Systemic Anti-Cancer (SACT)

Administration Policy

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This policy has been written in context of National policy with acknowledgement to the Northern Cancer Alliance Chemotherapy administration policy as a reference.			
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AMENDMENT HISTORY *(Complete for existing documents that need amendment within their 3-year life span)*				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**

1. Introduction

1.1 This policy aims to provide step by step guidance to support administration and minimise the risks associated with the delivery of Systemic Anti-Cancer Therapy (SACT) within the Lancashire and South Cumbria (LSC) Cancer Alliance.

1.2 This policy refers to the use of SACT in the treatment of malignant disease in adults and children and has been developed in line with the National Cancer Peer Review Programme Manual for Cancer Services: Chemotherapy Measures.

1.3 For the purposes of this policy the term 'chemotherapy' and 'cytotoxic' and SACT are used interchangeably and refers to all systemic anti-cancer therapy (SACT). Anti-cancer treatments in this context can refer to cytotoxic drugs, immunotherapies, monoclonal antibodies, protein kinase inhibitors and immunomodulating drugs.

1.4 For the purposes of this policy adult patients are individuals over 18 years.

1.5 SACT for malignant disease is provided by the following Acute Trusts:

- Lancashire Teaching NHS Foundation Hospitals
- East Lancashire Teaching Hospitals NHS Trust
- University Hospital of Morecombe Bay
- Blackpool Teaching Hospitals

1.6 SACT administration should be provided by a multidisciplinary team in which doctors, specialist nurses and pharmacists work to approved written protocols to provide integrated care both within the hospital and the community.

1.7 This policy aims to safeguard patients and staff by defining standards of practice for all disciplines involved in the prescribing, handling and administration of SACT. It should be read in conjunction with other relevant policies available for each individual Trust.

1.8 It is the responsibility of the individual Trust, via their local SACT Group, to develop a local SACT Operational Policy which supports and complies with this document. The policy should be approved by the head of the Clinical SACT service for the individual Trust and then submitted via local governance procedures for approval.

2. Limitations

2.1 This policy is intended to support best practice guidance for staff involved in administration and monitoring of patients, who are receiving SACT. It is designed to be complimentary to Trust Medicine Policies which will include drug administration and must be used alongside Trust Policy.

2.2 In the event of any variation between this policy and in Trust policy, readers are advised to follow their own Trust policy and bring the matter to the LSC SACT Group to discuss.

2.3 This policy does not deal with cytotoxic agents or monoclonal antibodies specifically for any other indication including that for immunosuppression purposes or for the treatment of non-malignant disease e.g. methotrexate for rheumatoid arthritis.

3. Initiating Treatment and Prescribing

3.1 All Clinical Staff involved in the prescription, preparation and administration of SACT will have completed relevant training and be reviewed on an annual basis of competence that is applicable to their area of clinical expertise.

3.2 Names of Prescribers of SACT should be updated at least annually and records kept for review.

3.3 Each trust should have a clear training and assessment policy with all staff, medical, nursing and pharmacy undergoing a clear training and competency assessment with annual CPD documented and recorded electronically in a central register.

3.4 Use of the iQemo electronic prescribing system

3.4.1 All prescribing of SACT must be done using the iQemo system

3.4.2 All prescriptions in iQemo must be marked as dispensed and administered as applicable

3.4.3 The workflow in iQemo is as follows:

Action	Performed by	Notes
Prescribing	Prescriber (e.g. doctor, NMP)	This should normally be done in advance of the patient's treatment to allow pharmacy to prepare the drug. It can be done in advance of the latest blood results provided the prescriber is satisfied that the treatment is otherwise appropriate for the patient.
Pharmacist clinical check	Pharmacist	This should normally be done in advance of the patient's treatment to allow pharmacy to prepare the drug. It can be done in advance of the latest blood results (except for carboplatin) provided the pharmacist is satisfied that the treatment is otherwise appropriate for the patient.
Go-ahead	Nurse, doctor, pharmacist	The go-ahead is entered into iQemo immediately prior to supplying/administering the drug to a patient. The person giving the go-ahead should have made all the necessary checks to ensure that the patient meets the criteria to proceed with treatment as detailed in the protocol. In certain circumstances (e.g. high-cost drugs or drugs with a short shelf life), pharmacy may wait until the go-ahead has been given before preparing the drug.

