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## **STANDARDS**

### **Cancer Care**

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## CANCER CARE

Accreditation Canada's sector- and service-based standards help organizations assess quality at the point of service delivery and embed a culture of quality, safety, and client- and family-centred care into all aspects of service delivery. The standards are based on five key elements of service excellence: clinical leadership, people, process, information, and performance.

Accreditation is one of the most effective ways for organizations to regularly and consistently examine and improve the quality of their services. The standards provide a tool for organizations to embed accreditation and quality improvement activities into their daily operations with the primary focus being on including the client and family as true partners in service delivery.

Client- and family-centred care is an approach that guides all aspects of planning, delivering and evaluating services. The focus is always on creating and nurturing mutually beneficial partnerships among the organization's team members and the clients and families they serve. Providing client- and family-centred care means working collaboratively with clients and their families to provide care that is respectful, compassionate, culturally safe, and competent, while being responsive to their needs, values, cultural backgrounds and beliefs, and preferences (adapted from the Institute for Patient- and Family-Centered Care (IPFCC) 2008 and Saskatchewan Ministry of Health 2011).

Accreditation Canada has adopted the four values that are fundamental to this approach, as outlined by the IPFCC, and integrated into the service excellence standards. The values are:

- 1. Dignity and respect:** Listening to and honouring client and family perspectives and choices. Client and family knowledge, values, beliefs, and cultural backgrounds are incorporated into the planning and delivery of care.
- 2. Information sharing:** Communicating and sharing complete and unbiased information with clients and families in ways that are affirming and useful. Clients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.
- 3. Partnership and participation:** Encouraging and supporting clients and families to participate in care and decision making to the extent that they wish.
- 4. Collaboration:** Collaborating with clients and families in policy and program development, implementation and evaluation, facility design, professional education, and delivery of care.

The Cancer Care Standards are designed to address the continuum of care for cancer care services from diagnosis and care planning, treatment, and transition planning. The standards address radiotherapy (external beam and brachytherapy) and systemic therapies (hormonal, biological, cytotoxic) provided in both an inpatient and outpatient setting. The standards do not cover surgical oncology or invasive procedures. This set of standards contains the following sections:

- **Investing in quality services**
- **Handling medications safely**
- **Building a prepared and competent team**
- **Providing safe and effective services**
- **Maintaining accessible and efficient information systems**
- **Monitoring quality and achieving positive outcomes**

All Accreditation Canada standards are developed through a rigorous process that includes a comprehensive literature review, consultation with a standards working group or advisory committee comprised of experts in the field, and evaluation by client organizations and other stakeholders. If you would like to provide feedback about the standards, please complete the feedback form in this document.

## **Glossary - List of standard terms for all services**

**Care delivery model:** A conceptual model that broadly outlines the way services are delivered. It is based on a thorough assessment of client needs, involving a collaborative approach and stakeholder input, which considers the best use of resources and services that are culturally appropriate. The benefits of using a care delivery model include improving access to services, providing safe, quality care, promoting a client-centred continuum of care, providing access to a balanced range of services, supporting a highly skilled and dedicated workforce, and reducing inequities in health status.

**Care plan:** May also be known as the service plan, plan of care, or treatment plan. It is developed in collaboration with the client and family and provides details on the client history as well as the plan for services including treatments, interventions, client goals, and anticipated outcomes. The care plan provides a complete picture of the client and their care and includes the clinical care path and information that is important to providing client-centred care (e.g., client wishes, ability/desire to partner in their care, the client's family or support network). The care plan is accessible to the team and used when providing care.

**Client:** The recipient of care. May also be called a patient, consumer, individual, or resident. Depending on the context, client may also include the client's family and/or support network when desired by the client. Where the organization does not provide services directly to individuals, the client refers to the community or population that

is served by the organization.

**Client representative or client advisor:** Client representatives work with the organization and often individual care teams. They may be involved in planning and service design, recruitment and orientation, working with clients directly, and gathering feedback from clients and team members. Integrating the client perspective into the system enables the organization to adopt a client- and family- centred approach.

**Co-design:** A process that involves the team and the client and family working in collaboration to plan and design services or improve the experience with services. Co-design recognizes that the experience of and input from the client and family is as important as the expertise of the team in understanding and improving a system or process.

**Electronic Health Record (EHR):** An aggregate, computerized record of a client's health information that is created and gathered cumulatively from all of the client's health care providers. Information from multiple Electronic Medical Records is consolidated into the EHR.

**Electronic Medical Record (EMR):** A computerized record of a client's health information that is created and managed by care providers in a single organization.

**Family:** Person or persons who are related in any way (biologically, legally, or emotionally), including immediate relatives and other individuals in the client's support network. Family includes a client's extended family, partners, friends, advocates, guardians, and other individuals. The client defines the makeup of their family, and has the right to include or not include family members in their care, and redefine the makeup of their family over time.

**Indicator:** A single, standardized measure, expressed in quantitative terms, that captures a key dimension of individual or population health, or health service performance. An indicator may measure available resources, an aspect of a process, or a health or service outcome. Indicators need to have a definition, inclusion and exclusion criteria, and a time period. Indicators are typically expressed as a proportion, which has a numerator and denominator (e.g., percentage of injuries from falls, compliance with standard procedures, team satisfaction). Counts, which do not have a denominator, may also be used (e.g., number of complaints, number of clients harmed as a result of a preventable error, number of policies revised). Tracking indicator data over time identifies successful practices or areas requiring improvement; indicator data is used to inform the development of quality improvement activities. Types of indicators include structure measures, process measures, outcome measures, and balancing measures.

**In partnership with the client and family:** The team collaborates directly with each individual client and their family to deliver care services. Clients and families are as involved as they wish to be in care delivery.

**Interoperable:** The ability of two or more systems to exchange information and use the information that has been exchanged.

**Medical devices and equipment:** An article, instrument, apparatus or machine used for preventing, diagnosing, treating, or alleviating illness or disease; supporting or sustaining life; or disinfecting other medical devices. Examples include blood pressure cuffs, glucose meters, breathalyzers, thermometers, defibrillators, scales, foot

care instruments, client lifts, wheelchairs, syringes, and single-use items such as blood glucose test strips.

**Medical equipment:** A subset of medical devices, considered to be any medical device that requires calibration, maintenance, repair, and user training.

**Partner:** An organization or person who works with another team or organization to address a specific issue by sharing information and/or resources. Partnership can occur at the organization level, team level, or through individual projects or programs.

**Patient safety incident:** An event or circumstance that could have resulted, or did result, in unnecessary harm to a client. Types of patient safety incidents are:

- *Harmful incident:* A patient safety incident that resulted in harm to the client. Replaces adverse event and sentinel event.
- *No harm incident:* A patient safety incident that reached a client but no discernible harm resulted.
- *Near miss:* A patient safety incident that did not reach the client.

**Policy:** A document outlining an organization's plan or course of action.

**Population:** Also known as community. A specific group of people, often living in a defined geographical area who may share common characteristics such as culture, values, and norms. A population may have some awareness of their identity as a group, and share common needs and a commitment to meeting them.

**Procedure:** A written series of steps for completing a task, often connected to a policy.

**Process:** A series of steps for completing a task, which are not necessarily documented.

**Scope of practice:** The procedures, actions, and processes that are permitted for a specific health care provider. In some professions and regions, scope of practice is defined by laws and/or regulations. In these cases, licensing bodies use the scope of practice to determine the education, experience, and competencies that are required for health care providers to receive a license to practice.

**Self-efficacy:** A person's estimate or judgment of his or her ability to cope with a given situation, or to succeed in completing tasks by attaining specific or general goals. An example of achieving a specific goal includes quitting smoking, whereas achieving a general goal includes continuing to remain at a prescribed weight level.

**Team:** The group of the care professionals who work together to meet the complex and varied needs of clients, families and the community. Teams are collaborative, with different types of health care professionals working together in service provision. The specific composition of a team depends on the type of service provided.

**Team leader:** Person(s) responsible for the operational management of a team. Duties include identifying needs, staffing, and reporting to senior management. Team leaders may be formally appointed or take a role naturally within the team.

**Timely/regularly:** Carried out in consistent time intervals. The organization defines appropriate time intervals for various activities based on best available knowledge and adheres to those schedules.

**Transition in care:** A set of actions designed to ensure the safe and effective coordination and continuity of care as clients experience a change in health status, care needs, health-care providers or location (within, between, or across settings (as defined by the Registered Nurses' Association of Ontario).

**With input from clients and families:** Input from clients and families is sought collectively through advisory committees or groups, formal surveys or focus groups, or informal day-to-day feedback. Input can be obtained in a number of ways and at various times and is utilized across the organization.

## Cancer Care Glossary

**Client navigation:** Client navigation is a proactive, intentional process of collaborating with a client and their family to provide guidance as they navigate multiple treatments, services, and potential barriers throughout the cancer journey. Navigators can be professional (registered nurse, social worker), or a peer (someone who has been through the cancer journey). Navigation also facilitates linking tertiary services with community cancer programs and primary health care teams.

**Collaborative team:** The team providing cancer care will evolve and adapt to the changing needs of the client. Depending on the needs and desires of the client and family and the services provided by the organization, the team may consist of medical oncologists, radiation oncologists, surgeons, general practitioners in oncology, and other specialists (e.g., pediatric oncologist, haematologists), medical physicists, radiation therapists, dosimetrists, registered nurses, nurse practitioners, oncology registered nurses, primary care providers, pharmacists, pharmacy technicians, physician assistants, patient navigators, psychologists, social workers, registered dietitians, oral health professionals, rehabilitation specialists (e.g., physiotherapists, occupational therapists, speech language pathologists), palliative care specialists, and service technicians.

**Cycle:** A cycle of treatment is defined as the length of time a particular medication or group of medications is administered. A client may undergo many cycles of treatment with differing medications, dosages, or durations.

**Genetic testing:** Genetic testing is a component of a cancer risk assessment. It is the process to identify individuals at risk for familial or hereditary cancer syndromes.

**Medical treatment plan:** The medical treatment plan for cancer care is specific to each client. The

medical treatment plan is developed for clients receiving systemic therapies, radiotherapy, concurrent therapies, and/or surgical interventions, and contains detailed information about the entire course of treatment. The medical treatment plan is part of the care plan, which includes the full scope of client information (e.g., patient history, transition planning).

**Partners:** Partners for cancer care may include primary care, inpatient services, urgent care, community pharmacy, home and community support services, long-term care organizations, palliative and end-of-life services, and psychosocial supports. Linkages and partnerships are also set up and maintained with other sectors (e.g., social services, housing, education, transportation).

**Prescriber:** The term "prescriber" refers to the person who writes the order for therapy. This is often the medical oncologist or radiation oncologist, but could also be other health care professionals depending on the circumstances and the appropriate scope of practice as set out by regulatory and legislative bodies.

**Quality assurance:** Quality assurance is crucial throughout treatment and involves procedures to ensure the consistency of the medical prescription, the safe fulfillment of that prescription, minimal exposure of team members, and effective monitoring of clients.

**Radiotherapy equipment:** Any equipment, device, or system used in radiotherapy during a course of treatment. This includes imaging devices, planning systems, treatment devices, specialized software (e.g., Oncology Information Systems) and quality assurance equipment.

**Radiotherapy treatment plan:** The radiotherapy treatment plan addresses the entire process necessary to plan and deliver the treatment to the patient. It includes imaging preparation, treatment planning, simulation, and treatment delivery. A treatment plan is specific to an anatomical treatment site. A client might have more than one treatment plan within a single course of treatment.

**Regimen:** Regimen refers to the entire plan for systemic therapy. The regimen includes the dosage, schedule, duration of the treatment, and number of cycles (when known). The regimen may include the cytotoxic agent as well as other medications used in its delivery or medications used to compliment the cytotoxic agent.

**Treatment protocols:** Treatment protocols may also be referred to as treatment guidelines. For cancer care, treatment protocols will vary by type of treatment (radiotherapy or systemic therapy) and will also vary by client and cancer type. Treatment protocols are used to guide what type(s) of treatment a client receives and may include systemic therapy regimens prescribed to clients, when and how imaging is completed, treatment delivery, and the frequency of treatment.

**Survivorship care plan:** A survivorship care plan is a comprehensive care summary and follow-up plan provided to clients and their primary care providers following the completion of treatment and/or when transitioning to another level or setting of care.

**Systemic cancer therapies:** Includes hormonal, biological, chemotherapeutic, or cytotoxic agents delivered through an oral or parenteral method.

