# SERVICE STANDARD 09F : CLINICAL SERVICES - ONCOLOGY SERVICES

*PREAMBLE*
*The Oncology Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community and cover the following but not limited to:-*
*a) appropriateness of clinical care*
*b) unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the oncologists in:-*
*i) overuse of treatments or procedures that do not help patients get better;*
*ii) underuse of care;*
*iii) misuse (or errors) of doing something incorrectly and harming patients.*

## TOPIC TOPIC 9F.1
## ORGANISATION AND MANAGEMENT

### STANDARD STANDARD 9F.1.1
The Oncology Services shall be organised, directed and coordinated with other services in the Facility to provide a high standard of inpatient and outpatient care to the community in a safe, efficient, effective, evidence based and caring manner with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information. The Oncology Services shall be easily accessible, patient focused and continuity of care assured.

| CRITERION NO. | CRITERIA FOR COMPLIANCE | SELF RATING | FACILITY COMMENTS | SURVEYOR FINDINGS | | |
|---|---|---|---|---|---|---|
| | | | | AREAS FOR IMPROVEMENT / RECOMMENDATIONS | SURVEYOR RATING | RISK |
| 9F.1.1.1 | Vision, Mission and values statements of the Facility are accessible. Goals and objectives that suit the scope of the Oncology Services are clearly documented and measurable that indicates safety, quality and patient centred care. These reflect the roles and aspirations of the service and the needs of the community. These statements are monitored, reviewed and revised as required and communicated to all staff. | NA | | | NA | |
| | **EVIDENCE OF COMPLIANCE** | | | | | |
| | 1. Vision, Mission and values statements of the Facility are available, endorsed and dated by the Governing Body. — NA | | | | | |
| | 2. Goals and objectives of the Oncology Services in line with the Facility statements are available, endorsed and dated. — NA | | | | | |
| | 3. Evidence of planned reviews of the above statements. — NA | | | | | |

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| | 4. | These statements are communicated to all staff (orientation programme, minutes of meeting, etc) | NA | | | | |
| | 5. | Achievement of goals and objectives are monitored, reviewed and revised accordingly. | NA | | | | |
| 9F.1.1.2<br>CORE | There is an organisation chart which:<br>a) provides a clear representation of the structure, functions and reporting relationships between the Person In Charge (PIC), Head of the Oncology Services, consultants, medical practitioners and staff of the Oncology Services.<br>b) is accessible to all staff and clients;<br>c) is revised when there is a major change in any of the following:<br>i) organisation;<br>ii) functions;<br>iii) reporting relationships;<br>iv) staffing patterns. | | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | | |
| | 1. | Clearly delineated current organisation chart with line of functions and reporting relationships between the Person In Charge (PIC), Head of the Oncology Services, consultants, medical practitioners and staff of the Oncology Services. | NA | | | | |
| | 2. | Organisation chart of the service is endorsed, dated and accessible. | NA | | | | |
| | 3. | The organisation chart is revised when there is a major change in any of the items (c)(i) to (iv). | NA | | | | |
| 9F.1.1.3 | The Governing Body shall ensure that the Oncology Services are organised as to:<br>a) facilitate the provision of oncology services to patients in the Facility in a safe, efficient, effective, and caring manner and with due regard for the needs, dignity and privacy of patients and confidentiality of their personal information;<br>b) assure continuity of care;<br>c) address the professional needs of the oncologists;<br>d) ensure that the oncologists are involved in the formulation of policies and procedures concerning patient care appropriate to the scope of services of the Facility. | | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | | |
| | 1. | Departmental/Service operational policies that address items (a) to (d). | NA | | | | |
| | 2. | Medical Staff By-Laws | NA | | | | |

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| | 3. | Evidence of involvement of oncologists in the formulation of policies and procedures concerning patient care. | NA | | | | |
| | 4. | Involvement of Head of the Service in the Medical and Dental Advisory Committee/Medical Advisory Committee and ward meetings. | NA | | | | |
| | 5. | Minutes of meetings | NA | | | | |
| | 6. | Proper and adequate equipment according to current standards. | NA | | | | |
| 9F.1.1.4 | There is a mechanism to ensure effective interaction between the Oncology Services<br>and the Governing Body and Management in all clinical aspects of healthcare and other relevant matters in the Facility. This mechanism is defined in the policies of the<br>Governing Body and is accomplished through:<br>a) the appointment/assignment of an oncologist as the Head of Oncology Services delineating his/her authority, responsibilities and accountabilities in a written document according to the relevant Acts, to manage and control the Oncology Services;<br>b) Medical and Dental Advisory Committee to advise the Governing Body on issues related to clinical governance, i.e. planning, coordinating, implementation, control and to improve activities relating to Oncology Services. | | NA | | | NA | |
| | | EVIDENCE OF COMPLIANCE | | | | | |
| | 1. | Letter of appointment/assignment and delineation of duties and responsibilities of the Head of the Service. | NA | | | | |
| | 2. | Letter of appointment and Terms of Reference as member of the Medical and Dental Advisory Committee/Medical Advisory Committee. | NA | | | | |
| 9F.1.1.5<br>CORE | The Head of Oncology Services has:<br>a) representation of the Service in committees and subcommittees where relevant;<br>b) representation of the Service in clinical staff liaison meetings;<br>c) involvement and provide regular input to the Senior Management Team. | | NA | | | NA | |
| | | EVIDENCE OF COMPLIANCE | | | | | |
| | 1. | Letter of representation of the Head of Service in committees and subcommittees where relevant, e.g. Blood Transfusion Committee, Medical Records Committee, Hospital Infection and Antibiotic Control Committee, etc. | NA | | | | |

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| | 2. | Minutes of meetings of committees | NA | | | | |
| | 3. | Minutes of meeting of Senior Management Team. | NA | | | | |
| 9F.1.1.6 | The assessment, planning, direction, evaluation and continuity of clinical care are the responsibility of oncologists managing individual patients, thus ensuring clinical independence. | | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | | |
| | 1. | Medical Staff By-Laws; clause indicate clinical care responsibility of oncologists. | NA | | | | |
| | 2. | Documented evidence of clinical notes in the patient's medical record; e.g. documentation on assessment, planning, direction, evaluation and continuity of clinical care, as well as patient care plan including the results of diagnostic tests, valid name stamp of medical practitioner. | NA | | | | |
| 9F.1.1.7 | The Head of Oncology Services shall be involved for the following aspects of management of the services:<br>a) the preparation of budget and ensuring that expenditure remains within the budget allocated;<br>b) human resource management and development;<br>c) development of policies and procedures and ensuring their compliance;<br>d) facility and equipment management;<br>e) safety and performance improvement activities and risk management. | | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | | |
| | 1. | Evidence of items (a) to (e) in the minutes of meetings of Oncology Services indicates the involvement of Head of Service. | NA | | | | |
| | 2. | Request for allocation of budget and staffing | NA | | | | |
| | 3. | Endorsement of policies and procedures | NA | | | | |
| | 4. | Implementation of performance improvement activities | NA | | | | |
| 9F.1.1.8 | Regular staff meetings are held between the Head of Service and staff with sufficient regularity to discuss issues and matters pertaining to the operations of the Oncology Services. Minutes are kept; decisions and resolutions made during meetings shall be accessible, communicated to all staff of the service and implemented. | | | NA | | | NA | |