3.5 SACT initiation

3.5.1 The first cycle of a course of SACT must only be prescribed and approved by a Consultant Haematologist/Oncologist. An Associate Specialist or senior specialist trainee (within 6 months of CCT) may also prescribe and approve the first cycle of treatment following local approval for specific treatments.

3.5.2 SACT will be chosen as the treatment modality for a patient by their consultant, depending on the known responsiveness of the tumour, stage of spread, history of other diseases or conditions, and performance status of the patient.

3.5.3 The decision to initiate SACT should made with the consultant responsible for the patients care (or appropriate cover/deputy), and with the patient and carer fully involved on an informed choice basis.

3.5.4 Before prescribing of the first cycle of treatment, the following information should be recorded: diagnosis; clinical staging; performance status; height and weight; treatment intent.

3.5.5 Essential investigations and tests should be requested, including those specified in the relevant chemotherapy protocol.

3.5.6 Initiating prescribers are responsible for ensuring all required Investigations are requested prior to commencing a course of SACT.

3.5.7 Initiating prescribers are responsible for ensuring completion of all necessary funding pre-approval forms (e.g. Blueteq)

3.5.8 On attaining CCT, consultants will be deemed trained and competent to initiate SACT and assess others according to GMC and relevant Royal college. However, maintenance of CPD should be demonstrated at annual appraisals, consultants should actively participate in 30-day mortality meetings and be involved in review of SACT policies and protocols.

3.5.9 A consultant may initiate SACT out with their sub site on behalf of a consultant colleague after consultant with the parent clinician.

3.5.10 It is considered good practice that endocrine therapies are also initiated by the consultant; however, the first prescription may be completed by a junior doctor or NMP on direct instruction.

3.6 Subsequent chemotherapy prescriptions

3.6.1 Registrars and Speciality Doctors (in oncology), Associate Specialists and oncology NMPs may prescribe subsequent cycles of chemotherapy once they have received appropriate training in SACT and use of the electronic prescribing system.

3.6.2 All non-medical prescribers and those medical prescribers not working within an official training programme should complete formal competency assessments as per UK SACT board guidance: https://www.uksactboard.org/_files/ugd/638ee8_1ce28c94342f4cd095b6a373d0859280.pdf

3.6.3 It is recommended that the NMP has a declaration of competency within each tumour type within their scope of practice or for a particular type of SACT. For example, an NMP based

within a lung cancer clinic should have a declaration of competency for lung cancer SACT. It is recognised that some practitioners may have specific areas of SACT expertise – for example, in an immunotherapy (IO) assessment clinic - and in these cases declaration of competency specifically of IO could be completed. The declaration of competency should be completed by an appropriate medical or NMP consultant with practice in the patient group for which the NMP prescribes. Once the clinical supervisor is assured the competencies for the appropriate level of training have been met, this should be confirmed by completion of a declaration of competency.

3.6.4 NMPs and non-training grade doctors moving from other trusts or posts that allowed SACT review and prescribing should still have formal declarations of competency recorded locally.

3.6.5 All routine prescribing of SACT should be completed on the electronic prescribing system at least 48 hours before the date of administration.

3.6.6 If a decision to stop SACT is made, this will be actioned on the electronic prescribing system in real time. IQemo will automatically remove the appointment from the schedule.

4. Responsibilities of pharmacy

4.1 All prescriptions for SACT will be verified by a suitable trained pharmacist.

4.2 The pharmacist will check funding is in place prior to preparation.

4.3 The pharmacist will ensure the specific regimen is appropriate for the patient with regards to tumour type, stage and line of treatment

4.4 The pharmacist will check that the regimen is being used in line with the treatment algorithm for that tumour type.

4.5 Deviation from the algorithm/protocol must have been authorised by the Trust lead for SACT/site specific lead consultant. See Network protocol deviation policy.

4.6 Prescriptions for carboplatin must be checked by a pharmacist using a serum creatinine level taken no more than 48 hours prior to administration with the following exceptions. 1st cycle prescriptions may be checked against serum creatinine levels taken no more than 14 days prior to administration. For carboplatin prescriptions to be administered on a Monday, a result from the previous Friday may be used.