## Legend

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### Dimensions



**Population Focus:** Work with my community to anticipate and meet our needs



**Accessibility:** Give me timely and equitable services



**Safety:** Keep me safe



**Worklife:** Take care of those who take care of me



**Client-centred Services:** Partner with me and my family in our care



**Continuity:** Coordinate my care across the continuum



**Appropriateness:** Do the right thing to achieve the best results



**Efficiency:** Make the best use of resources

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### Criterion Types



**High Priority** High priority criteria are criteria related to safety, ethics, risk management, and quality improvement. They are identified in the standards.



**Required Organizational Practices** Required Organizational Practices (ROPs) are essential practices that an organization must have in place to enhance client safety and minimize risk.

### Tests for Compliance

**Minor** Minor tests for compliance support safety culture and quality improvement, yet require more time to be implemented.

**Major** Major tests for compliance have an immediate impact on safety.



**Performance Measures** Performance measures are evidence-based instruments and indicators that are used to measure and evaluate the degree to which an organization has achieved its goals, objectives, and program activities.

## INVESTING IN QUALITY SERVICES

### 1.0 **Services are designed collaboratively to meet the needs of clients and the community.**



Client-centred  
Services



#### 1.1 Services are co-designed with clients and families, partners, and the community.

##### **Guidelines**

Collaboration with clients, partners, and the community in service design is achieved through client advocacy groups, community advisory committees, and client experience surveys. Gaps in services are identified and addressed where possible.



Population  
Focus

#### 1.2 Information is collected from clients and families, partners, and the community to inform service design.

##### **Guidelines**

New information may be solicited from clients and families, partners, and the community, or existing information may be used when it is still relevant. If it is not within the team's mandate to collect information, the team knows how to access and use information that is available. Information can come from internal and external sources such as the Canadian Institute of Health Information (CIHI), census data, end-of-service planning reports, wait list data, and community needs assessments.

The information includes the expressed needs of clients served by the organization as well as trends that could have an impact on the community and its health service needs.

Health service needs are influenced by health status, capacities, risks, and determinants of health (i.e., income, social support networks, education and literacy, employment/working conditions, access to health services, gender, and culture).



Appropriateness

- 1.3 Service-specific goals and objectives are developed, with input from clients and families.

**Guidelines**

Clients and families, the team, and community partners are involved in developing team goals and objectives. Goals and objectives are aligned with the organization's strategic directions and are the foundation for delivering services. Objectives are clear, have measurable outcomes and success factors, and are realistic and time-specific.

Goals and objectives are meaningful to the team. They are reviewed annually or as needed and their achievement is evaluated.

Goals and objectives align with federal and provincial/territorial objectives as required.



Efficiency

- 1.4 Services are reviewed and monitored for appropriateness, with input from clients and families.

**Guidelines**

Monitoring and evaluating its services allows the team to examine what services are being offered to and used by clients, and identify areas for improvement. The type of information gathered about services is determined with input from clients and families.

Monitoring the use of services can make internal processes more efficient by identifying service gaps, either within the organization or in the community. Services are assessed to determine whether they are being offered and used as intended, are of appropriate quality, and whether there are opportunities to improve the service design and range of services.

This information is used to improve efficiency by minimizing duplication, evaluating cost-effectiveness of technologies and interventions, and increasing consistency across the organization.

Choosing Wisely Canada (<http://www.choosingwiselycanada.org>) provides information on services for various areas of service that may be unnecessary or inappropriate.



Continuity

1.5

Partnerships are formed and maintained with other services, programs, providers, and organizations to meet the needs of clients and the community.

**Guidelines**

Meeting the full range of needs of clients and a community is beyond the capabilities of one team or organization. Partnerships may be created to help clients navigate services across the continuum of care, or to fill service gaps.

Partnerships may be formed with primary care, acute care, community organizations, mental health services, education, housing, or social services. The organization may also partner or establish linkages with federal, provincial, or territorial organizations as well as non-governmental organizations.

Linkages and partnerships vary depending on the range of services provided by the organization and clients' needs.



Continuity

- 1.6 Partnerships are formed with local, provincial, federal, and/or international cancer agencies and programs.

#### Guidelines

Cancer services vary across the country. Depending on where services are offered, the organization partners with appropriate cancer agencies and organizations to ensure that clients and families are provided with the most up-to-date care and have access to client- and family-centred resources and services in the community. At the provincial or federal level this may include information about new technologies or research, while at the local level this may include having a partnership with community services that are designed for clients and families living with cancer (e.g., client support groups), as well as organizations or services often used by clients (e.g., transportation services, home care or supports).



Accessibility

- 1.7 Information on services is available to clients and families, partner organizations, and the community.

#### Guidelines

The information addresses, at minimum, the scope of the organization's services; costs to the client, if any; how to access services; contact points; the effectiveness and outcomes of services; other services available to address the client's needs; and any partner organizations.

Clients and families, partner organizations, and the community are engaged to determine what information is required or desired, and to evaluate whether the information provided meets their needs.



Accessibility

- 1.8 Barriers that may limit clients, families, service providers, and referring organizations from accessing services are identified and removed where possible, with input from clients and families.

**Guidelines**

There is a process to identify, report, and try to remove barriers to access.

Barriers to access may include the proximity and distribution of services, the physical environment, the cultural acceptability of services, wait times, the types of services available, language barriers, financial barriers, availability of transportation, and access to 24-hour emergency services.

Where barriers are beyond the control of the organization or team, they work with partners and/or the community to minimize them.

## 2.0 **Sufficient resources are available to provide safe, high-quality, and client-centred services.**

### 2.1 Resource requirements and gaps are identified and communicated to the organization's leaders.

**Guidelines**

The resources needed to provide safe, effective, and high quality care are determined by team members and the organization. Resources may be human, financial, structural, informational, or technological.

Identifying resource requirements is a collaborative process between the team and the organization's leaders. It includes criteria to determine where resources are required, potential risks to the team and clients, gaps in services, service bottlenecks, or barriers to service delivery or access.

The team and the organization's leaders work together to determine how to effectively use available resources or where additional resources are required.

### 2.2 Technology and information systems requirements and gaps are identified and communicated to the organization's leaders.



Appropriateness



Appropriateness

**Guidelines**

Technology includes electronic medical/health records (EMR/EHR), decision tools, client tracking systems, wait list management systems, client self-assessment tools, or access to service-specific registries and/or databases. Depending on the organization, the need for systems could be complex (e.g., advanced software to increase interoperability) or support basic operation (e.g., newer computer systems).

As much as possible, innovative information technology is used to support the work of the service area.



Appropriateness

2.3

An appropriate mix of skill level and experience within the team is determined, with input from clients and families.

**Guidelines**

Ensuring an appropriate and optimal mix of skill level and experience supports safe, effective, client-centred service delivery and creates learning opportunities for team members.

Optimal evidence-based ratios of skills and experience are determined. Team members have a broad range of knowledge, skills, and experience working with various client groups.

Clients and families have a unique perspective on the skills level and experience available on their team. They may be able to point to services that were not available through their care team as well as individual skills and knowledge that could improve the client experience. For example, clients and families may be well positioned to recognize a resource or knowledge gap on the team (e.g., knowledge of community resources; experience working with clients and families with certain conditions, barriers, levels of understanding, or languages) as well as areas to improve communication (e.g., between teams, between providers, when and how the team communicates with clients and families).



Client-centred  
Services

- 2.4 Space is co-designed with clients and families to ensure safety and permit confidential and private interactions with clients and families.

#### Guidelines

To the extent possible, the physical space is designed to be safe and to respect privacy and confidentiality. Clients and families are involved in planning and designing the layout and use of space to meet their needs. Client dignity; respect, privacy, and confidentiality; accessibility; infection prevention and control; and other needs specific to the clients and community served are considered in space use and design.

When services are provided outside the organization (e.g., in a client's home or a community partner organization), the team works with the client or partner to maintain safety and privacy.



Appropriateness

- 2.5 The effectiveness of resources, space, and staffing is evaluated with input from clients and families, the team, and stakeholders.

#### Guidelines

Evaluating resources, space, and staffing helps determine the extent to which effective services are being provided and identifies opportunities for improvements. Input from clients and families, the team, and stakeholders is gathered through surveys, focus groups, advisory committees, and informal feedback.



Appropriateness

- 2.6 Team members and clients have access to information about community services, including palliative and end-of-life care.

**Guidelines**

Written and verbal information is provided as needed, and may include information about rehabilitation, community mental health, and primary care, depending on the population served and the resources available. The level of understanding, literacy, language, disability, and culture of the client population are considered when developing and providing information.

Information on palliative and end-of-life care includes information for clients and families as well as resources for the team.



Accessibility

- 2.7 A universally-accessible environment is created with input from clients and families.

**Guidelines**

The service environment is kept clean and clutter-free to support physical accessibility for those who use mobility aids such as wheelchairs, crutches, or walkers. The environment is also accessible for those with language, communication, or other requirements, such as those who have auditory, visual, cognitive, or other impairments.

Where team members work outside the organization (e.g., delivering care in the community, home care) they work with partners, clients, and families to support accessibility.

- 3.0 **RADIOTHERAPY ONLY: Radiotherapy equipment is appropriate, maintained, and safe for client care.**



Appropriateness

- 3.1 Radiotherapy only: Key stakeholders participate in the organization's process for selecting and prioritizing radiotherapy treatment and planning equipment as well as other devices used in care.

**Guidelines**

Key stakeholders participate in the organization's process for selecting and prioritizing radiotherapy equipment and devices. The process varies based on the care provided and includes the team involved in the delivery of radiotherapy (e.g., medical physicists, dosimetrists, radiation oncologists, radiation therapists) and may also include other stakeholders (e.g., biomedical engineers, infection control practitioners, information technologists).



Safety



3.2

Radiotherapy only: There is a process to identify and address equipment or software that needs to be updated or that does not meet best practice for service delivery.

**Guidelines**

Upgrades occur in a timely way so that access to and the quality of radiotherapy services are not adversely affected.

When standards, recommendations, or best practices are set through federal or provincial bodies (e.g., provincial cancer agencies), they are used. When these are not available, the organization has a process to determine what is acceptable.



Safety

3.3

Radiotherapy only: Technical quality control policies and procedures are developed and followed for all radiotherapy equipment.

**Guidelines**

Quality control policies and procedures are typically developed by a radiotherapy quality assurance team. They are developed and followed to ensure that all equipment is appropriate for providing safe and high-quality care and is compliant with applicable standards. For new equipment, a quality control procedure is implemented during installation and commissioning, and tested prior to clinical use.

Further information about radiation therapy equipment quality control guidelines can be found in the Canadian Partnership for Quality Radiotherapy Technical Quality Control Guidelines for Canadian Radiation Treatment Centres.



Safety

- 3.4 Radiotherapy only: Provincial and federal regulations to register, install, and calibrate radiotherapy equipment are followed.

**Guidelines**

All applicable regulations are followed. A subset of regulations can be accessed through the Canadian Nuclear Safety Commission.



Safety

- 3.5 Radiotherapy only: Independent audits of treatment device calibration of dosimetry are performed at least annually.

**Guidelines**

Proper calibration of treatment devices' dosimetry is essential to ensuring that the appropriate prescribed dose of radiation is delivered to clients. Independent external audits of dosimetry are performed for all treatment devices. Audit results are reviewed by the heads of Radiation Oncology, Medical Physics, and Radiation Therapy.

Further information about quality control reviews can be found in the Canadian Partnership for Quality Radiotherapy Technical Quality Control Guidelines for Canadian Radiation Treatment Centres.



Safety

- 3.6 Radiotherapy only: Independent quality control reviews are performed at least annually.

**Guidelines**

The independent verification of quality control tests is an essential element of any quality control program. To ensure redundancy and adequate monitoring, a qualified Medical Physicist independently verifies the implementation, analysis, and interpretation of the quality control tests of all radiotherapy equipment at least annually. Independent checks are documented.

Further information about quality control reviews can be found in the Canadian Partnership for Quality Radiotherapy Technical Quality Control Guidelines for Canadian Radiation Treatment Centres.



Safety

- 3.7 Radiotherapy only: The safety and quality assurance of radiotherapy equipment is reviewed following maintenance, repair, upgrade, or damage, before the equipment is returned to clinical use.

**Guidelines**

Radiotherapy equipment is only returned to clinical use after being tested for quality assurance following maintenance, repair, upgrade, or damage by or under the supervision of a qualified medical physicist.