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| | EVIDENCE OF COMPLIANCE | | | | | |
| | 1. | Minutes are accessible, disseminated and acknowledged by the staff. | NA | | | |
| | 2. | Attendance list of members with adequate representatives of the service. | NA | | | |
| | 3. | Frequency of meetings as scheduled. | NA | | | |
| | 4. | Discussion and resolutions are implemented (Problems not solved to be brought forward in the next meeting until resolved). | NA | | | |
| 9F.1.1.9 | Where there are medical practitioners in training, there is evidence that:<br>a) their responsibilities for patient care are documented;<br>b) their training needs are identified;<br>c) appropriate supervision and training are given to these medical practitioners. | | NA | | | NA |
| | EVIDENCE OF COMPLIANCE | | | | | |
| | 1. | Log books | NA | | | |
| | 2. | Assessment reports | NA | | | |
| | 3. | Training timetable, continuing medical education and attendances list. | NA | | | |
| 9F.1.1.10 | Appropriate statistics and records shall be maintained in relation to the provision of Oncology Services and used for managing the services and patient care purposes. | | NA | | | NA |
| | EVIDENCE OF COMPLIANCE | | | | | |
| | 1. | Records are available but not limited to the following: | | | | |
| | a) | workload/census for inpatients and outpatients; | NA | | | |
| | b) | annual report; | NA | | | |
| | c) | accident/incident reports; | NA | | | |
| | d) | staffing number and staff profile; | NA | | | |
| | e) | staff training records; | NA | | | |
| | f) | data on performance improvement activities, including performance indicators. | NA | | | |

TOPIC TOPIC 9F.2
HUMAN RESOURCE DEVELOPMENT AND MANAGEMENT

STANDARD STANDARD 9F.2.1
CREDENTIALING AND PRIVILEGING
The Oncology Services shall be directed by a qualified and competent oncologist, and staffed by suitably qualified and competent clinical staff to achieve the goals and objectives of the Oncology Services.

<table>
<tr><th rowspan="2">CRITERION NO.</th><th rowspan="2">CRITERIA FOR COMPLIANCE</th><th rowspan="2">SELF RATING</th><th rowspan="2">FACILITY COMMENTS</th><th colspan="3">SURVEYOR FINDINGS</th></tr>
<tr><th>AREAS FOR IMPROVEMENT / RECOMMENDATIONS</th><th>SURVEYOR RATING</th><th>RISK</th></tr>
<tr><td>9F.2.1.1<br>CORE</td><td>There is documented evidence of appropriate training and competency for the granting of clinical privileging. The criteria for determining privileges are specified and documented. There is a structured process to ensure the stated criteria are uniformly applied to all applicants. These include:<br>a) the criteria are designed to assure that patients will receive safe and quality care;<br>b) the criteria for individual privileging for specific procedures are documented in detail, e.g. competency records/log books, application from the individual practitioner, recommendations from peer/referee and minutes of meeting;<br>c) competency for each performance is dated, verified and signed by the supervisors;<br>d) the period of time for which the privileges are to be granted is specified;<br>e) current registration with the local professional registration bodies, e.g. Malaysian Medical Council, National Specialist Register (NSR);<br>f) peer recommendations are taken into account when privileges are being considered;<br>g) the recommendations of the relevant department and/or major professional services for privileges to be granted are taken into consideration.<br><br>EVIDENCE OF COMPLIANCE<br>1. Documented policies and procedures are established to govern the credentialing and privileging processes which include items (a) to (g). — NA<br>2. Compliance with policy and criteria for credentialing and privileging — NA<br>3. Competency records/log books — NA<br>4. Recommendations from peer/referee — NA<br>5. Annual Practising Certificate (APC), National Specialist Register (NSR) certificate and privileging certificate. — NA</td><td>NA</td><td></td><td></td><td>NA</td><td></td></tr>
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|---|---|---|---|---|---|---|---|
| | 6. | Availability of the list of procedures requiring credentialing and privileging. | NA | | | | |
| | 7. | Availability of list of procedures to include core procedures specific to the disciplines performed by medical officers. | NA | | | | |
| | 8. | Only radiation and clinical oncologists can prescribe radiotherapy. | NA | | | | |
| | 9. | Only clinical and medical oncologists can prescribe chemotherapy. | NA | | | | |
| | 10. | Pharmacist Certification for “Cancer Chemotherapy Preparation” training programme | NA | | | | |
| | 11. | Qualified and Privileged Medical Physicist | NA | | | | |
| | 12. | Qualified and Privileged nurses and radiographers for Oncology Services | NA | | | | |
| 9F.2.1.2 CORE | Documented evidence of privileges conferred by the Governing Body is available and accessible to relevant staff at point of care. | | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | | |
| | 1. | Formal letter of assignment or certificate of privileging with stipulated timeline are issued and reviewed accordingly. | NA | | | | |
| | 2. | Updated list of staff with privileges conferred is made accessible at point of care. | NA | | | | |
| 9F.2.1.3 | Clinical staff performs within the privileges conferred. | | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | | |
| | 1. | Verification of procedures performed by individuals at point of care within the awarded privileging rights with evidence of: | | | | | |
| | a) | list of procedures privileged; | NA | | | | |
| | b) | operating list; | NA | | | | |
| | c) | operating notes/clinical notes. | NA | | | | |
| 9F.2.1.4 | There are written and dated specific job descriptions for all categories of clinical staff<br>that include:<br>a) qualifications, training, experience and certification required for the position;<br>b) lines of authority;<br>c) accountability, functions, and responsibilities;<br>d) reviewed when required and when there is a major change in any of the following: | | | NA | | | NA | |

i) nature and scope of work;
ii) duties and responsibilities;
iii) general and specific accountabilities;
iv) qualifications required and privileges granted;
v) staffing patterns;
vi) Statutory Regulations.
e) administrative and clinical functions.

| EVIDENCE OF COMPLIANCE | | |
|---|---|---|
| 1. | Updated specific job description is available for each staff that includes but not limited to as listed in (a) to (e). | NA |
| 2. | Job description includes specialisation skills | NA |
| 3. | Relevant privileges granted where applicable | NA |
| 4. | The job description is acknowledged by the staff and signed by the Head of Service and dated. | NA |

STANDARD STANDARD 9F.2.2

*STAFF TRAINING, EDUCATION, APPRAISAL AND RESEARCH*

The Facility and all staff shall demonstrate an ongoing commitment to continuing medical education.