5. Consent

5.1 All patients receiving a new course of SACT should be provided with all the relevant information on the treatment intent, risks and benefits, in order to be able to make an informed consent on treatment.

5.2 Information should be given verbally and supported by the use of written patient information e.g. CRUK or Macmillan patient information.

5.3 Information must be given initially by the Consultant or ST responsible for the patient's care and will be reinforced by an appropriately trained oncology/haematology or SACT nurse.

5.4 Full written consent should be obtained on the appropriate form using the CRUK SACT specific consent forms wherever possible. If a treatment specific consent form is not available a generic chemotherapy and/or immunotherapy CRUK form should be used. Forms should be printed out contemporaneously to ensure the most up to date version is used.

5.5 Patients must be offered a copy of the signed consent form. A copy should be available in the patients notes and it is best practice to upload a copy of the consent form on the electronic prescribing system.

5.6 If a change in SACT regimen, or re-challenge with a previously used SACT regimen, is necessary, patients should be re-consented, after having received regimen-specific details.

5.7 Patients consented for clinical trials will be consented on trial specific documentation. But it is also best practice to record consent to the treatment the patient is receiving or randomised to on a CRUK consent form.

5.8 The practitioner administering the first treatment should check that written consent has been given. It is advisable that the practitioner checks the patient understands the treatment to be given and gains their verbal consent before continuing with the SACT administration.

6. Protocols and Prescriptions

6.1 SACT is prescribed according to agreed standardised algorithms and protocols, representing best practice. Consistency in prescribing for common cancers is essential to providing a standardised, safe, evidence-based chemotherapy service to all patients. All SACT protocols are validated by the LSCCA lead for each site-specific clinical reference group (CRG).

6.2 All SACT must be prescribed via an electronic prescribing system. Only exceptions are hormone only treatments such as tamoxifen.

6.3 In May 2025 the UK SACT board published recommendations for information at be included in a SACT protocol. All new and updated protocols should follow these recommendations.

https://www.uksactboard.org/_files/ugd/638ee8_2444b9e88d5e4d2eaa3e83b44624a4fd.pdf

As a minimum each treatment protocol should specify the following:

- Cancer type:- name of regimen and the therapeutic drugs used
- Therapeutic intent: palliative, adjuvant, neoadjuvant, radical, as applicable
- Doses of therapeutic drugs
- Routes of administration

- Number of cycles or whether this is indeterminate
- Length of cycle and number and timing of administrations within a cycle
- Tests required before starting a course and prior to an individual cycle
- Supportive drugs with each cycle – therapeutic drug dose modifications and their indications

6.4 Each trust should ensure their SACT data is accurately uploaded to the national SACT database

7. Off Protocol prescribing

7.1 Occasions may arise where a clinician wishes to prescribe a treatment not within the agreed LSC algorithms and protocols. Any deviation from agreed algorithms and protocols is a protocol deviation. The LSC Chemotherapy deviation policy must be followed. https://www.healthierlsc.co.uk/application/files/3017/1448/6907/Chemotherapy_Deviation_Policy_Review_date_March_26.pdf

8. Pre-treatment assessment process

8.1 The pre-treatment assessment policy for LSC should be followed for patients requiring first line SACT with or without radiotherapy and all existing patients who have had their SAC pathway changed to a new line of treatment.
https://www.healthierlsc.co.uk/application/files/6217/3221/0086/Pre-assessment_SACT_SOP_v1.pdf

8.2 Checks prior to SACT administration should include:

- Critical test results
- Regimen and individual drug identification
- Diluents and dilution volumes, and any hydration
- Supportive drugs have been given/taken as per prescription.
- Administration route and duration
- Cycle number
- The administration as per the schedule within the cycle
- Toxicities and complications from previous cycles
- That the minimum monitoring requirements by physical examination and by investigation are being met.
- Dose modifications or delays consequent of toxicities
- Response assessment according to the relevant regimen and treatment intention.

8.3 A patient's performance status must also be assessed prior to every cycle of treatment. Any patient whose performance status has worsened World Health Organisation must not be given treatment without medical review.

8.4 Venous access assessment should be made. Choice of intravenous access (IV) device should be made in consultation with the patient.

8.5 Consideration should be given to patients with pre-existing peripheral neuropathy resulting in reduced sensation to upper limbs and hands to have treatment via a central venous access device (CVAD).