Safety

- 3.8 Radiotherapy only: Information about equipment maintenance schedules is provided to clients and families.

**Guidelines**

Information may be provided as part of an information package or through orientation to services, or may be posted in client areas.



Safety

- 3.9 Radiotherapy only: There is a radiotherapy equipment log in which to record maintenance and downtime, and to identify and document upgrades, repairs, and other solutions to equipment issues.

**Guidelines**

Preventative maintenance records are retained according to provincial and federal regulations.



Safety

3.10

Radiotherapy only: When services are contracted from an external provider, the organization ensures that all safety requirements are met and documented.

**Guidelines**

Contracted services may include installing, calibrating, repairing, upgrading, and maintaining radiotherapy equipment as well as quality assurance services.



Safety

3.11

Radiotherapy only: There are defined policies and procedures to protect clients, team members, and the community in the event of equipment failure, damage, or malfunction.

**Guidelines**

Policies and procedures are clear and provide detailed information on what action should be taken in the event of equipment failure, damage, or malfunction. Actions may include steps to notify the appropriate team members and support services, and supporting clients.



Safety



3.12

Radiotherapy only: The radiotherapy treatment program has a process for managing radioactive waste of different types.

4.0

**SYSTEMIC THERAPY ONLY : Systemic therapy equipment is appropriate, maintained, and safe for client care.**



Safety



4.1

Systemic therapy only: All infusion pumps are clearly labelled with easy-to-follow instructions.

**Guidelines**

Instructions are typed, not hand written, and include step-by-step instructions on programming. Instructions do not include abbreviations, dashes, or symbols that could be misinterpreted.



Safety

4.2

Systemic therapy: The variety of systemic cancer therapy infusion pumps used by the team is limited.

## HANDLING MEDICATIONS SAFELY



Safety

### 5.0 **SYSTEMIC THERAPY ONLY: Systemic cancer therapy medications are handled in a safe and accurate manner.**

5.1 Systemic therapy only: Established guidelines for the safe handling of systemic cancer therapy medications are available to the team.

#### **Guidelines**

Guidelines related to the safe handling of systemic medications and occupational health and safety should be up to date. Team and client safety, as well as health and reproductive concerns, are considered when assigning duties. There is a method for responding to team concerns regarding the handling of systemic cancer therapy medications.

Policies also address education provided to team members, specific Personal Protective Equipment (PPE), work practices, waste management, spills management, and the handling of equipment.



Safety

5.2 Systemic therapy only: Established guidelines are followed for the safe handling of systemic cancer therapy medications.

#### **Guidelines**

Guidelines are followed for safe acquisition, storing, handling, preparing, administering, transporting, spills management, and waste disposal for cytotoxic agents and other potentially hazardous systemic cancer therapies.

Regulations are followed while working with systemic cancer therapy medications and appropriate personal protective equipment (PPE) is worn.



Safety

5.3 Systemic therapy only: Responsibility for acquiring, receiving, storing, preparing, administering, transporting, and disposing of systemic cancer therapy medications and contaminated supplies is identified.



Safety

5.4 Systemic therapy only: Organizational guidelines for spills of systemic cancer therapy medications are followed.

**Guidelines**

A hazardous spill kit is located wherever chemotherapy is dispensed and administered.



Safety



5.5 Systemic therapy only: All incidents involving systemic cancer therapy medications are documented and this information is used to make improvements.



Safety



5.6 Systemic therapy only: Organizational guidelines are followed for the safe disposal of systemic therapy medications.

**Guidelines**

There is access to protective equipment when disposing of systemic drug products.

**6.0 SYSTEMIC THERAPY ONLY: Systemic cancer therapy medications are safely managed.**



Safety

6.1 Systemic therapy only: There is a process to identify and document who is responsible for prescribing, verifying, dispensing, checking, and administering systemic cancer therapy medications.

**Guidelines**

Role clarity in managing and using medications helps reduce the likelihood of medication errors and patient safety incidents.



Safety



6.2

Systemic therapy only: Computerized physician order entry (CPOE) or Pre-Printed Orders (PPO) are used when ordering systemic cancer therapy medications.

**Guidelines**

Up-to-date documentation is maintained regarding orders and changes to orders for each client. Non -CPOE or non-PPO orders are the exception (e.g., a new indication for a systemic cancer therapy medication) and additional safety measures are taken in these rare cases.



Safety

6.3

Systemic therapy only: There is a policy mandating the minimum information to be included in orders for systemic cancer therapy medications.

**Guidelines**

Examples include two unique client identifiers, treatment plan, additional medications involved in the treatment plan (e.g., an anti-nauseant, hydration medication), full generic name of the systemic medication, dose calculation, administration date, duration of infusion, route and frequency, rate of infusion, and laboratory results.



Safety



6.4

Systemic therapy only: Verbal or telephone orders are not accepted for an entire cycle of systemic cancer therapy medications.

**Guidelines**

There is a process for accepting and documenting clarifications that are taken over the telephone.



Safety



6.5

Systemic therapy only: An organizational standard format is followed when ordering, labeling, and administering systemic cancer therapy medications.

**Guidelines**

A format that is detailed, accurate, and intuitive to the process is used. Tallman lettering is used for look-alike/sound-alike medications. For an example, see ISMP guidelines.



Safety

6.6

Systemic therapy only: The dose calculation is referenced when ordering and verifying systemic cancer therapy medications.

**Guidelines**

The dose calculation is clearly listed on the order form so it can be checked for accuracy at various points throughout the process.



Safety



6.7

Systemic therapy only: Each prescription is reviewed for completeness and accuracy before preparing, dispensing, and administering systemic cancer therapy medications.

**Guidelines**

At a minimum, each prescription shows the client's name, the name of the medication, the dosage and frequency, and the prescribing professional.

Prescriptions are reviewed by a qualified professional to assess the appropriateness of each medication, the use of multiple medications, and drug interactions.



Safety



6.8

Systemic therapy only: Abbreviations and dashes are not used when ordering systemic cancer therapy medications.

**Guidelines**

This includes the delivery instructions for systemic cancer therapy medications.



Safety



6.9

Systemic therapy only: Any changes to orders for systemic cancer therapy medications are managed, documented, and communicated.

7.0

**SYSTEMIC THERAPY ONLY: There are specific policies and procedures for preparing and dispensing systemic cancer therapy medications.**



Safety



7.1

Systemic therapy only: All systemic cancer therapy prescriptions are verified prior to preparation.

**Guidelines**

The order and medication must be verified by two qualified team members. If there is any question regarding the prescription, the prescribing team member is contacted.



Safety

7.2

Systemic therapy only: Established professional guidelines for the safe preparation and dispensing of systemic cancer therapy medications are followed.

**Guidelines**

Examples of guidelines include the number of orders for systemic cancer therapy medications prepared at one time, and conducting independent double checks during and after medication preparation.

## BUILDING A PREPARED AND COMPETENT TEAM



Appropriateness



### 8.0 Team members are qualified and have relevant competencies.

8.1 Required training and education are defined for all team members with input from clients and families.

#### Guidelines

The required training and education varies by role. They may be defined by a professional regulating body, may be formal or informal, and may include lived experience or work experience.

Clients and families can provide valuable input regarding education and training that could benefit team members and enhance services. For example, clients and families may identify a need for training on working with clients with diverse cultural backgrounds, religious beliefs, and care needs. Clients and families can also provide valuable input into where knowledge gaps may exist.

Input from clients and families is sought collectively through advisory committees or groups, formal surveys or focus groups, or informal day-to-day feedback. Input can be obtained in a number of ways and at various times and is utilized across the organization.



Appropriateness



8.2 Credentials, qualifications, and competencies are verified, documented, and up-to-date.

**Guidelines**

Requirements vary for different roles in the organization, including for regulated or unregulated team members.

Designations, credentials, competency assessments, and training are monitored and maintained to ensure safe and effective delivery of services. Professional requirements are kept up-to-date in accordance with provincial and organizational policies.

Services are delivered within accepted scopes of practice. Team members have the appropriate training and capacities to provide client-centred care and use equipment, devices, and supplies safely.



Appropriateness

8.3

A comprehensive orientation is provided to new team members and client and family representatives.

**Guidelines**

The orientation program covers, at minimum, the organization's mission, vision, and values; the team's mandate, goals, and objectives; the philosophy of client-centred care and how to apply its principles to practice; roles, responsibilities, and performance expectations; policies and procedures, including confidentiality; worklife balance initiatives; and the organization's approach to integrated quality management (e.g., quality improvement, risk management, utilization management, efficient use of resources).

Orientation processes and activities are documented.

Client-centred  
Services

8.4

Education and training are provided to team members on how to work respectfully and effectively with clients and families with diverse cultural backgrounds, religious beliefs, and care needs.

**Guidelines**

Cultural education and training build the skills, knowledge, and attitudes that are required to safely and appropriately deliver interventions and services to culturally diverse populations. The training may cover topics such as disability, level of understanding, or mental health.

Cultural education and experience are part of the recruitment (including position advertisements) and selection processes.



Client-centred  
Services

- 8.5 Education and training are provided on the organization's care delivery model.

**Guidelines**

The education and training program covers the philosophy of client- and family-centred care adopted by the organization, the expected behaviours associated with a client-centred approach, how to apply the principles to problem solve or address issues in the organization, clients' rights, the ways in which clients are involved in planning and delivering services in the organization, and the quality improvement initiatives that are being undertaken.



Appropriateness

- 8.6 Education and training are provided on the organization's ethical decision-making framework.

**Guidelines**

Training and support to handle ethical issues is provided to team members. Ethics-related issues include conflicts of interest, conflicting perspectives between clients and family and/or team members, a client's decision to withdraw care or to live at risk, and varying beliefs or practices.



Safety



8.7

Education and training are provided on the safe use of equipment, devices, and supplies used in service delivery.

#### Guidelines

Information about the safe use of equipment is provided to all team members. They are trained on how to use existing and new equipment, devices, and supplies. Retraining may be requested or required if a team member does not feel prepared to use the equipment, device, or supplies, or has not used the equipment or device for a long time.

Training includes handling, storage, operation, and cleaning; preventive maintenance; and what to do in case of breakdown.



Safety



8.8

Education and training are provided on the organization's disaster and emergency plan, with a focus on the specific types of services provided.

#### Guidelines

Training includes information about the organization's broader processes to mitigate the impact of emergencies and disasters as well as procedures used during an emergency. Specific training is provided regarding equipment that may be impacted during an emergency (e.g., radiotherapy equipment), equipment failure, and putting clients at ease during an emergency.



Appropriateness

8.9

Education and training are provided on information systems and other technology used in service delivery.

#### Guidelines

Education and training may cover topics such as knowledge of computer applications, word processing, software, time management tools, communication tools, research applications, cell phone use, and protecting the privacy of client information.



Continuity



8.10

Education and training are provided on how to identify palliative and end-of-life care needs.

#### Guidelines

Training includes information on the organization's process to provide or facilitate access to palliative care and end-of-life services, communicating with families about end-of-life issues, and how and when to initiate discussions about palliative and end-of-life care.

Federal, provincial, and territorial legislation and regulations regarding consent and substitute decision making are followed.



Worklife



8.11

Team member performance is regularly evaluated and documented in an objective, interactive, and constructive way.

#### Guidelines

An established process to evaluate each team member's performance is followed. Client and/or peer input is part of the evaluation process.

The evaluation may consider the team member's ability to carry out responsibilities, apply the principles of client-centred care, and contribute to the values of the organization. It may also consider the individual's strengths; opportunities for growth; contributions toward patient safety, worklife, and respecting client wishes; or specific competencies described in the position profile. The evaluation may identify issues that require follow up such as unprofessional or disruptive behaviour or challenges adopting client-centred care practices.

A performance evaluation is usually done before the probationary period is completed and annually thereafter, or as defined by the organization. An evaluation may also be completed after retraining or when new technology, equipment, or skills are introduced.



Client-centred  
Services

- 8.12 Client and family representatives are regularly engaged to provide input and feedback on their roles and responsibilities, role design, processes, and role satisfaction, where applicable.

#### Guidelines

Regular communication between team members/leaders and client and family representatives ensures that the relationship is mutually beneficial. Discussions include opportunities for increased collaboration and role satisfaction.

Though an open and transparent dialogue is encouraged, team leaders recognize that client and family representatives are to remain independent from the organization, to ensure their opinions and recommendations remain unbiased.



