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)

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1. Introduction

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 Cancer Alliance.

For the purposes of this policy the term The terms “SACT‟ and “chemotherapy‟ are used interchangeably to refer to systemic anti-cancer therapy, which includes monoclonal antibodies/targeted therapies, intravenous, intrathecal and oral chemotherapy.

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

2. Limitations

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.

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 Alliance SACT Group to discuss.

This policy does cover the use of SACT for non- cancer treatment.

3. Initiating Treatment and Prescribing

3.1 Chemotherapy initiation

The Department of Health Chemotherapy Peer Review Measures for Chemotherapy (Adult) (available via the NHS England Quality Surveillance Programme) require that “Clinical assessments and the decision to initiate the first cycle of a course of chemotherapy should be restricted to consultant medical staff, medical trainee staff (ST 3 and above) and also NCCG (Non Consultant Career Grade) medical staff who are assessed as competent for this by their approved training programme. Note this applies to medical oncology, clinical oncology and haemato-oncology only.” In accordance with Chemotherapy Standards, junior medical staff (i.e. F1, F2, ST1 and ST2) CANNOT prescribe SACT

3.2 Subsequent chemotherapy prescriptions

Registrars and Speciality Doctors (in oncology), Associate Specialists and advanced nurses may prescribe subsequent cycles of chemotherapy once they have received appropriate training in chemotherapy and use of the electronic prescribing system.
N.B. The electronic system acts as gatekeeper as clinicians may be permitted specific rights.
The definition of SACT includes cytotoxics, small molecules (such as tyrosine kinase inhibitors) and biological therapies. It is considered good practice that endocrine therapies are initiated by the Consultant; however, the first prescription may be completed by a junior doctor/advanced nurse on direct instruction.

3.3 Consent

Written consent must be obtained for all SACT prior to prescription. A copy will be provided to the patient with evidence of the regimen, acknowledging they have received written information with related toxicities.

It is the responsibility of the Clinician instigating the treatment to obtain the consent.

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 chemotherapy administration.

4.0 Protocols and Prescriptions

4.1 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).

4.2 All SACT must be prescribed via an electronic prescribing system. The Chemotherapy Peer Review Measures for Chemotherapy (Adult) (available via the NHS England Quality Surveillance Programme) recommends:

Electronic prescribing system

There should be a database driven, electronic prescribing platform in use which at least fulfils the following:

- it enables electronic prescribing using approved protocols;
- it should have replaced manual prescriptions as the default method for the CCS;
- it provides an auditable record of chemotherapy, prescribed and administered; the record encompassing the national mandatory chemotherapy dataset (SACT);
- it enables data extraction using Business Objects/Data Warehousing.

There should be local configuration of the electronic prescribing system to allow electronic interfacing between and integration of:

- Patient demographics; laboratory test results; dispensing.

4.3 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

4.4 **Off Protocol prescribing**

Occasions may arise where a clinician wishes to prescribe a treatment not within the agreed LSCCA algorithms and protocols. Any deviation from agreed algorithms and protocols is a protocol deviation. The LSCCA Chemotherapy deviation policy must be followed.

5.0 Pre-treatment assessment process

5.1 The speciality specific nominated health care professional (doctor, nurse, pharmacist) administrator must holistically assess and review the patient prior to each cycle of treatment, or/and at designated times within the patient's pathway, as defined within the protocol. The individual undertaking pre-treatment checks must;

- Ensure that the patient's medical condition supports the proposed administration of their treatment. Note: An active mode of enquiry should be adopted when questioning patients to assess their performance status and complications / toxicities.
- Check results of all critical tests / investigations, blood parameters and specific drug calculations specified within the treatment protocol / local guidance
- Check that any supportive medications have been administered in accordance with the patient's prescription e.g. anti-emetics, pre-medication, topical applications, etc.

5.2 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 (WHO) > PS 3 must not be given treatment without Medical review.

5.3 Checks prior to administration as set out by The Chemotherapy Peer Review Measures for Chemotherapy (Adult) (available via the NHS England Quality Surveillance Programme) 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.

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

6.0 Patient Identification procedure

- It is essential that the patient undergoing chemotherapy is correctly identified prior to delivery of the treatment.

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

- 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……"

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

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

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

7.0 Safe Handling and Disposal of Cytotoxic Waste

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

7.2 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.

7.3 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.

7.4 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.

7.5 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.

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

8.0 Transportation of SACT for Administration within Organisations

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

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

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

8.4 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.

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9.0 SACT Administration

9.1 Administration of SACT must be undertaken on named wards / outpatient departments where it is agreed as part of the wards regular activity .

9.2 It is acknowledged that in some circumstances 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.

9.3 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.

9.4 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 treatment. Each Trust must include the named ward(s) in local policy.

9.5 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.

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

9.7 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 chemotherapy protocols requiring infusional drugs being administered continuously over a number of days will be initiated during “normal working hours”.

9.8 Guidance for administration via any route

- All medication must be checked in accordance with:
- The patient’s prescription and protocol
- Trust’s procedures / guidelines pertaining to the administration of medicines including those pertaining to the route of administration
- Professional guidelines

9.9 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 5).
- 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.
- Medication containers / packaging must be inspected to ensure there is no leakage or spillage.

10.0 Intravenous Administration

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

10.2 Commence an infusion of a compatible solution as prescribed.

10.3 Prepare any supplementary drugs / specific equipment for administration in accordance with the patient’s prescription / treatment protocol e.g. antiemetics, non PVC intravenous giving set etc.

10.4 If using a peripheral cannula an appropriate size and position of should be chosen. The general rule is to use the smallest cannula into the largest vein possible.

10.5 Consult the patient regarding sensation around the vascular access insertion area and inspect the cannula / central line site / port for signs of displacement, swelling and local inflammation. (All information pertaining to vascular access, including the location and condition of the cannula / central line / port, must be documented in the patient’s notes).

11.0 Infusions

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

11.2 Electronic devices should always be used to administer infusions.

11.3 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.

12.0 Bolus injections

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

12.1 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.

12.2 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 (in most cases this will be Sodium Chloride 0.9%)

12.3 An intravenous 'flush' of a prescribed compatible solution should be administered between each drug and on completion of the patient's regimen.

12.4 Vesicant drugs

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

12.5 Vinca Alkaloids

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

12.6 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.

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

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

13.0 Intrathecal SACT

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

14.0 Oral SACT

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) chemotherapy.

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

14.2 Ensure supportive medications are co-administered as prescribed.

14.3 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.

14.4 Admission of a patient receiving oral SACT

Note: 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. 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.

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 Chemotherapy/Acute oncology Nurse – Lancashire Teaching Hospitals NHS foundation Trust.