9. Patient Identification procedure

9.1 It is essential that the patient undergoing SACT is correctly identified prior to delivery of the treatment.

9.2 The patient identification verification/check should be made by a registered nurse who has undergone the relevant SACT training and has been deemed competent to administer SACT.

9.3 The identity of the patient MUST be established to ensure that an active response is made by the patient and not a passive response

e.g. "please could you tell me your name and date of birth?" Not "is your name and date of birth……"

9.4 The patient identification verification must be checked prior to the initiation of bolus or infusion SACT. In those regimens that require longer and multiple infusions, this verification must be completed prior to each new SACT drug

9.5 The patient check must match the SACT prescription and the details on the SACT that is to be administered.

9.6 If the patient check, patient prescription and the SACT drugs do not all match then the drug should NOT be administered. This should then be reported to the senior nurse in charge.

10. SACT Administration

10.1 Designated Facilities for Administration of SACT

10.1.1 Administration of SACT must be undertaken on named wards / outpatient departments where it is agreed as part of the ward's regular activity. This should be clearly documented in each trust's local SACT operational policy.

10.1.2 Named wards / departments must, depending on the type of medication / route of administration, must have appropriate protocol documents and equipment for the management of anaphylactic shock, cardiac arrest, spillage and extravasation.

10.1.3 SACT must be administered by a SACT administrator (i.e. qualified practitioner who is competent in the appropriate medication administration route, has received specific training and is deemed competent in SACT administration). These individuals must also have been assessed by an accredited assessor and undertake an annual review of competence (see SACT competency)

10.1.4 Parenteral SACT should not be given anywhere other than the wards specified in the local policy, or if a patient's condition warrants it, on the Intensive Care Unit.

10.1.5 It is acknowledged that in some circumstances parenteral SACT may need to be administered outside the usual "named ward / area". This would apply to situations where the patient's requirement for specialist or intensive care, provided within a non-designated area, outweighs any potential risks associated with administering these medicines outside the "named ward / area" or when patients who are having anticancer medication / chemotherapy are admitted to non-designated area for additional interventions.

10.1.6 Such requests must be reviewed and sanctioned by the Trust SACT Lead Clinician and Lead SACT Nurse (or appropriate deputies) before treatment can proceed.

10.1.7 In these instances, it is imperative that the non-designated area is supported by medical, nursing and pharmaceutical staff from the "named ward / area" where the patient's treatment would usually be managed / administered.

10.1.8 Clinical staff in these areas must contact members of the patient's specialist team for specific information and advice regarding the prescribing (treatment plan / protocol), administration, safe handling and management / observation of the patient during treatments.

10.1.9 SACT must be administered during normal working hours. For the purpose of this document "normal working hours" refers to the usual "daytime hours" when medical, nursing and support services are available to support the delivery of anticancer medications on the "named ward / area". Although it is practicable, in most cases, to commence treatment and administer "bolus" / short infusions during "normal working hours", it is acknowledged that in some Trusts for some groups of patients this may not be possible, Consult Local Trust Policy for further details. Complex multi agent SACT protocols requiring infusional drugs being administered continuously over a number of days will be initiated during "normal working hours".

10.1.10 SACT is not normally given outside standard hours.

10.2 Emergency SACT (first cycle)

10.2.1 In certain situations, with aggressive cancers that are known to be responsive to chemotherapy, delay of the first cycle may be associated with an adverse outcome and chemotherapy should be commenced as soon as possible. The decision to consider that a situation warrants emergency chemotherapy must be made by the patient's consultant in

liaison with the relevant senior nurse in charge and clinical lead for SACT. The pharmaceutical validation of the chemotherapy in these circumstances will be undertaken by a pharmacist under the direction of a chemotherapy competent pharmacist.

10.3 Nurse's Responsibilities:

10.3.1 SACT competent nurses are responsible for checking all blood results relevant to the protocol prior to administration. If the results are abnormal and outside of the relevant parameters on the specific protocol, authorisation must be obtained from a consultant, ST trainee or advanced clinical practitioner.

10.3.2 All bloods for weekly, two, three and four weekly regimens can be taken 48hrs before SACT administration date unless otherwise directed by treating clinician.