| CRITERION NO. | CRITERIA FOR COMPLIANCE | SELF RATING | FACILITY COMMENTS | SURVEYOR FINDINGS | | |
|---|---|---|---|---|---|---|
| | | | | AREAS FOR IMPROVEMENT / RECOMMENDATIONS | SURVEYOR RATING | RISK |
| 9F.2.2.1 | There are continuing education activities for staff including oncologists to pursue professional interests and to prepare for current and future changes in practice.<br>**EVIDENCE OF COMPLIANCE**<br>1. Training calendar includes in-house/external courses/ workshop/conferences — NA<br>2. Contents of training programme — NA<br>3. Training records on continuing education activities are kept and maintained for each staff including training in life support. — NA<br>4. Certificate of attendance/degree/post basic training — NA | NA | | | NA | |
| 9F.2.2.2 | The educational needs of staff and the Facility, as evidenced by the results of medicalcare evaluation such as incident reports, performance improvement studies and complaints, are taken into consideration when the content and structure of educational activities are planned.<br>**EVIDENCE OF COMPLIANCE**<br>1. Evidence of inclusion of results of audit activities, e.g. mortality and morbidity reviews, incident reporting, etc in educational activities. — NA<br>2. Evidence of improvement made from corrective or preventive measures from incident reports. — NA | NA | | | NA | |
| 9F.2.2.3 | In a Facility where undergraduate medical, nursing and allied health training programmes are conducted, the Facility shall ensure that there are sufficient skilled trained staff to provide clinical supervision of students.<br>**EVIDENCE OF COMPLIANCE**<br>1. Sufficient skilled trained staff to provide clinical supervision as per terms of Memorandum of Understanding. — NA | NA | | | NA | |

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|---|---|---|---|---|---|---|
| 9F.2.2.4 | There is evidence of an initial and on-going Facility approved training programme for staff to maintain competency in their current positions as the demand of the positions evolve.<br><br>EVIDENCE OF COMPLIANCE<br>1. There is evidence of an initial and on-going Facility approved training programme for staff to maintain competency in their current positions as the demand of the positions evolve. — NA<br>2. A staff development plan based on training needs assessment is available. — NA<br>3. Training schedule/calendar is in place. — NA<br>4. Training module, e.g. safe handling of cytotoxic drugs, spill or leak management etc. — NA | NA | | | NA | |
| 9F.2.2.5 | Staff including oncologists receive evaluation of their performance at the completion of the probationary period and annually thereafter, or as defined by the Facility.<br><br>EVIDENCE OF COMPLIANCE<br>1. Performance appraisal for staff including oncologists is completed upon probationary period and as an annual exercise. — NA | NA | | | NA | |
| 9F.2.2.6 | Where appropriate the Facility shall endeavour to undertake clinical research using available resources.<br><br>EVIDENCE OF COMPLIANCE<br>1. Documented evidence of research activities e.g. protocol, policies, consent etc. — NA | NA | | | NA | |

STANDARD STANDARD 9F.2.3

*STAFFING LEVEL AND STAFF COMPETENCY*

The Head and staff of the Oncology Services including medical practitioners are individuals qualified by education, training and experience commensurate with the requirements of the various positions and relevant laws.

| CRITERION NO. | CRITERIA FOR COMPLIANCE | SELF RATING | FACILITY COMMENTS | SURVEYOR FINDINGS | | |
|---|---|---|---|---|---|---|
| | | | | AREAS FOR IMPROVEMENT / RECOMMENDATIONS | SURVEYOR RATING | RISK |
| 9F.2.3.1 | Deployment of all service providers for the Oncology Services takes the following factors into consideration:<br>a) the number of persons deployed is proportional to the number of patients being cared for as in regulatory requirements and for the intensity of care provided;<br>b) the categories of service providers based on qualifications and experience providing care reflect the complexity of clinical problems being managed;<br>c) staffing needs shall take into consideration absences due to leave or illness; double shift duties by clinical staff shall be documented and monitored;<br>d) adequate staffing levels of appropriate competency shall be maintained throughout the hours the services are in operation. Where services need to be provided on a 24-hour basis, staffing level reflects the intensity of activities during each shift;<br>e) where it is not possible to have service providers on duty on site, e.g. after working hours, provision is made for relevant medical practitioners to be available on call. | NA | | NA | NA | |

| EVIDENCE OF COMPLIANCE | | | |
|---|---|---|---|
| 1. | Documentation and planning on deployment of staff that includes but not limited to items (a) to (e) with evidence of: | | |
| a) | deployment based on staff to patient ratio, bed occupancy rate and complexity of cases; | NA | |
| b) | special skills/training of staff; post basic trained nurses available in every shift; | NA | |
| c) | contingency plan during acute shortage; | NA | |
| d) | duty roster. | NA | |

STANDARD STANDARD 9F.2.4

*STAFF ORIENTATION*

A structured orientation programme introduces new staff to their services, operational policies and relevant aspects of the Facility to prepare them for their roles and responsibilities.

<table>
<tr><th rowspan="2">CRITERION NO.</th><th rowspan="2">CRITERIA FOR COMPLIANCE</th><th rowspan="2">SELF RATING</th><th rowspan="2">FACILITY COMMENTS</th><th colspan="3">SURVEYOR FINDINGS</th></tr>
<tr><th>AREAS FOR IMPROVEMENT / RECOMMENDATIONS</th><th>SURVEYOR RATING</th><th>RISK</th></tr>
<tr><td>9F.2.4.1</td><td>There is a structured orientation programme for all newly appointed staff to the Oncology Services, including oncologists and for those new to specific areas that include the following:<br>a) explanation of the goals, objectives, policies and procedures of the Facility and those of the Oncology Services;<br>b) lines of authority and areas of responsibility;<br>c) explanation of particular duties and functions;<br>d) explanation of the methods of assigning clinical care and the standards of clinical practice;<br>e) handover communication;<br>f) processes for resolving practice/ethical dilemmas in a timely manner;<br>g) information about safety procedures;<br>h) training in basic/advanced life support techniques;<br>i) methods of obtaining appropriate resource materials;<br>j) staff appraisal procedures for the Oncology Services;<br>k) education on Patient and Family Rights;<br>l) education on MSQH Standards requirements.<br><br>EVIDENCE OF COMPLIANCE<br>1. Policy requiring all new staff to attend a structured orientation programme — NA<br>2. There is Oncology Services orientation programme with relevant topics not limited to topics covered from (a) to (l). — NA<br>3. Attendance list — NA</td><td>NA</td><td></td><td></td><td>NA</td><td></td></tr>
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TOPIC TOPIC 9F.3
POLICIES AND PROCEDURES