Worklife



- 8.13 Team members are supported by team leaders to follow up on issues and opportunities for growth identified through performance evaluations.

#### Guidelines

Issues may be identified by the team member or the team leaders and are used to develop an action plan or professional development plan.



Worklife

- 8.14 Ongoing professional development, education, and training opportunities are available to each team member.

#### Guidelines

Team leaders encourage team members to participate in opportunities for professional or skills development on a regular basis. Additional training or education may be given based on the team member's performance evaluation or as identified through professional development plans.

**9.0 RADIOTHERAPY ONLY: The radiotherapy team is qualified and prepared to deliver safe radiotherapy.**



Efficiency



9.1 Radiotherapy only: There is a designated program lead (or leads) for the radiotherapy program.

**Guidelines**

Having a designated program lead (or leads) ensures that there is defined accountability within the program. The program lead (or leads) for radiotherapy is responsible for medical and administrative oversight of the radiotherapy program and meets requirements determined by the organization, applicable colleges, and regulatory bodies.



Efficiency



9.2 Radiotherapy only: There is a designated Radiation Safety Officer for cancer care.

**Guidelines**

The Radiation Safety Officer reports directly to the CEO of the organization or a senior leadership delegate other than the radiotherapy program lead for issues regarding radiation safety. The radiation safety officer is certified by Canadian Nuclear Safety Commission (CNSC).



Safety



9.3 Radiotherapy only: A radiation oncologist and medical physicist are accessible to support the team at all times when services are being delivered.

**Guidelines**

When questions arise, it is important that the team is able to access a radiation oncologist and/or medical physicist. The parameters of availability and acceptable time frames are determined by the program and followed by the team.

When these individuals are not immediately available on site, a process is followed to provide access through other avenues (e.g., telemedicine, remote connection).



Safety



9.4

Radiotherapy only: Ongoing education and training on radiation safety are provided to the team.

**Guidelines**

When team members are working with radiation, it is crucial that they have been trained on radiation safety and have current information.

Training provides employees with the knowledge required to work safely with radiation devices and nuclear substances. Training meets the requirements of the Canadian Nuclear Safety Commission (CNSC) and provincial regulations (where available).



Safety



9.5

Radiotherapy only: Education and training are provided on the safe and efficient use of radiotherapy equipment and software.

**Guidelines**

Radiotherapy involves complex and dynamic processes that are continually changing and that involve new technologies. Education and training in radiotherapy needs to keep pace with these changes to ensure a safe environment for clients, families, team members, and the public.

Training is provided to those who are new to the organization, to temporary staff, and to those who are returning after an extended leave. Training is provided to all team members when a new type of radiotherapy equipment or software is introduced, following an upgrade, and whenever an evaluation of competence indicates that retraining is needed.



Safety

9.6

Radiotherapy only: Equipment and software instructions and user guides are easily accessible at all times for each type of radiotherapy equipment and software in use.

**Guidelines**

Instructions and user guides also includes information from the manufacturer regarding any special safety precautions. Safety bulletins released by the manufacturer after the initial installation are accessible to team members.



Safety



9.7

Radiotherapy only: The effectiveness of radiotherapy equipment and software training is evaluated and improved as required.

**Guidelines**

Examples of mechanisms for evaluation include investigating patient safety incidents related to radiotherapy equipment and software use, and monitoring evaluations of competence.

10.0

**SYSTEMIC THERAPY ONLY: Team members are qualified and prepared to deliver systemic therapies.**



Safety



10.1

REQUIRED ORGANIZATIONAL PRACTICE: A documented and coordinated approach for infusion pump safety that includes training, evaluation of competence, and a process to report problems with infusion pump use is implemented.

### Guidelines

Infusion pumps, used to deliver fluids into a client's body in a controlled manner, are used extensively in health care, including in the home environment, and are associated with significant safety issues and harm to clients.

This ROP focuses on parenteral delivery (i.e., routes other than the digestive tract or topical application) of fluids, medications, blood and blood products, and nutrients. It includes stationary and mobile intravenous infusion pumps, patient-controlled analgesia, epidural pumps, insulin pumps, and large-volume pumps. It excludes gastric feeding pumps.

Team members need training and education to maintain their competence in using infusion pumps safely, given the variety of pump types and manufacturers, the movement of team members between services, and the use of temporary staff. Safety is best achieved when organizations have a comprehensive approach that combines training and evaluation with the appropriate selection, procurement, and standardization of infusion pumps across an organization (see Accreditation Canada standards for medication management).

When evaluations reveal problems with infusion pump design, organizations can work with manufacturers to make improvements. Organizations are encouraged to report problems externally (e.g., to Health Canada or Global Patient Safety Alerts) so that other organizations can implement safety improvements.

### Test(s) for Compliance

<b>Major</b>	10.1.1	Instructions and user guides for each type of infusion pump are easily accessible at all times.
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<b>Major</b>	10.1.2	<p>Initial and re-training on the safe use of infusion pumps is provided to team members:</p> <ul style="list-style-type: none"> <li>• Who are new to the organization or temporary staff new to the service area</li> <li>• Who are returning after an extended leave</li> <li>• When a new type of infusion pump is introduced or when existing infusion pumps are upgraded</li> <li>• When evaluation of competence indicates that re-training is needed</li> </ul> <p>When infusion pumps are used very infrequently, just-in-time training is provided.</p>
<b>Major</b>	10.1.3	<p>When clients are provided with client-operated infusion pumps (e.g., patient-controlled analgesia, insulin pumps), training is provided, and documented, to clients and families on how to use them safely.</p>
<b>Major</b>	10.1.4	<p>The competence of team members to use infusion pumps safely is evaluated and documented at least every two years. When infusion pumps are used very infrequently, a just-in-time evaluation of competence is performed.</p>
<b>Minor</b>	10.1.5	<p>The effectiveness of the approach is evaluated. Evaluation mechanisms may include:</p> <ul style="list-style-type: none"> <li>• Investigating patient safety incidents related to infusion pump use</li> <li>• Reviewing data from smart pumps</li> <li>• Monitoring evaluations of competence</li> <li>• Seeking feedback from clients, families, and team members.</li> </ul>
<b>Minor</b>	10.1.6	<p>When evaluations of infusion pump safety indicate improvements are needed, training is improved or adjustments are made to infusion pumps.</p>



Safety



10.2

Systemic therapy only: Training regarding the safe handling of systemic cancer therapy medications and/or contaminated materials is provided to the team and regularly reviewed.

#### Guidelines

Training includes staff from outside of the systemic cancer therapy team (e.g., portering, laundry, reception, receiving staff, transporting and housekeeping services) as appropriate. Information is provided about personal protective equipment (PPE) as well as the proper disposal of medications and safe cleaning methods.

The term “regularly” is defined by the team and that schedule is adhered to.



Safety

10.3

Systemic therapy only: Up-to-date information about systemic cancer therapy regimens and medications provided in the organization is accessible to the team.

#### Guidelines

Information is updated on an ongoing basis or anytime there is a significant change. Information is stored in an easily accessible location either in hard copy or electronically. All team members know how and where to access this information.

Information includes uses, dosing, preparing, administration guidelines, side effects (both common and uncommon), client monitoring, and how to manage an overdose.



Safety



10.4

Systemic therapy only: Training and education on new medications or regimens is provided to the team before the medications or regimens are put into use at the organization.

#### Guidelines

Training and education includes uses, dosing, preparing, administration guidelines, side effects both common and uncommon, client monitoring, safe handling, and any specific handling requirements.



Appropriateness



## 11.0 Services are provided within a collaborative team environment.

11.1 A collaborative approach is used to deliver services.

### Guidelines

An interdisciplinary collaborative team needs to evolve and adapt to the changing needs of the client. Depending on the needs and desires of the client and family, the team may consist of specialized roles (e.g., care providers) and support roles (e.g., care planners, translators, security staff, or representatives from community partner organizations). Students, volunteers, and client representatives or advisors may also be included as part of the team.

A team leader (or leaders) is defined and the role of each team member is made clear to the client and family.

The collaborative team is established based on defined criteria such as accepted standards of practice; legal requirements; knowledge, experience, and other qualifications; volume or complexity of caseload; changes in workload; and client safety and needs.



Appropriateness

11.2 The team works in collaboration with clients and families.

### Guidelines

Clients and families are engaged in shared decision making and understand how care is provided. The client defines the makeup of their family, and has the right to include or not include family members of their choice in their care, and the right to redefine the makeup of their family over time. Family includes an individual's extended family, their partners, friends, advocates, guardians, and other representatives.



Worklife

- 11.3 Position profiles with defined roles, responsibilities, and scope of employment or practice exist for all positions.

#### Guidelines

Position profiles include a position summary, qualifications and minimum requirements, the nature and scope of the work, and reporting relationships. They are developed for all team members including those who are not directly employed by the organization (e.g., contracted team members, partners, client and family representatives).

Role clarity is essential in promoting client and team safety as well as a positive work environment. Understanding roles and responsibilities and being able to work to one's full scope of practice helps create meaning and purpose for team members.



Safety



- 11.4 Standardized communication tools are used to share information about a client's care within and between teams.

#### Guidelines

Standardized communication increases consistency, minimizes duplication, and improves teamwork while promoting patient safety. Tools may include protocols, technologies, or standardized processes such as SBAR (Situation Background Assessment Recommendation).

Team members are trained on organizational policies and practices regarding standardized communication tools.



Appropriateness

- 11.5 The effectiveness of team collaboration and functioning is evaluated and opportunities for improvement are identified.

**Guidelines**

The process to evaluate team functioning and collaboration may include a review of its services, processes, and outcomes. This could be done by administering a team functioning questionnaire to team members, clients and families, and partners to stimulate discussion about areas for improvement.

The team evaluates its functioning when there has been a significant change to the structure of the team.

**12.0 Well-being and worklife balance is promoted within the team.**

**12.1** The workload of each team member is assigned and reviewed in a way that ensures client and team safety and well-being.

**Guidelines**

Appropriate criteria are used for determining workload depending on the environment and the unique demands of different services areas, including hours of work, caseload, role complexity, complexity of client care, physical or emotional demands, repetitive nature of tasks, and level of responsibility. The preferences and availability of each team members are also considered.

In some cases teams may designate a maximum workload for team members. The process of assigning and reviewing workload includes monitoring and tracking hours and clients and when additional measures are needed (e.g., staffing transfers or team re-design).

An environment where team members are comfortable discussing demands and stress levels in the workplace is promoted by the organization and leaders. Measures are taken to alleviate these pressures as much as possible. These can include scheduling strategies, workload sharing, and scheduled time for documentation.

**12.2** Work and job design, roles and responsibilities, and assignments are determined with input from team members, and from clients and families where appropriate.



Worklife



Worklife

**Guidelines**

Job design refers to how a group of tasks, or an entire job, is organized. Job design addresses all factors that affect the work, including job rotation, work breaks, and working hours.

When developing and reviewing job design, roles, responsibilities, and assignments, team member and client and family input and feedback is considered. They can all provide unique insight into areas of job design that directly impact them. The flexibility of job design, roles, responsibilities, and assignments will vary depending on the type of services being delivered, the clients being served, and the individual team members involved. Assignments include who each provider cares for, as well as other elements of the team members' roles (e.g., participation in quality improvement activities, training new staff members).



Worklife

12.3

Team members are recognized for their contributions.

**Guidelines**

Recognition activities may be individual, such as awards for years of service or special achievements, or they may involve team recognition or activities.

Recognition can be formal or informal and may be verbal, written, or focus on promoting an atmosphere where team members feel appreciated for their contributions.



Worklife

12.4

There is a policy that guides team members to bring forward complaints, concerns, and grievances.



Safety



12.5

Education and training on occupational health and safety regulations and organizational policies on workplace safety are provided to team members.



Safety



12.6

Education and training are provided on how to identify, reduce, and manage risks to client and team safety.

**Guidelines**

Training may include physical hazards; challenges with equipment; handling spills, waste, or infectious materials; working with clients who may pose a risk to themselves or others; and challenges with handling, storing, or dispensing medications.

Common risks to the team may include lack of training on safety issues, performing improper lifts, improper use of equipment, or working alone.



Safety



12.7

Education and training are provided to team members on how to prevent and manage workplace violence, including abuse, aggression, threats, and assaults.

### Guidelines

Acts of violence include abuse, aggression, threats, and assaults. They may be committed by clients, their families, teams, or anyone else in the workplace.