10.3.3 Prior to cycle one bloods within 14 days are acceptable unless otherwise directed by treating clinician

10.3.4 If the patient cannot go ahead with SACT. Nursing staff can defer treatment for up to 7 days.

10.3.5 The 'go ahead' should be given to pharmacy by 12 mid-day the day prior to the date of administration.

10.3.6 Before the patient can receive SACT the practitioner designated to administer the drug must make a satisfactory assessment of the patient as below.

10.3.7 Prior to administering treatment, the administrator must check that:

- The prescription has been written in accordance with their protocol and guidelines identified above and authorised by appropriate personnel.
- The patient is able to proceed with their treatment as outlined in the pre-treatment assessment process (section 8).
- Confirm that the patient has received all the information they require to provide informed consent to treatment.
- Two qualified practitioners are required to check and administer the patient's medicines.
- Details on the medication (container and contents) must correspond with the patient's prescription and this must reflect the treatment protocol.

10.3.7.1 Medication containers / packaging must be inspected to ensure there is no leakage or spillage.

11. Intravenous Administration

The following guidance should be read in conjunction with any local Trust procedures or policies.

12. Selection of Venous Access Device

12.1 Peripheral Venous Cannulation

12.1.1 Small-gauge Teflon® or silicone cannulae which preserve vein integrity and cause least pain to the patient is recommended.

12.1.2 When inserting the cannula, the professional must be knowledgeable about where to site the cannula, which gauge cannula to use, and general good practice.

12.1.3 An appropriate size and position should be chosen. The general rule is to use the smallest cannula into the largest vein possible (avoiding use of ante-cubital fossa).

12.1.4 The most appropriate location is considered to be the forearm (although a large straight vein over the dorsum of the hand is preferable to a small vein in the forearm).

12.1.5 Avoid use in the following:

- Siting a cannula over a joint, sites directly below a venepuncture site or failed cannulation attempt when administering vesicants, as there can be a leak via the old site.
- Areas proximal to skin lesions or wounds.
- Limbs where there is lymphatic impairment following surgery, chemical occlusion or radiotherapy even if there is no obvious lymphoedema.
- Veins in the lower limbs (legs or feet) should never be used

12.1.6 Most difficulties arise when few or no veins in good condition are available and at this point a central venous access device should be considered.

12.1.7 Site of cannula placement and date should be documented in patient's records as per local policy. Number and sites of attempted cannulation should also be documented.

12.2 Central Venous Catheters

12.2.1 Where the recipient of therapy has insufficient or unsuitable peripheral veins, infusions are prolonged, or venous access becomes difficult, insertion of a central venous catheter may be indicated.

12.2.2 Central venous access is the route of choice if drugs or fluids are to be administered over a long period of time, if they are irritant to the peripheral veins, or have the potential to cause tissue necrosis.

12.2.3 Care and maintenance, and access of CVADs should be in accordance with Trust guidelines and local policies.

12.3 Bolus injections

12.3.1 The following guidance should be read in conjunction with local Trust procedures

12.3.2 Administer bolus injections via the port / connector of an administration set primed with a compatible solution.

Clean port / connector of the intravenous giving set using 2% Chlorhexidine in 70% Isopropyl Alcohol impregnated swab for 30 seconds and allowed to air dry just prior to accessing.

12.3.3 The speed of administration of a bolus injection will be influenced by a number of factors including the medication and the volume of the bolus to be infused, the route of administration i.e. peripheral or central; and patient characteristics. All bolus injections should be administered slowly, usually over a period of approximately 3-30 minutes, via a fast-running infusion of a prescribed compatible fluid.

12.3.4 Ensure the patient is aware to tell the administering nurse if they feel any pain or discomfort at the cannula site or distant to the cannula site throughout the administration period.

12.3.5 An intravenous 'flush' of a prescribed compatible solution (at least 20ml) should be administered between each drug and on completion of the patient's regimen.

12.4 Infusions

12.4.1 Ensure correct administration equipment and filter is selected for therapy

12.4.2 Ensure the drug is running to correct prescribed flow rate. If using an infusion pump, the rate, volume and pressure must be set and checked as per Trust Policy.

12.4.3 Change infusion bags at waist height over a plastic tray. (Infusion bags should never be changed while hanging from a drip stand).

12.4.4 Electronic devices should always be used to administer infusions.

12.4.5 Regularly consult the patient about sensation around the venous access insertion site and observe the site before commencing an infusion bag and hourly during infusions.