STANDARD STANDARD 9F.3.1
*DEVELOPMENT, DERIVATION AND DOCUMENTATION*
There are written and dated policies and procedures for all activities of the Oncology Services. These policies and procedures reflect current standards of medical practice, relevant regulations, statutory requirements, and the purposes of the services. These policies and procedures, terms of reference, by-laws, rules or regulations, state how the clinical staff including medical practitioners regulate themselves and provide patient care. There shall be a list of procedures requiring informed consent specific to oncology. Possible risks and complications arising from procedures shall be documented either in specific consent forms or in patient's records.

| CRITERION NO. | CRITERIA FOR COMPLIANCE | SELF RATING | FACILITY COMMENTS | SURVEYOR FINDINGS | | |
|---|---|---|---|---|---|---|
| | | | | AREAS FOR IMPROVEMENT / RECOMMENDATIONS | SURVEYOR RATING | RISK |
| 9F.3.1.1<br>CORE | There are written policies and procedures for the Oncology Services which are consistent with the overall policies of the Facility, regulatory requirements and current standard practices. These policies and procedures are signed, authorised and dated. There is a mechanism for and evidence of a periodic review at least once in every three years.<br><br>EVIDENCE OF COMPLIANCE<br>1. Documented policies and procedures for the service. NA<br>2. Policies and procedures are consistent with regulatory requirements and current standard practices. NA<br>3. Evidence of periodic review of policies and procedures. NA<br>4. The policies and procedures are endorsed and dated. NA | NA | | | NA | |
| 9F.3.1.2 | Policies and procedures are developed by a committee in collaboration with staff, medical practitioners, Management and where required with other external service providers and with reference to relevant sources involved.<br><br>Cross departmental collaboration is practised in developing relevant policies and procedures where applicable.<br><br>EVIDENCE OF COMPLIANCE<br>1. Minutes of committee meetings on development and revision on policies and procedures. NA | NA | | | NA | |

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| | 2. | Minutes of meeting with evidence of cross reference with other departments | NA | | | | |
| | 3. | Cross departmental policies | NA | | | | |
| 9F.3.1.3<br>CORE | The policy and procedure documentation shall cover at least the following topics and any others required by law:<br>a) description of the organisational structure of the Oncology Services;<br>b) clinical practice guidelines;<br>c) clinical documentation includes pain as the 5th vital sign where appropriate;<br>d) handover communication;<br>e) treatment prescription (includes drug and radiation), dispensing and administration. All cancer chemotherapy are ordered on approved format;<br>f) blood transfusion where applicable;<br>g) continuing of care including regular review of patient, review of investigation results, discharge (planned or At Own Risk), referrals and escort as necessary;<br>h) pain management;<br>i) management of patients under police custody/prisoner;<br>j) management of cases with an infectious disease including notification of notifiable diseases;<br>k) the responsibilities of all staff in relation to internal and external disasters are documented, and known to the staff (contingency plan);<br>l) incident reports shall be compiled, investigated, discussed, recorded and action plans implemented;<br>m) end of life care;<br>n) management of a death. | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | |
| | 1. | Documented policies and procedures that address but not limited to items (a) to (n). | NA | | | | |
| | 2. | Checklist for patient chart documentation: | | | | | |
| | a) | history and physical examination; | NA | | | | |
| | b) | past medical history; | NA | | | | |
| | c) | review of systems and review of imaging studies and laboratory data; | NA | | | | |
| | d) | histopathology diagnosis; | NA | | | | |
| | e) | recommendations for treatment. | NA | | | | |
| | 3. | Treatment prescriptions should include planning and checklist for chemotherapy, radiation therapy and brachytherapy where applicable. | NA | | | | |

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| 9F.3.1.4 | Current policies and procedures are communicated to all staff.<br>EVIDENCE OF COMPLIANCE<br>1. Training and briefing on the current policies and procedures/Minutes of meetings — NA<br>2. Circulation list and acknowledgement — NA | | NA | | | NA | |
| 9F.3.1.5<br>CORE | There is evidence of compliance with policies and procedures<br>EVIDENCE OF COMPLIANCE<br>1. Compliance with policies and procedures through:<br>a) staff interview on practices; — NA<br>b) verify with observation on practices; — NA<br>c) results of audit on practices; — NA<br>d) practices in line with established policies and procedures. — NA | | NA | | | NA | |
| 9F.3.1.6 | Copies of policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-<br>Laws and statutory requirements are accessible to staff.<br>EVIDENCE OF COMPLIANCE<br>1. Copies of relevant policies and procedures, protocols, guidelines, relevant Acts, Regulations, By-Laws and statutory requirements are accessible on-site for staff reference. — NA | | NA | | | NA | |
| 9F.3.1.7 | The services shall operate on a 24-hour basis providing a level of care appropriate to<br>the activities of the patients in the Facility.<br>EVIDENCE OF COMPLIANCE<br>1. Operational policy on 24-hour services — NA<br>2. Staffing level reflects good mix of experienced staff and the intensity of activities during each shift. — NA<br>3. On-call roster is dated and authorised. — NA<br>4. Observation for compliance with policy — NA | | NA | | | NA | |

TOPIC TOPIC 9F.4
FACILITIES AND EQUIPMENT

STANDARD STANDARD 9F.4.1
The Head of Oncology Services shall ensure adequate facilities and equipment that are safe and appropriate are available for the staff to function effectively and to meet the goals and objectives of the services.

| CRITERION NO. | CRITERIA FOR COMPLIANCE | | SELF RATING | FACILITY COMMENTS | SURVEYOR FINDINGS | | |
|---|---|---|---|---|---|---|---|
| | | | | | AREAS FOR IMPROVEMENT / RECOMMENDATIONS | SURVEYOR RATING | RISK |
| 9F.4.1.1 | There are adequate and appropriate facilities and equipment with proper utilisation of space to enable staff to carry out their professional, teaching and administrative functions. | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | |
| | 1. | Adequate and proper utilisation of space. | NA | | | | |
| | 2. | Appropriate type of equipment to match the complexity of services. | NA | | | | |
| | 3. | Adequate facilities and equipment at each patient care area for safe care. (e.g. defibrillators, emergency cart, hand washing facilities, etc) | NA | | | | |
| | 4. | Easy access and clear exit routes | NA | | | | |
| | 5. | Absence of overcrowding | NA | | | | |
| 9F.4.1.2 | Existing facilities shall take cognisance of the safety of staff and patients. | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | |
| | 1. | Design and layout of the unit, e.g. wards, treatment rooms, dirty and clean utility rooms, access, lighting, signage, etc address the safety aspects of patients and staff. | NA | | | | |
| | 2. | Adequate equipment and supplies for Oncology Services, e.g. emergency trolley, functioning patient call bell, etc. | NA | | | | |
| | 3. | Equipment should have scheduled planned preventive maintenance (PPM). | NA | | | | |
| 9F.4.1.3 | Suitable and adequate forms of communication and inter-communication systems and equipment are provided to enable clinical staff to communicate among themselves and with the other members of the healthcare team. | | NA | | | NA | |