Where possible, team members use de-escalation techniques as a preventive measure. De-escalation techniques are minimally intrusive and the least restrictive way to manage violence. Some training programs on how to safely work with clients who are at risk of or who exhibit aggressive or responsive behaviors include:

- CPI Training (Crisis Prevention and Intervention)
- GPA (Gentle Persuasive Approach)
- U-First!

Training and education include the use of a standardized risk assessment tool such as the Hamilton Anatomy of Risk Management (HARM) tool. Training may address:

- Identifying triggers
- Assessing and communicating a client's potential for violence and recognizing signs of agitation and aggression
- Reducing harassment
- Responding to and managing violence (e.g., non-violent crisis intervention, emergency code response guidelines, conflict resolution and mediation, and self-defense)
- The trauma-informed approach
- Communication techniques

Training may also specify the team's alternate procedure for when de-escalation techniques are unsuccessful.



Safety



12.8

The organization's policy on reporting workplace violence is followed by team members.

### Guidelines

Perceived, potential, or actual incidents of physical or verbal violence are reported to the appropriate authorities in accordance with applicable legislation, and may be reported in the client medical record depending on the nature of the incident.



## PROVIDING SAFE AND EFFECTIVE SERVICES



Accessibility

### **13.0 Access to services for current and potential clients, families, teams, and referring organizations is provided in a timely and coordinated manner.**

13.1 There is a process to respond to requests for services in a timely way.

#### **Guidelines**

Requests for service may come from clients, families, other teams, or referring organizations. There may be different processes to respond to a request based on who is requesting the services and what is being requested.

Requests for service, the process to respond to requests, and the definition of timely will vary by type of service being offered.

Responsiveness is monitored by setting and tracking times for responding to requests for services as well as through gathering feedback from clients and families, referring organizations, and other teams.



Appropriateness

13.2 Information about the client is gathered as part of the intake process and as required.

#### **Guidelines**

This process may be called admission, intake, pre-admission, screening, start of service, or moving in. The information is validated and reviewed. It is used to determine if the organization's services fit with the client's needs and preferences, identify the client's immediate needs, and decide on service priorities.

The intake process is adjusted as needed for clients and families with diverse needs such as language, culture, level of education, lifestyle, and physical or mental disability.



Accessibility

13.3 Defined criteria are used to determine when to initiate services with clients.

**Guidelines**

The needs of potential clients are assessed in relation to the capacity of the team to meet those needs.



Accessibility

13.4 There is an established process to respond to oncological emergency treatment requests.

**Guidelines**

Unscheduled or emergency requests for treatment can occur. To best address these instances, there is a process to respond to such requests so the quality and safety of emergency care is not compromised and regularly scheduled patients are considered.



Accessibility

13.5 When the team is unable to meet the needs of a potential client, access to other services is facilitated.

**Guidelines**

In the case where the organization is unable to meet the client's needs, the rationale is explained and access to other services is facilitated. The information is documented for use in service planning.



Accessibility

13.6 The team has and follows wait time guidelines for time from referral to consultation, and from ready to treat to first treatment.

**Guidelines**

Wait time guidelines typically address two time intervals: 1) wait time from referral to consultation, and 2) wait time from the ready to treat until treatment initiation. The team uses wait times guidelines appropriate to its organization and region.

National wait time guidelines and benchmarks are available through the Canadian Association of Radiation Oncologists (CARO) and the Wait Time Alliance.



Client-centred  
Services

13.7

Expected treatment timelines are discussed with clients.

**Guidelines**

Communicating openly and sharing information about cancer treatment helps clients understand their diagnosis and treatment plan, and encourages clients to ask questions and be involved in their care. Treatment timelines are communicated to clients and include when treatment will begin, how long it will last, and when it is expected to end.



Accessibility

13.8

Clients and families have access to genetic testing and counselling, as appropriate.

**Guidelines**

Genetic testing for hereditary cancers helps identify those at risk and increases early detection. Genetic testing and counselling are provided by cancer genetics professionals who can provide accurate risk assessment information and support to clients with predisposition to cancer. Organizations that do not have access to genetic testing and counselling on site help clients access services elsewhere.



Accessibility

13.9 Clients and families have access to fertility counseling and preservation, as appropriate.

#### Guidelines

The team works with clients and families whose fertility may be impacted by treatment to ensure they understand the risks involved and have access to fertility preservation services when appropriate.

Client-centred  
Services

13.10 There is a process to ensure that each client is able to effectively navigate their services.

#### Guidelines

The nature of cancer care is complex. Navigation support is linked to improved client outcomes through an improved understanding of care plans, better coping strategies, and increased compliance with treatment.

Having an established process ensures that clients and families have access to the supports necessary to effectively navigate services. In many cases this may mean facilitating access to peer or professional client navigators. Navigation support can be initiated at any point during the cancer journey—from the discovery of an abnormal screening result, to treatment, rehabilitation, survivorship planning, or palliative care.



Accessibility

13.11 Clients and families are made aware of the team member who is responsible for coordinating their service, and how to reach that person.

#### Guidelines

The assigned team member may be the collaborative team member with the most consistent contact with the client, or the primary provider responsible for care.



Client-centred  
Services

## 14.0 Clients and families are partners in service delivery.

14.1 There is an open, transparent, and respectful relationship with each client.

### Guidelines

The team supports a respectful and transparent relationship with clients by introducing themselves and explaining their role; asking permission before performing tasks; explaining what they are doing; using a respectful tone; expressing concern or reassurance; providing an opportunity for questions, input, and feedback; respecting cultural and religious beliefs or lifestyle; and respecting confidentiality and privacy.



Continuity

14.2 There is a process to communicate with the primary care or referring provider, in partnership with the client and family.

### Guidelines

The care team connects with the client's primary care provider or community health support network to ensure continuity of services. Information about the client's diagnosis, care plan, prognosis, and survivorship plan are communicated with the primary care team or referring provider at appropriate intervals.



Client-centred  
Services

14.3 Clients and families are encouraged to be actively engaged in their care.

### Guidelines

The environment encourages clients and families to be active participants in their care, ask questions, and provide input at all stages of the care process.



Client-centred  
Services

- 14.4 The capacity of each client to be involved in their care is determined in partnership with the client and family.

**Guidelines**

Each client will have differing levels of ability to be involved in their own care. At each stage, the appropriate team member works with the client, family, or substitute decision maker to determine how much and what type of information the client or family requires to be meaningfully involved in their care. This information is documented in the client record.



Client-centred  
Services

- 14.5 The client's wishes regarding family involvement in their care are respected and followed.

**Guidelines**

The team finds ways to include members of the client's support network in the client's care.

Applicable legislation when a substitute decision maker or family is involved in decision-making is respected. There is a process to resolve conflicts regarding level of desired involvement between the client and family.



Client-centred  
Services

- 14.6 Complete and accurate information is shared with the client and family in a timely way, in accordance with the client's desire to be involved.

**Guidelines**

Sharing detailed and complete information is critical for informed choice and shared decision making between clients, families, and the team. Information is delivered according to individual needs and interests, as well as levels of understanding.

Clients and families are made aware of the risks and benefits of care; the client's roles and responsibilities in service delivery; the benefits, limitations, and possible outcomes of proposed services or interventions; how to prepare for tests and treatments; the availability of counselling and support groups; and how to reach team members in an emergency or crisis.

Varying levels of information may be required at different points in the client's care and are accommodated wherever possible. Similarly, different messages will require different delivery methods (e.g., serious topics require a more structured approach).



Client-centred  
Services

14.7

The team verifies that the client and family understand information provided about their care.

**Guidelines**

The level of understanding, literacy, language, disability, and culture are considered when providing information to clients and families.

Processes to verify clients' understanding include encouraging and allotting time for questions, having the client repeat back information, ensuring a linguistic or cultural match wherever possible, using visuals or videos where possible, and creating an ongoing exchange where confirming understanding is a recurring event.

The Always Use Teach-back! Website ([www.teachbacktraining.org/](http://www.teachbacktraining.org/)) provides useful tools to learn how to confirm client understanding of information.



Client-centred  
Services

14.8 Translation and interpretation services are available for clients and families as needed.

**Guidelines**

Written materials are available in the languages commonly spoken in the community, as required. Interpretation services are available when required by clients or families, wherever possible.



Client-centred  
Services

14.9 The client's capacity to provide informed consent is determined.

**Guidelines**

The process of evaluating a client's capacity to consent is carried out on an ongoing basis. With respect to decision making for consent purposes, “capacity” means the ability to understand the information relevant to the decision, appreciate foreseeable consequences of a decision or failure to make a decision, and weigh the risks and benefits of that decision.

Federal, provincial, and territorial legislation are followed when working with children and youth. When dealing with the elderly, minors, or those deemed incapable of consenting, clients are involved to the greatest extent possible in making decisions about their services, and the team values their questions and input.



Client-centred  
Services



14.10 The client's informed consent is obtained and documented before providing services.

**Guidelines**

Informed consent consists of reviewing service information with the client, family, or substitute decision maker; informing the client about available options and providing time for reflection and questions before asking for consent; respecting the client's rights, culture, and values including the right to refuse consent at any time; and recording the client's decision in the client record. The consent process is ongoing.

Implied consent occurs when providing services where written consent is not needed, such as when clients arrive for an appointment or class, have blood pressure taken, present their arm to have blood drawn, arrive for service through Emergency Medical Services (EMS), or present with life-threatening or emergent condition(s) and require immediate resuscitation.



Appropriateness



14.11

When clients are incapable of giving informed consent, consent is obtained from a substitute decision maker.

**Guidelines**

A substitute decision maker is consulted when clients are unable to make their own decisions, and an advance directive is used, where available, to ensure decisions are in line with the client's wishes. In these cases, the substitute decision maker is provided with information about the roles and responsibilities involved in being a substitute decision maker, and given the opportunity to discuss questions, concerns, and options. Selecting the appropriate substitute decision maker is done in consideration of the applicable legislation and may be an advocate, family member, legal guardian, or caregiver.

If consent is given by a substitute decision maker, his or her name, relationship with the client, and the decision made is documented in the client record.

When working with children and youth, informed consent is received and documented from the child, youth, family or legal guardian before providing services. The consent process includes involving them as much as possible in the decisions about their service, intervention, or treatment, and valuing their questions and input.



Appropriateness

14.12

Clients and families are provided with opportunities to be engaged in research activities that may be appropriate to their care.

#### Guidelines

There is an ethical review process to determine when to involve a client in a research activity. Research activities may include clinical trials, assessments of new protocols, or changes to existing protocols. Clients and families are included in participatory research project design and implementation where appropriate, (e.g., gathering qualitative data for quality improvement initiatives).



Appropriateness



14.13

Ethics-related issues are proactively identified, managed, and addressed.

#### Guidelines

Ethics-related issues are ones in which values may be in conflict, making it hard to reach a decision. The issues may be very serious, life-and-death matters, or related to day-to-day activities. Examples include conflicts of interest; respecting a client's choice to live at risk; triaging community members during an emergency; requests to withdraw or end services, including life-sustaining supports or treatments; and end-of-life care.

The organization's ethics framework is used to manage and address ethics-related issues. They may be addressed by an ethics committee or consultation team that may include health service professionals, clergy, or ethicists. In addition to clinical consultation, the ethics committee may be involved in policy review and ethics education.

Ethics-related issues involving particular clients are documented in the client record.



Client-centred  
Services



14.14

Clients and families are provided with information about their rights and responsibilities.

#### Guidelines

Client and family rights include the right to have privacy and confidentiality protected; be aware of how client information is used; have access to their record and information about them; be treated with respect and care; maintain cultural practices; pursue spiritual beliefs; live at risk; and be free from abuse, exploitation, and discrimination.

Client and family rights regarding service delivery include the right to refuse service or refuse to have certain people involved in their service; participate in all aspects of their service and make personal choices; have a support person or advocate involved in their service; appeal a care plan decision or file a complaint; take part in or refuse to take part in research or clinical trials; receive safe, competent service; and raise concerns about the quality of service.

Client and family responsibilities include treating others with respect, providing accurate information, reporting safety risks, and observing rules and regulations.

The information is provided at intake or admission and is adapted to meet diverse needs such as language, culture, level of education, lifestyles, and physical or mental disability. When the information cannot be provided to the client and family on intake, it is provided at the earliest opportunity.



Client-centred  
Services



14.15

Clients and families are provided with information about how to file a complaint or report violations of their rights.



