Evidence of how these events are managed to prevent accidents	
14	Audits of identified deficiencies or areas requiring action	

Radiation Treatment Area – Standard Operating Procedures		
	Protocols and Procedure of Radiation or Brachytherapy	
15	Comprehensive Quality Assurance Protocol	
16	Protocols to deal with scheduled and unscheduled breaks in treatment	
17	Licensing and authorisation in place with roles identified and defined within department	
18	Internal Rules are available	

Radiation Therapy Planning and Treatment Equipment		
	Linear Accelerators & Orthovoltage Protocols	
19	Procedures for operating the Linacs (Manuals)	
20	Protocols on the QC procedures as per SASQART	
21	Records on the QC procedures are stored	
22	Maintenance and service records are available	
23	Evidence of adherence to protocols on the QA procedures following upgrades and maintenance	
24	Independent yearly SASQART quality review including TRS 398 & any 2 additional tests from SASQART	

	Treatment planning systems	
25	Procedures on the operating of the TPS (Manual)	
26	Protocols on the QC procedures as per SASQART	
27	Records on the QC procedures are stored	
28	Evidence of adherence to protocols on the QA procedures following upgrades and maintenance	

	QA Equipment	
29	Evidence on the maintenance of the equipment	
30	Records of calibration/traceability (TRS 398) of local standard ionization chamber are available	

Reference:

1. Comprehensive Audits of Radiotherapy Practices: A Tool for Quality Improvement (QUATRO) Endorsed by EFOMP, ESTRO, IAEA and IOMP

Completed by: …… Signed: …… Date: .....