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|---|---|---|---|---|---|---|---|
| | EVIDENCE OF COMPLIANCE | | | | | | |
| | 1. | Appropriate telecommunication modalities available for daily operation and during emergencies. | NA | | | | |

STANDARD STANDARD 9F.4.2

*FACILITIES AND EQUIPMENT FOR PATIENT CARE*

Adequate facilities and equipment shall be available to provide safe and effective patient care.

| CRITERION NO. | CRITERIA FOR COMPLIANCE | | SELF RATING | FACILITY COMMENTS | SURVEYOR FINDINGS | | |
|---|---|---|---|---|---|---|---|
| | | | | | AREAS FOR IMPROVEMENT / RECOMMENDATIONS | SURVEYOR RATING | RISK |
| 9F.4.2.1 | Facilities are suitably located to facilitate easy access and to provide an atmosphere of user, environmental and 'disabled' friendly. | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | |
| | 1. | Floor plan indicates accessibility and patient and user friendly. | NA | | | | |
| | 2. | Feedback from patient satisfaction survey | NA | | | | |
| | 3. | Incident reporting relating to facilities if any. | NA | | | | |
| 9F.4.2.2 | Equipment, both for emergency and non-emergency usage, shall be appropriate to the level of care. | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | |
| | 1. | Availability of emergency and non-emergency equipment appropriate to level of care, such as defibrillator, emergency trolley, suction machine, electrocardiogram (ECG) machine, infusion or syringe pump, vital sign monitor, etc. | NA | | | | |
| | 2. | Scheduled checking of items in emergency trolley | NA | | | | |
| 9F.4.2.3 | There is documented evidence that equipment complies with relevant national/international standards and current statutory requirements. | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | |
| | 1. | Certification of equipment from certified bodies, e.g. Standards and Industrial Research Institute of Malaysia (SIRIM), Agency Nuclear Malaysia, etc as evidence of compliance to the relevant standards and Acts. | NA | | | | |
| | 2. | Testing, commissioning and calibration records (certificates or stickers) | NA | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 3. | Biological Safety Cabinet (BLSC) for preparation of chemotherapy drugs comply with Class II Type B or better, externally-vented BLSC which must have airflow monitoring devices and be certified every year. | NA | | | | |
| | 4. | Sterile disposable equipment is used for all cancer chemotherapy drugs, luer-lock devices etc. | NA | | | | |
| 9F.4.2.4<br>CORE | There is evidence that the facility has a comprehensive maintenance programme such as predictive maintenance, planned preventive maintenance and calibration activities, to ensure the facilities and equipment are in good working order. | | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | | |
| | 1. | Planned Preventive Maintenance records, such as schedule, stickers, etc. | NA | | | | |
| | 2. | Planned Replacement Programme (where applicable) | NA | | | | |
| | 3. | Complaint records | NA | | | | |
| | 4. | Asset inventory | NA | | | | |
| 9F.4.2.5 | Where specialised equipment is used, there is evidence that only staff who are trained<br>and authorised by the Facility operate such equipment. | | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | | |
| | 1. | User training records | NA | | | | |
| | 2. | Competency assessment record | NA | | | | |
| | 3. | Letter of authorisation | NA | | | | |
| | 4. | List of staff trained and authorised to operate specialised equipment | NA | | | | |
| 9F.4.2.6 | Equipment is upgraded (based on evidence) from time to time so as to keep pace with<br>advancement in operative and diagnostic techniques and technology. | | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | | |
| | 1. | Equipment are being replaced and upgraded to meet current standard of care and advancement in technology in a planned and systematic manner. | NA | | | | |

STANDARD STANDARD 9F.4.3

*FACILITIES FOR ONCOLOGY OUTPATIENT SERVICES*

Where specialist outpatient services are provided, there are adequate outpatient clinics to enable the provision of safe and effective patient care; and patient privacy and confidentiality are assured.

| CRITERION NO. | CRITERIA FOR COMPLIANCE | | | SELF RATING | FACILITY COMMENTS | SURVEYOR FINDINGS | | |
|---|---|---|---|---|---|---|---|---|
| | | | | | | AREAS FOR IMPROVEMENT / RECOMMENDATIONS | SURVEYOR RATING | RISK |
| 9F.4.3.1 | The Specialist Outpatient Services shall have the following features:<br>a) the organisation and management of the clinics are planned to ensure prompt attention to patients, minimal waiting time, and avoidance of unnecessary visits by the patients;<br>b) record keeping shall be efficient;<br>c) an appointment or queuing system is used to manage patient consultations;<br>d) the clinic is easily accessible including for non-ambulant patients and is easily identified through adequate signage;<br>e) the clinic is located close to other facilities, e.g. radiology and pharmacy;<br>f) adequate provision is made for patient comfort. | | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | | |
| | 1. | The Specialist Outpatient Services address items (a) to (f) with evidence of but not limited to the following: | | | | | | |
| | a) | list of services available and offered to patients; | NA | | | | | |
| | b) | flow chart on work process; | NA | | | | | |
| | c) | safe keeping of medical records; | NA | | | | | |
| | d) | security of data in Health Information System; | NA | | | | | |
| | e) | clinic appointment system; | NA | | | | | |
| | f) | monitoring of waiting time; | NA | | | | | |
| | g) | adequate and appropriate signage; | NA | | | | | |
| | h) | floor plan indicates accessibility to supporting services and optimisation of space; | NA | | | | | |
| | i) | adequate patient personal use items, e.g. wheelchair, | NA | | | | | |
| | j) | adequate waiting area, rest rooms, refreshments, reading material and parking space. | NA | | | | | |
| 9F.4.3.2 | Adequate numbers of rooms are provided to ensure patient privacy and confidentiality | | | NA | | | NA | |

for various patient care activities including:
a) consultation (only one patient in a room at any time);
b) conduct of minor procedures and nursing procedures;
c) performance of various tests.

| EVIDENCE OF COMPLIANCE | | |
|---|---|---|
| 1. | Adequate facilities for consultation and patient care activities that address items (a) to (c) with evidence of but not limited to the following: | |
| a) | privacy of patient is ensured; | NA |
| b) | procedure room appropriately equipped; | NA |
| c) | patient monitoring device is available where required; | NA |
| d) | list of procedures done. | NA |

TOPIC TOPIC 9F.5
SAFETY AND PERFORMANCE IMPROVEMENT ACTIVITIES

STANDARD STANDARD 9F.5.1
The Head of Oncology Services shall ensure the provision of quality performance with staff involvement in the continuous safety and performance improvement activities of the Services. The Head of Oncology Services shall ensure compliance to monitoring of specific performance indicators.