Client-centred  
Services



14.16

A process to investigate and respond to claims that clients' rights have been violated is developed and implemented with input from clients and families.

**Guidelines**

An environment where clients, families, and team members feel comfortable raising concerns or issues is promoted. The organization may provide access to a neutral, objective person from whom clients and families can seek advice or consultation. Where electronic health records are used, there is a process to receive and respond to client complaints and questions regarding the privacy of the electronic record.

Claims brought forward by team members or other teams are also addressed.

**15.0 Care plans are developed in partnership with the client and family based on a comprehensive assessment.**

**15.1** Each client's physical and psychosocial health is assessed and documented using a holistic approach, in partnership with the client and family.

**Guidelines**

Elements of physical health include:

- Medical history
- Allergies
- Medication profile
- Health status
- Nutritional status
- Palliative care needs
- Dietary needs

Elements of psychosocial health include:

- Functional and emotional status family and caregiver involvement
- Communication and self-care abilities and strengths
- Mental health status, including personality and behavioural characteristics
- Cognitive status
- Socio-economic status
- Cultural and spiritual beliefs and needs.



Appropriateness





Client-centred  
Services

15.2 The assessment process is designed with input from clients and families.

#### **Guidelines**

The assessment process is as streamlined and straightforward as possible, so that clients are not required to repeat information to multiple providers or team members. Where applicable, an interdisciplinary or collaborative assessment may be completed with the client, family, and appropriate team members.



Client-centred  
Services

15.3 Goals and expected results of the client's care and services are identified in partnership with the client and family.

#### **Guidelines**

The client's physical and psychosocial needs, choices, and preferences as identified in the client assessment are used to develop service goals. Service goals and expected results suit the client's individual circumstances, are achievable, measurable, and complement those developed by other team members and organizations with which the client is involved.



Client-centred  
Services

15.4 Standardized assessment tools are used during the assessment process.

### Guidelines

Tools are standardized and adopted across the team, and where applicable, across the organization. Assessment tools are designed to assist the team to systematically collect and interpret all of the information gathered during the assessment process. Benefits of using standardized tools for the client and the care provider include being more efficient, collecting more accurate information, consistency of assessment, and reliability of results and improved opportunity for communication between the client and the care provider.

The standardized assessment tools used will vary depending on the needs of the client and the type and range of services provided. Examples of standardized assessment tools are the Glasgow Coma Scale, the Clinical Frailty Scale, the Beck Depression Inventory, or the InterRAI tool. The standardized assessment tools used are evidence-informed and meaningful for the services provided.



Safety



15.5

**REQUIRED ORGANIZATIONAL PRACTICE:** Inpatient care only: Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.

## Guidelines

Research suggests that more than 50 percent of clients have had at least one discrepancy between the medications they take at home and those ordered upon admission to hospital. Many of these discrepancies have the potential to result in adverse drug events.

Medication reconciliation begins with generating a Best Possible Medication History (BPMH) that lists all the medications the client is taking including prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements. The BPMH also details how they are being taken including the dose, frequency, route of administration, and strength if applicable. Creating the BPMH involves interviewing the client, family, or caregivers, and consulting at least one other source of information such as the client's previous health record, or a community pharmacist. Once generated, the BPMH is an important reference tool for reconciling medications at care transitions.

Medication reconciliation at admission can be achieved using one of two models. In the proactive model, the BPMH is used to generate admission medication orders. In the retroactive model, the BPMH is generated after admission medication orders have been written; a timely comparison of the BPMH and admission medication orders is then made. Regardless of the model used, it is important to identify, resolve, and document medication discrepancies.

At care transitions, in addition to the medications the client is currently receiving, it is important to also consider the medications that were taken prior to admission (as identified in the BPMH), which may be appropriate to continue, restart, discontinue, or modify. For example, medication reconciliation should happen at discharge or when medications are changed or reordered as part of a transfer involving a change in the service environment (e.g., from critical care to a medicine unit, or from one facility to another within an organization). Medication reconciliation is not required for bed relocation.

Clients should be regarded as active partners in the management of their medications and provided with information about the medications they should be taking in a format and language they understand. Clients should be encouraged to keep an up-to-date medication list and share it with their providers.

**Test(s) for Compliance**

- Major**      15.5.1      Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with clients, families, caregivers, and others, as appropriate.
- Major**      15.5.2      The BPMH is used to generate admission medication orders or the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented.
- Major**      15.5.3      The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.
- Major**      15.5.4      The client, community-based health care provider, and community pharmacy (as appropriate) are provided with an accurate and up-to-date list of medications the client should be taking following discharge.



Safety



- 15.6**      **REQUIRED ORGANIZATIONAL PRACTICE:** Outpatient services only: Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information at ambulatory care visits when medication management is a major component of care.

### Guidelines

Ambulatory care includes a wide range of services and client populations; thus it is important to focus medication reconciliation on clients for whom medication management is a major component of care. Organizations should identify and document which ambulatory care clinics meet the requirement for medication reconciliation, keeping in mind that clinical judgment should always be a consideration when managing client medications.

Medication reconciliation begins with generating a Best Possible Medication History (BPMH) that lists all the medications the client is taking including prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements. The BPMH also details how they are being taken including the dose, frequency, route of administration, and strength, if applicable. Creating the BPMH involves interviewing the client, family, or caregivers, and consulting at least one other source of information such as the client's previous health record, or a community pharmacist. Once generated, the BPMH is an important reference tool for reconciling medications at care transitions.

The gathered lists of medications are compared, and when medication discrepancies are identified, they are resolved by the most responsible prescriber, either within the team or by referral. The prescriber indicates which medication(s) should be continued, discontinued, or modified and the reason(s) why.

Clients should be regarded as active partners in the management of their medications and provided with information about the medications they should be taking in a format and language they understand. Clients should be encouraged to keep an up-to-date medication list and share it with their providers.

### Test(s) for Compliance

<b>Major</b>	15.6.1	Ambulatory care clinics, where medication management is a major component of care, are identified by the organization. This designation is documented, along with the agreed upon frequency at which medication reconciliation should occur for clients of the clinic.
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- Major**      15.6.2      During or prior to the initial ambulatory care visit, a Best Possible Medication History (BPMH) is generated and documented in partnership with the client, family, caregivers, and others, as appropriate.
- Major**      15.6.3      During or prior to subsequent ambulatory care visits, the BPMH is compared with the current medication list and any medication discrepancies are identified and documented. This is done as per the frequency required by the organization.
- Major**      15.6.4      Medication discrepancies are resolved in partnership with clients and families or medication discrepancies are communicated to the client's most responsible prescriber and actions taken to resolve medication discrepancies are documented.
- Major**      15.6.5      The client and the next care provider (e.g., primary care provider, community pharmacist, home care services) are provided with an accurate and up-to-date list of medications the client should be taking at the last visit or upon discharge from the clinic.



Safety



**15.7**      **REQUIRED ORGANIZATIONAL PRACTICE:** To prevent falls and reduce the risk of injuries from falling, universal precautions are implemented, education and information are provided, and activities are evaluated.

## Guidelines

Clients admitted to hospital are at greater risk of falling and injuring themselves as they find themselves in an unfamiliar environment while also adjusting to a change in their physical or cognitive functioning (Stephenson et al., 2016). Reducing injuries from falls can increase quality of life, prevent loss of mobility and pain for clients, and reduce length of stay and costs.

Effective fall prevention and injury reduction requires an interdisciplinary approach and support from all levels of an organization. It is helpful to implement a coordinated approach to fall prevention and injury reduction within the organization, while recognizing the unique needs across different services, and to designate individuals to facilitate its implementation.

Organizations should identify and adopt precautions for all clients, regardless of risk of falling. The acronym S.A.F.E. (Safe environment; Assist with mobility; Fall-risk reduction; and Engage client and family) describes the key strategies for universal fall precautions. The Institute for Clinical Systems Improvement guideline (2012) also recommends the following universal interventions: familiarize the client to the environment; keep call buttons within reach at all times and observe clients demonstrate their use; keep clients' personal possessions within reach; have sturdy handrails in bathrooms, rooms, and hallways; keep the bed in low position with brakes locked; provide non-slip, well-fitting footwear to clients; use night lights or supplemental lighting; keep floor surfaces clean and dry; clean up all spills promptly; keep care areas uncluttered. It is important to identify precautions that align with the clinical setting and needs of clients in that setting.

Education about the importance of fall prevention and injury reduction, universal precautions and strategies to prevent falls and reduce injuries from falling is provided regularly to team members and volunteers. Clients, families, and caregivers are provided with easy to understand information that empowers them to play an active role in fall reduction and injury prevention.

It is important to regularly evaluate whether or not current precautions to prevent falls and reduce injuries from falling are having the desired impact and are meeting client, family, and team member needs. Effectiveness can be evaluated through a variety of means, whether informal discussions, interviews, surveys, audits, or evaluation processes. Measurement for improvement initiatives and post-fall debriefings may also help identify safety gaps and prevent the recurrence of falls or reduce injuries from falling.

**Test(s) for Compliance**

- Major**      15.7.1      Universal fall precautions, applicable to the setting, are identified and implemented to ensure a safe environment that prevents falls and reduces the risk of injuries from falling.
- Major**      15.7.2      Team members and volunteers are educated, and clients, families, and caregivers are provided with information to prevent falls and reduce injuries from falling.
- Minor**      15.7.3      The effectiveness of fall prevention and injury reduction precautions and education/information are evaluated, and results are used to make improvements when needed.



Safety



**15.8**      **REQUIRED ORGANIZATIONAL PRACTICE:** Inpatient care only: Medical and surgical clients at risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) are identified and provided with appropriate thromboprophylaxis.

**NOTE:** This ROP does not apply for pediatric hospitals; it only applies to clients 18 years of age or older.  
 This ROP does not apply to day procedures or procedures with only an overnight stay.

### Guidelines

Venous thromboembolism (VTE) is the collective term for deep vein thrombosis (DVT) and pulmonary embolism (PE). VTE is a serious and common complication for those in hospital or undergoing surgery. The incidence of VTE can be reduced or prevented by identifying clients at risk and providing appropriate, evidence-informed thromboprophylaxis. The American College of Chest Physicians Evidence-Based Clinical Practice Guidelines are a helpful resource for the prevention of VTE.

The widespread human and financial impact of thromboembolism is well documented. VTE is associated with increased client mortality; it is the most common preventable cause of hospital death. Appropriate evidence-informed thromboprophylaxis reduces cost and median length of stay.

There are many evidence-based clinical practice guidelines that recommend thromboprophylaxis for large groups of clients (e.g. the American College of Chest Physicians Evidence-Based Clinical Practice Guidelines, 9th edition) or for specific subgroups (e.g. American Society of Clinical Oncology, Society of Obstetricians and Gynaecologists of Canada). These guidelines are very useful resources and generally reflect the accepted standard of practice.

### Test(s) for Compliance

<b>Major</b>	15.8.1	There is a written venous thromboembolism (VTE) prophylaxis policy or guideline.
<b>Major</b>	15.8.2	Clients at risk for VTE are identified and provided with appropriate, evidence-informed VTE prophylaxis.
<b>Minor</b>	15.8.3	Measures for appropriate VTE prophylaxis are established, the implementation of appropriate VTE prophylaxis is audited, and this information is used to make improvements to services.

**Major** 15.8.4 Major orthopedic surgery clients (i.e., those having hip and knee replacements or hip fracture surgery) who require post-discharge prophylaxis are identified and there is a process to provide them with appropriate post-discharge prophylaxis.

**Minor** 15.8.5 Information is provided to clients and team members about the risks of VTE and how to prevent it.



Safety



**15.9** REQUIRED ORGANIZATIONAL PRACTICE: Inpatient care only: Each client's risk for developing a pressure ulcer is assessed and interventions to prevent pressure ulcers are implemented.

NOTE: This ROP does not apply for outpatient settings, including day surgery, given the lack of validated risk assessment tools for outpatient settings.

## Guidelines

Pressure ulcers have a significant impact on client quality of life, resulting in pain, slower recovery, and increased risk of infection. Pressure ulcers are also associated with increased length of stay, cost, and mortality. Effective pressure ulcer prevention strategies can reduce the incidence of pressure ulcers and are an indication of higher quality care and services.

Pressure ulcer prevention strategies require an inter-disciplinary approach and support from all levels of an organization. It is useful to develop a plan to support comprehensive education on pressure ulcer prevention, and to designate individuals to facilitate the implementation of a standardized approach to risk assessments, the uptake of best practice guidelines, and the coordination of health care teams.