12.4.6 After the administration of each drug ensure that the line is flushed with at least 20mls of a compatible infusion fluid at the same rate as the previous infusion.

12.5 Continuous infusional anti-cancer treatment:

12.5.1 Patient should have Central Venous Access Device insitu.

12.5.2 Ensure that the correct Infusion Device is used as per the prescription.

12.5.3 Ensure the drug is running to correct prescribed flow rate.

12.5.4 Ensure that patient has been given instructions on the use of the infusion device and the action to be taken should any alarm or fault occur, including telephone contact information. If patient is receiving treatment by an ambulatory pump, they should be advised on how to observe that the pump is infusing and to use contact numbers in case of any leakage or spillage.

12.6 Vesicant drugs

12.6.1 Where there are concerns regarding venous access consideration should be given to delivering intravenous medications via a central venous catheter.

12.6.2 Due to the risks associated with extravasation when administered peripherally these medications are usually administered by bolus injection. When administered peripherally as a bolus injection they require uninterrupted observation of the patient and their administration site by a competent chemotherapy administrator throughout the infusion of the drug.

12.6.3 Vesicant drugs should be administered first if giving drugs in combination and it is ideal to administer vesicant drugs into a newly sited cannula, if this is not possible the member of staff must be confident that the cannula is patent before proceeding with any infusion of treatment.

12.6.4 If there is any concern that the drug has extravasated, refer to the Network guideline for extravasation.

12.7 Vinca Alkaloids

12.7.1 The prescribed dose of vinca alkaloids should be supplied ready to administer in a 50ml minibag of sodium chloride 0.9%

12.7.2 The following warning should be prominently displayed on the label of ALL vinca alkaloid doses “For Intravenous Use Only- Fatal If Administered by Other Routes”.

12.7.3 There should be judicious use of colour and design on the label, outer packaging and delivery bags to further differentiate minibags containing vinca alkaloids from other minibag infusions.

12.7.4 The vinca minibag should be administered intravenously over 5-10 minutes and the patient closely monitored for signs of extravasation. If extravasation is suspected refer to the Lancashire and South Cumbria Cancer Alliance policy for the management of extravasation for further management.

13. Intrathecal SACT

13.1 If Intrathecal Chemotherapy is to be administered refer to the appropriate individual Trust policy for intrathecal administration.

13.2 The number of intrathecal administrations which have been undertaken over the previous 12 months should be monitored. If the number falls below 10 per year, a risk assessment for all those involved in the process of administration of intrathecal chemotherapy should be undertaken.

13.3 The only drugs routinely administered by this route are:

- Methotrexate
- Cytarabine
- Hydrocortisone

14. Oral SACT

14.1 The overarching principle for the administration of oral SACT is that administration is carried out and monitored to the same standards as for parenteral (IV) SACT.

14.2 Ensure compliance with the Nursing and Midwifery Council (NMC) guidelines on the administration of medicines.

14.3 Ensure supportive medications are co-administered as prescribed.

14.4 Providing oral medication

- Check patient details ensuring it is the correct patient receiving the correct drug.
- Give written and verbal information including advice about who to contact in the event of any complications
- Ensure the patient understands how and when the medication should be taken
- Confirm the quantity of tablets and the dosage of the medication with the patient.

- Document that the medication has been issued in the nursing notes and sign the prescription.

14.5 Admission of a patient receiving oral SACT

14.5.1 When patients taking oral anticancer therapy are admitted into hospital oral anticancer medicine **MUST NOT** be prescribed or administered until it is confirmed that it is clinically appropriate and safe to do so. The patient's drugs should only be prescribed following authorisation by the oncology team.

14.5.2 If a patient's oral medication is suspended on admission and then restarted by the patient's specialist team, during their admission or on discharge, specific details regarding the revision in the duration / timing of cyclical treatment must be recorded within the patient's medical notes.

14.6 Administration of Oral SACT for inpatients:

14.6.1 The health professional dispensing tablets must use a no-touch technique. Gloves must be worn if touching is unavoidable. Hands must be washed thoroughly before and after administration.