| CRITERION NO. | CRITERIA FOR COMPLIANCE | SELF RATING | FACILITY COMMENTS | SURVEYOR FINDINGS | | |
|---|---|---|---|---|---|---|
| | | | | AREAS FOR IMPROVEMENT / RECOMMENDATIONS | SURVEYOR RATING | RISK |
| 9F.5.1.1 | There are planned and systematic safety and performance improvement activities to<br>monitor and evaluate the performance of the Oncology Services. The process includes:<br>a) Planned activities<br>b) Data collection<br>c) Monitoring and evaluation of the performance<br>d) Action plan for improvement<br>e) Implementation of action plan<br>f) Re-evaluation for improvement<br>Innovation is advocated. | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | |
| | 1. Planned performance improvement activities include (a) to (f) — NA<br>2. Records on performance improvement activities — NA<br>3. Minutes of performance improvement meetings — NA<br>4. Performance improvement studies — NA<br>5. Mortality and morbidity audits with remedial actions — NA<br>6. Records on innovation if available. — NA | | | | | |
| 9F.5.1.2 | The Head of Oncology Services has assigned the responsibilities for planning, monitoring and managing safety and performance improvement activities to appropriate<br>individual/personnel within the respective services. | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | |
| | 1. Minutes of meetings — NA<br>2. Letter of assignment of responsibilities — NA | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 3. | Job description | NA | | | | |
| 9F.5.1.3 | The Head of the Oncology Services shall ensure that the staff are trained and complete<br>incident reports which are promptly reported, investigated, discussed by the staff with<br>learning objectives and forwarded to the Person In Charge (PIC) of the Facility.<br>Incidents reported have had Root Cause Analysis done and action taken within the agreed time frame to prevent recurrence.<br><br>EVIDENCE OF COMPLIANCE | | | NA | | | NA | |
| | 1. | System for incident reporting is in place, which include: | | | | | |
| | a) | Training of staff | NA | | | | |
| | b) | Policy on incident reporting | NA | | | | |
| | c) | Methodology of incident reporting | NA | | | | |
| | d) | Register/records of incidents | NA | | | | |
| | 2. | Completed incident reports | NA | | | | |
| | 3. | Root Cause Analysis | NA | | | | |
| | 4. | Corrective and preventive action plans | NA | | | | |
| | 5. | Remedial measure | NA | | | | |
| | 6. | Minutes of meetings | NA | | | | |
| | 7. | Acknowledgment by Head of Service and PIC/Hospital Director | NA | | | | |
| | 8. | Feedback given to staff regarding incident reporting. | NA | | | | |
| 9F.5.1.4<br>CORE | The staff including oncologists provide an appropriate peer group structure<br>for performing the safety and performance improvement activities to accomplish clinical care evaluation.<br>a) The oncologists undertake clinical reviews of all risk assessments, incident reports, audits and safety and performance improvement activities:<br>i) as a single committee for all safety and performance improvement activities;<br>ii) in multidisciplinary committees within the Services;<br>iii) in a variety of purpose-specific committees, such as mortality and morbidity, infection control, blood transfusion, etc.<br>b) Whatever structure is utilised, provision is made for review and analysis of the clinical work of each individual clinical service, department, unit or function.<br><br>EVIDENCE OF COMPLIANCE | | | NA | | | NA | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 1. | Performance improvement activities | NA | | | | |
| | 2. | Minutes of meetings | NA | | | | |
| | 3. | Relevant reports and documents, e.g. clinical audit reports, incident reports, mortality and morbidity review reports, etc. | NA | | | | |
| 9F.5.1.5<br>CORE | There is tracking and trending of specific performance indicators not limited to but at least three (3) of the following:<br>a) number of mortality/morbidity audits/meetings being conducted in the department with documentation of cases discussed<br>b) percentage of patients developed extravasation chemotherapy treatment (Target: less than 5%)<br>c) percentage of oncology systemic therapy prescription (from prescription to administration) | | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | | |
| | 1. | Specific performance indicators monitored. | NA | | | | |
| | 2. | Records on tracking and trending analysis. | NA | | | | |
| | 3. | Remedial measures taken where appropriate | NA | | | | |
| 9F.5.1.6 | Feedback on results of safety and performance improvement activities are regularly communicated to the staff. | | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | | |
| | 1. | Results on safety and performance improvement activities are accessible to staff. | NA | | | | |
| | 2. | Evidence of feedback via communication on results of performance improvement activities through continuing medical education/meetings. | NA | | | | |
| | 3. | Minutes of service/committee meetings | NA | | | | |
| 9F.5.1.7 | Appropriate documentation of safety and performance improvement activities is kept<br>and confidentiality of medical practitioners, staff and patients is preserved. | | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | | |
| | 1. | Documentation on performance improvement activities and performance indicators. | NA | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 2. | Policy statement on anonymity on patients and providers involved in performance improvement activities. | NA | | | | |

TOPIC TOPIC 9F.6
SPECIAL REQUIREMENTS – ONCOLOGY SERVICES

STANDARD STANDARD 9F.6.1
*RADIOTHERAPY SERVICES*
The Facility is constructed, equipped, operated and maintained in a manner that ensures appropriate radiotherapy services are available to treat cancer patients effectively taking into consideration the safety of the patients, visitors, and staff, and in accordance to relevant regulatory requirements.