Effective pressure ulcer prevention starts with a validated risk assessment scale, such as:

- The Braden Scale for Predicting Pressure Sore Risk
- The Norton Pressure Sore Risk Assessment Scale
- interRAI Pressure Ulcer Risk Scale (long-term care)
- The Waterlow Score
- The Gosnell Scale
- The Knoll Scale
- SCIPUS (Spinal Cord Injury Pressure Ulcer Scale)

A number of best practice guidelines are also available to inform the development of pressure ulcer prevention and treatment strategies, including risk assessments, reassessments, interventions, education, and evaluation. In Canada, comprehensive guidelines have been developed by the Registered Nurses Association of Ontario. International guidelines have been developed in collaboration between the European Pressure Ulcer Advisory Panel and the American National Pressure Ulcer Advisory Panel.

## Test(s) for Compliance

<b>Major</b>	15.9.1	An initial pressure ulcer risk assessment is conducted for clients upon admission, using a validated, standardized risk assessment tool.
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<b>Major</b>	15.9.2	The risk of developing pressure ulcers is assessed for each client at regular intervals and when there is a significant change in the client's status.
<b>Major</b>	15.9.3	Documented protocols and procedures based on best practice guidelines are implemented to prevent the development of pressure ulcers. These may include interventions to prevent skin breakdown; minimize pressure, shear, and friction; reposition; manage moisture; optimize nutrition and hydration; and enhance mobility and activity.
<b>Minor</b>	15.9.4	Team members, clients, families, and caregivers are provided with education about the risk factors and protocols and procedures to prevent pressure ulcers.
<b>Minor</b>	15.9.5	The effectiveness of pressure ulcer prevention is evaluated, and results are used to make improvements when needed.



Appropriateness

15.10 Each client's preferences and options for services are discussed as part of the assessment, in partnership with the client and family.

#### **Guidelines**

The client's expressed needs, preferences and the options for care and service are discussed with the client and family. The team and client engage in shared-decision making that considers client preferences, expected outcomes, and risks and benefits of the options.

For example, various strategies to manage pain—such as analgesics including opioids and adjuvants, as well as physical, behavioural, and psychological interventions—may be discussed and the client is able to select the preferred option.

Other preferences that are discussed include options for self-care, privacy, visitors, treatments and testing, and personal care, such as sleeping, bathing, and eating.



Client-centred  
Services

- 15.11 An assessment of the client's palliative and end-of-life care needs is completed, where appropriate, in partnership with the client and family.

**Guidelines**

The need for a palliative care assessment may be expressed by the client or family or identified by the team. The types of services that may be required are identified. Early identification of palliative care needs allows clients and families to be involved in care planning and can improve the quality of care and family satisfaction throughout the process.

In an organization or service area that does not provide palliative and end-of-life care, the assessment identifies the need to connect the client and family to the appropriate services.



Continuity

- 15.12 Diagnostic and laboratory testing and expert consultation are available in a timely way to support a comprehensive assessment.



Continuity

- 15.13 The results of the assessment are shared with the client and other team members in a timely and easy-to-understand way.

**Guidelines**

Sharing assessment results as applicable improves clarity and prevents duplication. In order to provide information that is easy to understand, information is tailored to the client's literacy level, language, and culture.



Continuity



15.14

A comprehensive and individualized care plan is developed and documented in partnership with the client and family.

#### Guidelines

The care plan is based on the results of the assessment and the client's service goals and expected results. It includes the roles and responsibilities of the team, other organizations, and clients and their families. It includes detailed information about the client's history, assessments, diagnostic results, allergies, and medication, including any medication issues or adverse drug reactions.

The plan addresses where and how frequently services will be delivered; timelines for starting services, reaching the service goals and expected results, and completing services; how achievement of the service goals and expected results will be monitored; and plans for transition or follow-up once service ends, if applicable.

Client-centred  
Services

15.15

Planning for care transitions, including end of service, are identified in the care plan in partnership with the client and family.

#### Guidelines

Including information in the care plan about transition planning, whether to home, another team, an alternate level of care, or end of service, enhances coordination among teams or partner organizations and helps prepare clients for the end of service. Client involvement in end-of-service planning ensures the client and family are prepared and know what to expect.

Discussions about the client's transition and post-care needs and preferences are part of developing the care plan. The discussion may include post-care follow up, ability to perform self-care, referrals to community supports, or other anticipated needs or challenges.

16.0

**Medical treatment plans for cancer care are developed in partnership with the client and family based on a comprehensive assessment.**



Efficiency

- 16.1 During the initial assessment and diagnosis, a standardized process is followed to determine the client's stage of cancer.

#### Guidelines

The TNM tumour staging system is used for diagnosis, prognosis, and treatment planning. T stands for tumour size, N for the number of nodes involved, and M for metastases.

Team members are trained in reporting, interpreting, and understanding TNM. The stage assessment methods or protocols are followed, and the TNM stage is documented in the client's record.

The accuracy of cancer staging is continuously monitored, and improvements are made as appropriate.



Safety



- 16.2 Each client is assessed for previous cancer treatments, in partnership with the client and family.

#### Guidelines

Cancer recurrence and previous treatments affect client treatment plans. When recommending a treatment plan, it is important to consider the type, location, and size of the recurrent or previous cancer, as well as the client's overall health. Additional considerations include the type of treatment previously received, response to treatment, the client's experience with previous treatments, and the amount of time that has passed since treatment ended.



Safety



- 16.3 Each client is assessed for contraindications to treatment, in partnership with the client and family.

#### Guidelines

Clients are assessed for possible contraindications to therapy including pregnancy, the presence of implantable devices, pre-existing lung disease, pre-existing tuberculosis, cardiomyopathy, treatment toxicity, or prior radiotherapy to the same part of the body.



Safety



16.4

Radiotherapy only: There are policies and procedures to identify and monitor clients with implanted electronic devices during radiotherapy.

#### Guidelines

To minimize the risk to clients who have implanted electronic devices, precautions are taken during the planning and treatment of radiotherapy. The policy addresses the necessary steps when working with a client who has an implanted electronic device. Steps include communicating the presence of the device to the team before treatment planning or delivery, consultation with the appropriate medical specialist (e.g., cardiologist, neurologist, gastroenterologist), and informing clients about the risk of malfunction and what steps will be taken to monitor them throughout their treatment.

Client-centred  
Services

16.5

There is a process to address clients' requests to bring their own medications and have them administered.

#### Guidelines

The process addresses other prescription medication the client may be taking as well as herbal supplements and natural health products. The process may include verifying the quality of medications that have been brought in by the client, and closely monitoring the client during the administration of medications.

Client-centred  
Services

16.6

The client's medical treatment plan includes evidence-informed strategies to prevent, assess, and manage symptoms specific to the treatments the client is receiving.

**Guidelines**

The team considers the prevention, assessment, and management of both psychosocial and physical symptoms and considers symptoms that may not necessarily be associated with cancer therapy. The team works with the client to promote an environment in which the client is comfortable reporting symptoms.

The team consults with experts and uses research, evidence, and validated tools to prevent, assess, and manage symptoms.



Client-centred  
Services

16.7

The medical treatment plan includes strategies to manage pain.

**Guidelines**

Strategies to manage pain may include analgesics, including opioids or adjuvants when needed, along with physical, behavioural, and psychological interventions, and interventional strategies such as palliative radiotherapy. The team consults with experts and uses research and evidence to understand the best ways to manage pain and other symptoms.



Client-centred  
Services



16.8

The team has discussions with each client and family regarding the medical treatment plan, potential side effects, and what to expect during treatment.

**Guidelines**

Information includes the process and purpose of the therapy, expectations, side effects, changes to energy levels, nutritional needs, physical changes, emotional effects, impact on daily life, changes to sexual health or functioning, and impact on routine activities. Evidence-informed resources regarding the use of complementary medications or therapies during treatment may also be provided.

Clients and families are encouraged to ask questions to team members at any time.



Safety



**17.0 Care plans are implemented in partnership with clients and families.**

**17.1** REQUIRED ORGANIZATIONAL PRACTICE: Working in partnership with clients and families, at least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them.

**Guidelines**

Using person-specific identifiers to confirm that clients receive the service or procedure intended for them can avoid harmful incidents such as privacy breaches, allergic reactions, discharge of clients to the wrong families, medication errors, and wrong-person procedures.

The person-specific identifiers used depends on the population served and client preferences. Examples of person-specific identifiers include the client's full name, home address (when confirmed by the client or family), date of birth, personal identification number, or an accurate photograph. In settings where there is long-term or continuing care and the team member is familiar with the client, one person-specific identifier can be facial recognition. The client's room or bed number, or using a home address without confirming it with the client or family, is not person-specific and should not be used as an identifier.

Client identification is done in partnership with clients and families by explaining the reason for this important safety practice and asking them for the identifiers (e.g., "What is your name?"). When clients and families are not able to provide this information, other sources of identifiers can include wristbands, health records, or government-issued identification. Two identifiers may be taken from the same source.

**Test(s) for Compliance**

**Major** 17.1.1 At least two person-specific identifiers are used to confirm that clients receive the service or procedure intended for them, in partnership with clients and families.



Appropriateness

17.2 The client's individualized care plan is followed when services are provided.

Client-centred  
Services

17.3 Each client's psychosocial health is monitored throughout their care.

### Guidelines

Psychosocial health is monitored, as distress is common among clients who are living with cancer. Emotional distress arises from pain, fatigue, the impact of treatment on daily life (e.g., childcare, financial concerns, employment, and social life), nutritional concerns, and other physical symptoms.

All clients are routinely screened for distress at the time of diagnosis, critical points throughout the cancer journey, and specific care transition points (e.g., recurrent disease, post-treatment, and palliative/end-of-life care). Screening for distress helps to identify key indicators that may prompt further assessment and more appropriate referral.

To evaluate a client's psychosocial health or emotional distress, standardized measures that are short, simple, and have good psychometric properties are used. Assessment tools are often combined to allow for the psychosocial, physical, and practical domains to be screened together in a standardized way. Information is often monitored through patient-reported outcomes tools such as the Canadian Problems Checklist and the Edmonton Symptom Assessment System (ESAS).



Safety



17.4 The client and family are provided with education regarding preventing, recognizing, and managing side effects related to cancer therapy.

**Guidelines**

Written, verbal, and/or electronic information is provided about side effects related to cancer therapy, when the client should contact a health care professional, and when to access emergency services. The client and family are provided with contact information for regular hours and after hours of operation.



Safety



17.5

Clients are provided with education about care for vascular access devices and infusion sites.

**Guidelines**

Information about different infusion sites and access devices is provided. Information should include signs of infection, thrombosis, when to contact a medical professional, and when to seek emergency services.



Appropriateness

17.6

All services received by the client, including changes and adjustments to the care plan, are documented in the client record.

**Guidelines**

The client record is accessible to the team involved in care, including the client, and is contained in a single client record.



Appropriateness



17.7

Treatment protocols are consistently followed to provide the same standard of care in all settings to all clients.

-   17.8 The client's health status is reassessed in partnership with the client, and updates are documented in the client record, particularly when there is a change in health status.
- Guidelines**
- Delays or failures to report a change in health status, in particular deterioration in a client's condition, are significant barriers to safe and effective care and services. Changes in the client's health status are documented accurately, in a timely manner, and communicated to all team members.
-   17.9 Client progress toward achieving goals and expected results is monitored in partnership with the client, and the information is used to adjust the care plan as necessary.
- Guidelines**
- Documenting progress toward goals is done using both qualitative and quantitative methods and includes the client and family. It may include the use of standardized assessment tools, discussion with clients and families, and observation.
-  17.10 Each client's risk for cancer recurrence and re-treatment is considered and discussed with the client.
-   17.11 There is a process to share information between organizations when clients are receiving care at more than one organization.

**Guidelines**

Due to the complexity of cancer treatments and the availability of services, clients may be receiving care from more than one organization. In these cases, effective communication and information sharing is crucial to the client's care and experience.



Client-centred  
Services

17.12

Access to spiritual space and care is provided to meet clients' needs.

**Guidelines**

Spiritual care is available to meet the needs of clients, as required. It includes access to a spiritual leader appropriate to the client's beliefs (e.g., a chaplain, imam, rabbi, or non-denominational counsellor). Clients and families have access to a designated space to observe spiritual practice.

The client's spiritual needs and preferences are seen as integral to the care and healing process, and are discussed when making care decisions that may involve an ethical or spiritual component.