14.6.2 Patient must swallow tablets or capsules whole do not crush tablets or break open capsules. If crushing/breaking open tablets/capsules are essential, advice must be sought from pharmacy. Do not use any tablets or capsules if there is any loose powder or liquid present in the container – inform pharmacy and request a replacement.

14.6.3 If a tablet is dropped it should be placed in a bag and returned in original box to hospital at their next visit along with any unused medication

14.6.4 Patient receiving oral SACT must be given advice of safe storage, handling and disposal of their SACT.

15. Subcutaneous or Intramuscular Injection

15.1 A subcutaneous injection is given beneath the epidermis into the fat and connective tissue underlying the dermis.

15.2 An intramuscular injection is given into the muscle.

15.3 Choose a suitable site for injection and prepare the skin as per local policy.

15.4 Ensure the appropriate gauge needle is attached securely to the syringe and take care to minimise risk of spillage on the skin.

15.5 For subcutaneous injection, use a pinch technique, and administer the injection using a 90° angle. Aspiration is not required prior to injection.

15.6 Administer an intramuscular injection using the Z track technique. This involves displacing the skin and the subcutaneous layer in relation to the underlying muscle so that the needle track is sealed off before the needle is withdrawn, so minimizing reflux.

15.7 After administration, remove the needle and syringe, and cover the site with a plaster, or gauze, ensuring there is no leakage from the site.

15.8 If further injections are required, rotate the site of administration.

16. Monitoring

16.1 Observe and instruct the patient to inform staff of signs of local and systemic reactions which can occur during, or immediately after, drug administration e.g. drug specific side effects, venous irritation, phlebitis, flare reaction, extravasation, hypersensitivity / anaphylaxis. These should be managed in accordance with local, regional and national procedures / guidelines.

16.2 Dispose of all cytotoxic contaminated waste immediately as per Trust guidelines.

16.3 Record details of administration in the patient's medical notes and patient held records in accordance with the organisational guidelines.

16.4 Telephone triage will be implemented for all high-cost drugs prior to administration.

16.5 Non-medical follow up is appropriate for all patients on treatment when agreed with the consultant, non-medical professional and patient.

16.6 Patients are not required to have formal medical or ANP FU in between all cycles of SACT, for example if a patient is tolerating treatment well with good response. It is important the patient is aware to contact the SACT helpline with any issues in between reviews and the agreed follow up schedule should be clearly documented in the medical notes.

17. Safe Handling and Disposal of Cytotoxic Waste

17.1 Cytotoxic Medicines are hazardous substances, as defined by the Control of Substances Hazardous to Health Regulations 2002 (COSHH).

17.2 Under COSHH regulations each Trust has a legal duty to assess the risks from handling cytotoxic drugs for employees, and anyone else affected by this type of work, and to take suitable precautions to protect their health. Consult local Trust Policy for local arrangements for the risk assessment of hazardous substances.

17.3 Pregnant staff must avoid exposure to SACT. As a minimum a risk assessment must be undertaken if a pregnant member of staff works with SACT to assess their risk of exposure. As a minimum, pregnant staff must not handle or administer SACT if risk assessment undertaken following local Trust policy shows there is a risk of exposure.

17.4 All personnel involved in the handling of SACT within the Trust must be given appropriate training on health and safety issues related to SACT, including spillage and disposal of contaminated waste.

17.5 Personal protective equipment (PPE) must be worn when handling SACT. The choice of PPE must be linked to a risk assessment and must follow local Trust policy, for example, gloves must be worn at all times when handling SACT.

17.6 Each Trust must have local policy that describes how cytotoxic waste, and cytotoxic spillages must be handled.

18. Transportation of SACT for Administration within Organisations

18.1 All SACT should be delivered to the clinical areas in a ready to use form or a suitable safe transfer device.

18.2 Medicines should be transported in a sealed, leak proof container to prevent or contain any spillage.

18.3 The containers should be marked “cytotoxic drugs” and should only be used for that purpose.

18.4 Once on the ward / department, it is the responsibility of the individual who has transported the SACT to hand over the container to a qualified member of the team who will store the medication according to local Trust Policy.

This Guidance document was developed in consultation with senior oncology medical, nursing and pharmacy staff within the Lancashire and South Cumbria Cancer Alliance.

Comments on content / implementation should be directed to Jo Wilkinson, Lead SACT Nurse – Lancashire Teaching Hospitals NHS foundation Trust.