| CRITERION NO. | CRITERIA FOR COMPLIANCE | SELF RATING | FACILITY COMMENTS | SURVEYOR FINDINGS | | |
|---|---|---|---|---|---|---|
| | | | | AREAS FOR IMPROVEMENT / RECOMMENDATIONS | SURVEYOR RATING | RISK |
| 9F.6.1.1<br>CORE | There is documented evidence that the Facility operates under a valid license as required in accordance to the Atomic Energy Licensing Act 1984.<br><br>EVIDENCE OF COMPLIANCE<br>1. Valid license — NA<br>2. Approval from Atomic Energy Licensing Board — NA | NA | | | NA | |
| 9F.6.1.2<br>CORE | The Facility providing radiotherapy shall have the minimum equipment required to carry out therapy effectively namely :<br>a) Linear accelerator (or similar)<br>b) Treatment planning computer<br>c) Simulator or CT simulator or equivalent;<br>d) Equipment, for calibration including dosimeter<br>e) Tertiary collimation methods such as multi leaf collimators or block cutting and casting equipment<br><br>EVIDENCE OF COMPLIANCE<br>1. Availability of equipment (a) to (e) to carry out therapy. — NA | NA | | | NA | |
| 9F.6.1.3<br>CORE | Facility that has a brachytherapy machine or live sources, e.g. radioiodine, shall operate in accordance with the relevant laws and statutory requirements:<br>a) High Dose Rate (HDR) Brachytherapy:<br>i) Facilities are as specified by the appropriate authority.<br>ii) There is evidence that the HDR after loader undergoes quality assurance tests at the beginning of each treatment day, and emergency safety container and kit are always available.<br>b) Low Dose Rate (LDR) Brachytherapy:<br>i) There are special single rooms as specified by the appropriate authority. | NA | | | NA | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | ii) Policies and procedures are in place for staff handling these patients.<br>iii) Proper warning signs are placed on the door of the room.<br>iv) Facilities for proper storage of all radiation sources are mandatory in accordance to applicable laws.<br>c) Seed Implants<br>i) Policies and procedures are in place for staff handling these patients.<br>ii) Proper warning signs are placed on the door of the room.<br>iii) Facilities for proper storage of all radiation sources are mandatory.<br>iv) Patients shall be monitored for radiation prior to discharge to ensure safe radiation levels<br><br>EVIDENCE OF COMPLIANCE<br>1. Checklist for HDR brachytherapy including for daily quality assurance and treatment planning. NA<br>2. Calibration certificates for new sources. NA<br>3. Checklist for LDR brachytherapy and safe room monitoring including approved personnel access and double locks. NA<br>4. When brachytherapy is performed, written directives are documented for each procedure and should include the treatment site, isotope, number of sources and the planned dose to designated points. NA<br>5. After completion a written summary of treatment delivery should include total dose of brachytherapy and external beam therapy, date of source insertion and documentation of a radiation safety survey of the patient and room. NA<br>6. Items (i) to (iv) for Seed Implants should be addressed by the Facility. NA | | | | | |
| 9F.6.1.4<br>CORE | There is a full time medical physicist trained in radiotherapy who conducts or supervises the calibration, dosimetry, and quality assurance in therapeutic use of radiation including teletherapy and brachytherapy.<br><br>EVIDENCE OF COMPLIANCE<br>1. Availability of trained medical physicist NA<br>2. Specified job description NA | NA | | | NA | |
| 9F.6.1.5<br>CORE | There is documented evidence that all radiotherapy equipment, where applicable, complies with relevant standards. The equipment are checked and calibrated at prescribed intervals by designated personnel to ensure equipment functions at optimum/preset levels of performance. | NA | | | NA | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | EVIDENCE OF COMPLIANCE | | | | | | |
| | 1. | Checklist for daily, weekly and monthly check | NA | | | | |
| | 2. | Recalibration log | NA | | | | |

STANDARD STANDARD 9F.6.2

*RADIATION SAFETY*

There is an effective Facility-wide radiation safety programme to deal with radiation hazards to patients, visitors, and staff.

| CRITERION NO. | CRITERIA FOR COMPLIANCE | SELF RATING | FACILITY COMMENTS | SURVEYOR FINDINGS | | |
|---|---|---|---|---|---|---|
| | | | | AREAS FOR IMPROVEMENT / RECOMMENDATIONS | SURVEYOR RATING | RISK |
| 9F.6.2.1 CORE | There are documented safety procedures specific to potentially hazardous areas and for hazardous substances.<br>**EVIDENCE OF COMPLIANCE**<br>1. Documented safety procedures specific to potentially hazardous areas and for hazardous substances. — NA<br>2. Identified hazardous areas — NA<br>3. Identified hazardous substances — NA<br>4. On-site verification on compliance with safety procedures — NA | NA | | | NA | |
| 9F.6.2.2 CORE | Special safety measures in the form of facilities and equipment are provided for hazardous areas in accordance with requirements of local statutory authorities and applicable standards.<br>**EVIDENCE OF COMPLIANCE**<br>1. Facilities and equipment provided for hazardous areas in accordance with requirements of local statutory authorities and applicable standards. — NA<br>2. Personal protective equipment are available. — NA<br>3. Compliance to usage of personal protective equipment — NA | NA | | | NA | |
| 9F.6.2.3 CORE | A Radiation Safety Committee shall be established in accordance to the statutory Acts and Regulations and shall ensure evidence of:<br>a) safety measures against radiation hazard for staff, patients, and visitors;<br>b) appropriate radiation delivery by trained therapy radiographers;<br>c) monitoring of radiation exposure of staff (special precaution for pregnant staff);<br>d) proper disposal of waste products;<br>e) medical examination including Full Blood Count for staff exposed to radiation once in three years and more frequent for those exposed to higher ionizing radiation. | NA | | | NA | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | EVIDENCE OF COMPLIANCE | | | | | | |
| | 1. | Terms of Reference of Radiation Safety Committee to address items (a) to (e) | NA | | | | |
| | 2. | Minutes of meetings | NA | | | | |
| 9F.6.2.4<br>CORE | There is evidence of safety measures against radiation hazard for patients:<br>a) the decision to treat with radiotherapy shall be made by a qualified clinical/radiation oncologist;<br>b) accepted treatment protocols;<br>c) choice of machines and related equipment;<br>d) appropriate use of machines according to specifications. | | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | |
| | 1. | Safety measures against radiation hazard for patients address items (a) to (d). | NA | | | | |
| | 2. | Documented formal treatment planning system and quality assurance plan should be available. | NA | | | | |
| | 3. | At completion of treatment, the oncologist or medical officer shall review the entire chart to affirm the fulfilment of the prescription dose and document in patient's chart/folder. | NA | | | | |
| | 4. | Patient to be evaluated by the oncologist or medical officer at least weekly and examination be documented in the patient chart or case notes. | NA | | | | |
| | 5. | At completion of treatment, a follow-up plan should be documented in the patient notes. Follow-up notes should be documented. | NA | | | | |
| 9F.6.2.5<br>CORE | There are safety measures against radiation hazard for staff:<br>a) Design of work station to conform to radiation safety standards.<br>b) Adequate radiation warning signs.<br>c) Protective clothing and equipment (with safety interlocks, proper location of emergency buttons and related safety equipment) are provided and their usage monitored.<br>d) Film badges/monitoring devices are used, properly maintained and detailed records are kept. | | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | |
| | 1. | Safety measures against radiation hazard for staff include but not limited to items (a) to (d). | NA | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 9F.6.2.6<br>CORE | There are safety measures against radiation hazard for visitors:<br>a) adequate signages at all premises housing radiation sources, including multilingual signs warning women of childbearing age about radiation dangers are prominently displayed;<br>b) control the visit to patients undergoing brachytherapy treatments, e.g. the age and health status of visitors and duration of visit, etc.<br><br>EVIDENCE OF COMPLIANCE<br>1. Safety measures against radiation hazard for visitors include but not limited to items (a) and (b). — NA | NA | | | NA | |

STANDARD STANDARD 9F.6.3

*CHEMOTHERAPY SERVICES*

The Facility is constructed, equipped, operated, and maintained in a manner that ensures appropriate chemotherapy services are available to treat cancer patients effectively taking into consideration the safety of the patients, visitors, and staff, and in accordance to relevant regulatory requirements.

| CRITERION NO. | CRITERIA FOR COMPLIANCE | SELF RATING | FACILITY COMMENTS | SURVEYOR FINDINGS | | |
|---|---|---|---|---|---|---|
| | | | | AREAS FOR IMPROVEMENT / RECOMMENDATIONS | SURVEYOR RATING | RISK |
| 9F.6.3.1<br>CORE | There are documented policies and procedures that chemotherapy services shall be performed within requirements that include the following:<br>a) chemotherapy shall be prescribed and supervised by accredited and experienced oncologists;<br>b) all patients shall be treated according to established chemotherapy protocols, and variances from protocols are monitored;<br>c) there is evidence of collaborative care among specialists in chemotherapy, surgery, radiotherapy, and palliative medicine for optimum clinical management;<br>d) all principal clinical support services shall be readily available, e.g. dietetics, physiotherapy, occupational therapy, counselling etc.<br><br>EVIDENCE OF COMPLIANCE<br>1. Policies and procedures which address items (a) to (d). — NA<br>2. Compliance with policies and procedures — NA<br>3. Patient's medical record — NA<br>4. Patient chart review for evidence of team discussion — NA | NA | | | NA | |
| 9F.6.3.2<br>CORE | Privileged oncology trainees, medical officers and trained nurses with approved certification or oncologists shall deliver intravenous chemotherapy.<br><br>EVIDENCE OF COMPLIANCE<br>1. Verification of procedure performed by individual at point of care within the awarded privileging rights with evidence of privileging certificates. — NA | NA | | | NA | |
| 9F.6.3.3<br>CORE | Day care chemotherapy option is made available where there is a dedicated area for treatment, trained personnel and necessary support facilities such as pharmacy services for reconstitution of chemotherapy drugs.<br><br>EVIDENCE OF COMPLIANCE | NA | | | NA | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | 1. | Availability of day care service with dedicated areas. | NA | | | | |
| | 2. | Qualified and competent personnel | NA | | | | |
| | 3. | Support facilities, e.g. pharmacy services for reconstitution of chemotherapy drugs. | NA | | | | |
| 9F.6.3.4<br>CORE | There shall be documented record of the treatment received by the patient, prescribed protocol of therapy, types of drugs, dosages, and dates when given or reviewed and reasons given for changes. | | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | | |
| | 1. | Patient's medical record documentation | NA | | | | |
| | 2. | Observation/patient interview during survey | NA | | | | |
| 9F.6.3.5<br>CORE | There is evidence that healthcare professionals provide the patient and carer with clear, pre- and post-treatment information and possible side effects, e.g. nausea and vomiting, neutropaenic sepsis etc. | | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | | |
| | 1. | Patient's consent form for chemotherapy | NA | | | | |
| | 2. | Patient and carer orientation checklist | NA | | | | |
| 9F.6.3.6<br>CORE | The reconstitution of chemotherapy drugs is done in a safe and appropriate environment including facility, using the correct equipment and by trained personnel in accordance with regulatory requirements. | | | NA | | | NA | |
| | EVIDENCE OF COMPLIANCE | | | | | | | |
| | 1. | Functional facilities for reconstitution of chemotherapy drugs as per National Pharmaceutical Control Bureau (BPFK). | NA | | | | |
| | 2. | Trained and certified pharmacist to reconstitute chemotherapy drugs. | NA | | | | |

STANDARD STANDARD 9F.6.4
*RADIOACTIVE AND CYTOTOXIC WASTE*

| CRITERION NO. | CRITERIA FOR COMPLIANCE | SELF RATING | FACILITY COMMENTS | SURVEYOR FINDINGS | | |
|---|---|---|---|---|---|---|
| | | | | AREAS FOR IMPROVEMENT / RECOMMENDATIONS | SURVEYOR RATING | RISK |
| 9F.6.4.1<br>CORE | There is evidence of safe handling and disposal of cytotoxic consumables, including the use of approved colour coded waste bags, protective clothing, and appropriate collection and storage facility prior to removal from the site, and mechanism of monitoring such handling.<br>**EVIDENCE OF COMPLIANCE**<br>1. Cytotoxic containers clearly and visibly display the cytotoxic hazard symbol. — NA<br>2. Clearly marked chemotherapy waste receptacles are kept in all areas where cytotoxic drugs are stored, prepared or administered. — NA<br>3. All cytotoxic drug waste is separated from general waste. — NA<br>4. Cytotoxic waste is destroyed in an incinerator approved for the destruction of cytotoxic drugs. If incinerator not available, transported to and bury in a licensed hazardous waste dump. If the service is outsourced, the contractual agreement should include the standard operating procedures for disposal of cytotoxic waste. — NA | NA | | | NA | |
| 9F.6.4.2<br>CORE | The labelling and disposal of scheduled waste (cytotoxic and radioactive) as defined in the Environmental Quality Act 1974 (Act 127) and subsequent amendments are implemented in accordance with the requirements of the relevant Acts.<br>Notes/Explanation<br>These procedures, including the removal of waste from the site, are in accordance with the requirements of the relevant authority or authorities such as The Environmental Quality Act 1974 (Act 127) and subsequent amendments and the subsidiary legislation referring to Scheduled Waste, Prescribed Premises, Prescribed Activities, Atomic Energy Licensing Act 1984.<br>**EVIDENCE OF COMPLIANCE**<br>1. Compliance with the Environmental Quality Act — NA | NA | | | NA | |
| 9F.6.4.3<br>CORE | Spillages kits shall be readily available to contain spillage of cytotoxic drugs with documented procedures regarding their usage. | NA | | | NA | |

| EVIDENCE OF COMPLIANCE | | |
|---|---|---|
| 1. | Cytotoxic drug spill kit should be located at an easily accessible area and clearly labelled. It must be reviewed regularly to ensure its contents have not deteriorated, and have been restocked upon use. | NA |
| 2. | The minimum contents of cytotoxic drug spill kit should include: | |
| a) | Spill handling procedure (1) | NA |
| b) | Cytotoxic spill caution sign (1) | NA |
| c) | Personal protective equipment: | |
| i) | Head cover (1) | NA |
| ii) | Goggles/ full-face chemical splash shield (1) | NA |
| iii) | Disposable N95 face mask (1) | NA |
| iv) | Disposable gown (1) | NA |
| v) | Chemo nitrile gloves (1 pair) | NA |
| vi) | Surgical nitrile gloves (1 pair) | NA |
| vii) | Booties (1) | NA |
| d) | Brush and small dustpan (1) | NA |
| e) | Clinical waste plastic bag labelled ‘Cytotoxic waste, handle with care’ (2) | NA |
| f) | Bag ties (2) | NA |
| g) | Forceps (1) | NA |
| h) | Absorbent pad (12) | NA |
| i) | Strong alkaline cleaning agent (1) | NA |
| j) | Water (1) | NA |
| k) | Small sharps container (1) | NA |
| l) | Cytotoxic drug spill incident report form (1) | NA |

| SERVICE SUMMARY | |
|---|---|
| - | |
| OVERALL RATING : | NA |
| OVERALL RISK : | - |