Client-centred  
Services

17.13

Clients and families have access to psychosocial and/or supportive care services, as required.

**Guidelines**

Emotional support and counselling can help clients and families cope with the health needs and health-related issues. Supports may address coping with a diagnosis, help with decision making, dealing with side effects, or ethics-related issues such as advance directives.



Client-centred  
Services

17.14

Each client's oral health needs are met, as appropriate.

**Guidelines**

Clients with cancer have higher rates of oral complications due to cancer treatments, such as chemotherapy, radiotherapy, and immunosuppressive therapy. Issues with oral hygiene can affect treatment outcomes and cause oral complications impacting health and wellness.

Each client's oral health is assessed before treatment planning begins. Clients are provided with information about how to care for their oral hygiene while receiving care. Clients in need of more advanced dental care before or during oncological treatments are provided with information about how to access dental services.



Safety



17.15

There is a process to respond to changes in medical treatment plans.

**Guidelines**

Medical treatment plans can change for various reasons and may require adjustment. Adjustments may be due to side effects or how the cancer is reacting to the current plan. Regardless of the reason, teams must establish processes to alert or respond to changes in treatment plans. Processes include conducting interdisciplinary case conference rounds and posting alerts in the client file or electronic medical record (EMR).

Client-centred  
Services

17.16

There is a process for initiating palliative and end-of-life care, as required.

**Guidelines**

Services are initiated by the team, client, or family, and take into consideration the assessment results. Involvement in palliative and end-of-life care will differ depending on the services provided by the team and the clients served. Where palliative and end-of-life care is not provided by the team, clients are connected with the appropriate services.



Client-centred  
Services

- 17.17 Support for the family, team members, and other clients is provided throughout and following the death of a client.

#### Guidelines

Relevant information is shared with clients and families about the dying process, such as the signs and symptoms of imminent death; coping strategies; how to provide support and comfort during the final hours; and grief and bereavement services.

The client's family and friends are encouraged to use community support systems. When these are insufficient, or when family and friends are identified as being at risk for complex grief reactions, access is facilitated to bereavement services for clients, families, team members, and volunteers, including volunteer support or professional services.

- 18.0 **Medications and cancer therapies are administered in a safe and accurate manner.**



Safety

- 18.1 Organizational guidelines for spills of cytotoxic medications are followed.

#### Guidelines

A hazardous spill kit is located wherever clients who are receiving chemotherapy are commonly found. This includes where systemic therapy is dispensed and administered as well as in client areas and in other services that typically work with clients receiving chemotherapy.



Safety

- 18.2 The team meets the legal requirements and standards of practice when administering medications, systemic therapies, and providing radiation therapy services.

**Guidelines**

Legal requirements may refer to the use of narcotics, radiation devices, and radioactive substances. Standards of practice may refer to those established by professional colleges, e.g. pharmacy, nursing, medicine, medical technologists, medical physicists.



Continuity



18.3

Care is coordinated for clients who are receiving multiple services and/or treatments to provide safe, client-centred care.

**Guidelines**

Clients who receive cancer care often receive multiple therapies and work with multiple services within an organization (e.g., systemic therapy services, radiotherapy services, surgical services, palliative care, diagnostic services, mental health services, nutrition supports). Care is coordinated to ensure client safety and ensure that clients are accessing services in the most efficient and effective way both for the client and for the teams providing services.

A coordinating or most responsible physician is identified for each client receiving multiple treatments or services. Communication between teams is crucial and can occur verbally, in writing, or through electronic systems. Teams work together to make the treatment process as client and family focused as possible and coordinate appointments and treatments to minimize the impact on the client and family.



Safety



18.4

A policy is followed to identify critical client information and ensure that this information is always available to team members providing services.

**Guidelines**

Critical information is information required by other teams that if missed might cause harm to the client (e.g., allergies, do not resuscitate [DNR] orders, advanced care plans, infection issues). This information must be available to all teams providing services to the client; the team partners with the client to ensure they know what information all the care providers need to know when moving between services.



Safety

18.5

Environmental distractions are minimized for team members who are performing critical tasks requiring concentration.

#### Guidelines

Environment workspace and processes are designed to minimize distractions. Examples of critical tasks requiring concentration are ordering, verifying, and administering medications and systemic therapies, contouring treatment sites and organs at risk, planning a treatment, and delivering a radiotherapy treatment.



Safety



18.6

The client's height, weight, and pertinent clinical parameters are reviewed and documented regularly throughout treatment.

#### Guidelines

A change in body mass could alter the dosage of a systemic therapy medication or the radiotherapy treatment plan. Team members must verify there has not been a significant change.

There are established guidelines for what is considered a significant change in body mass.



Safety



18.7

The administration of medications, systemic therapies, and radiotherapy are documented.

#### Guidelines

This may include the medication name, dosage, route and rate of administration, daily radiation dose, and date and time of treatment. Information provided may vary by modality.



Safety



18.8

Each client is assessed for side effects and toxicity during treatment.

#### Guidelines

Toxicity symptoms can begin within one to two hours of receiving treatment and can last for several months in some cases.

19.0

**RADIOTHERAPY ONLY: Radiotherapy is delivered to clients in a safe and effective manner.**



Safety



19.1

Radiotherapy only: The radiotherapy program has policies and procedures for clinical care, imaging, treatment planning, and treatment delivery.

#### Guidelines

The radiotherapy program follows imaging, treatment planning, and delivery guidelines and has a process to select and regularly review guidelines to ensure they reflect current research and best practice information. The radiation treatment program has a process to decide among conflicting guidelines or multiple recommendations.

Policies and procedures address, at a minimum, wait times, patient identification, staging, clinical guideline implementation, informed consent, client education, authorization of imaging, planning, and treatment. Policies and procedures are reviewed regularly.



Safety



19.2

Radiotherapy only: The imaging, planning, and treatment processes are discussed with the client prior to service delivery.

#### Guidelines

The imaging, planning, and treatment process, equipment used, what to expect during procedures, and verification of laterality are discussed with the client prior to service delivery. The client is provided with opportunity to ask questions. Team members use processes to verify clients' understanding such as encouraging and allotting time for questions and having the client repeat back information.



Safety



19.3

Radiotherapy only: A policy is followed to authorize or change a radiation treatment plan.



Safety



19.4

Radiotherapy only: There is a policy mandating the minimum information to be included in the medical treatment order for radiotherapy.

#### Guidelines

The medical treatment order for radiotherapy is used for initiating the process of planning and delivery. Although the precise prescription may not be known at the time the order is created, it includes, at a minimum: imaging information, dose, fractionation, treatment site, laterality, and treatment intent. Other information that may be included: prescriber information; a unique client identifier (e.g., number) as well as full name, date of birth, and gender; diagnosis; modality; and treatment interval.

Clients who are receiving concurrent therapies are clearly identified in the treatment plan.



Safety



19.5

Radiotherapy only: There is a policy mandating the minimum information to be included in radiotherapy treatment prescriptions.

#### Guidelines

The radiotherapy prescription clearly references the prescribed dose to a particular plan point or isodose line; includes sufficient information to deliver the treatment as intended without ambiguity (e.g., including at a minimum, dose and fractionation, treatment site, and confirmation of laterality); uses at least two patient-specific identifiers; and is authorized by a Radiation Oncologist.



Safety



19.6

Radiotherapy only: Each client's radiotherapy treatment plan is independently verified by a second professional prior to the first treatment and when there has been a change in the treatment parameters.

**Guidelines**

Radiotherapy treatment plans are peer reviewed by professionals in accordance with their expertise. Professionals authorized to participate in a second independent review include medical physicists, dosimetrists, and radiation therapists. The radiotherapy program has procedures describing the minimum checks to be performed and qualifications required to provide a second check. Special attention is given to complex treatments.



Safety



19.7

Radiotherapy only: Each client's radiotherapy treatment plan is peer reviewed by a radiation oncologist.

**Guidelines**

Peer review includes the review of the full treatment plan, including contouring of all structures. Radiotherapy treatment plans are peer reviewed before treatment has begun. When peer review is not available prior to the beginning of treatment, it is completed before 25% of the total prescribed dose has been delivered.



Safety



19.8

Radiotherapy only: Calculations of monitor units or treatment time are verified by an independent system for each radiotherapy treatment plan prior to first treatment and when there has been a change in treatment parameters.

**Guidelines**

Calculations of either monitor units or treatment time (depending on equipment) are performed by a primary calculation system. An independent system is used to verify the primary system. Calculation systems are most frequently software, but could also be hand calculations. This verification is performed before initiation of the first treatment and each time the treatment plan parameters have been changed.



Safety

19.9

**Radiotherapy Only:** The organization uses consistent technical terms and nomenclature to ensure safe and efficient care.

**Guidelines**

The uniformity of nomenclature and technical terms helps prevent misunderstandings and errors. Whenever possible, international recommendations (e.g., the International Commission on Radiological Units and Measurements) on nomenclature should be followed to assure good communication between organizations.

Client-centred  
Services

19.10

**Radiotherapy only:** All radiotherapy treatments received by clients are documented.

**Guidelines**

The detailed description of treatment must be specific enough so that the plan can be recreated at a later time or another institution or by a different oncology team if the client requires re-treatment.

20.0

**SYSTEMIC THERAPY ONLY:** Systemic therapies are delivered to clients in a safe and effective manner.



Safety



20.1

Systemic therapy only: The client's height, weight, and pertinent clinical parameters as identified by the regimen are reviewed upon each cycle, or as clinically indicated; this information is documented and any significant changes are communicated.

#### Guidelines

A change in weight could alter the dosage to be administered, so team members must verify there has not been a significant change.

There are established guidelines for what is considered a significant change in body mass.



Safety



20.2

Systemic therapy only: The administration of systemic cancer therapies is documented.

#### Guidelines

This may include the medication name, dosage, route of administration, date and time of administration, and rate of administration.



Safety



20.3

Systemic therapy only: Independent double checks for dose and rate of administration are conducted on infusion pumps prior to administration.

#### Guidelines

The risk to patient safety is reduced by checking and documenting infusion pump functioning.

In the case of home infusion, the proper functioning of pumps is checked prior to the client leaving the organization.



Safety

20.4

Systemic therapy only: Guidelines for central venous access device management are followed by the team.



Safety



**21.0 SYSTEMIC THERAPY ONLY: The team partners with clients and families to ensure the safe ambulatory delivery of treatments.**

**21.1** Systemic therapy only: There is a process to provide clients with detailed instructions regarding the administration and safe handling of oral systemic cancer therapies.

**Guidelines**

To maximize safety, clients are provided with detailed instructions about the proper administration of oral systemic cancer therapy medications. The client is invited to ask questions to ensure that they have understood the information. Detailed information includes, for example, safe handling and storage, and administration frequency and procedure. Information also includes instructions on what to do if medications are missed or if medications are not taken due to vomiting.



Continuity

**21.2** Outpatient systemic therapy only: Follow-up processes are established with clients who are receiving oral therapies.

**Guidelines**

Clients receiving oral therapy are at particular risk because they are not regularly seen in the treatment area. A follow-up process is established with these clients to monitor their side effects, adherence, and risk of toxicity.



Safety



**21.3** Outpatient systemic therapy only: Clients are provided with comprehensive information regarding home infusion and signs of malfunction.

**Guidelines**

The information includes what to expect, functioning of the pump, care for the pump, any changes that will be displayed, signs of malfunction, when to contact the organization, when to return to the organization, and when to contact emergency services.

The client's level of understanding, literacy, language skills, and disability, as well as their culture are all considered when providing information.

Steps are taken to ensure that the client and family understand the information provided and questions are encouraged.



Safety



21.4

Outpatient systemic therapy only: In cases of home infusion, independent double checks of infusion pumps are conducted before the client leaves the organization.

**Guidelines**

The risk to patient safety is reduced by checking and documenting infusion pump functioning.



Safety



21.5

Outpatient systemic therapy only: Any home care staff who will be involved in care during home infusions are provided with education by the team.

**Guidelines**

Any education that is provided to home care staff is documented.



Safety



21.6

Outpatient systemic therapy only: Clients and families are provided with information about when to contact emergency services.



Client-centred  
Services



21.7

Outpatient systemic therapy only: Clients and families are provided with information about self-care management.

**Guidelines**

Clients and families are given information about their condition and how to improve their overall health. Clients are provided with information about medications, supplies and equipment, safe storage, and assistive services where applicable.

22.0

**Clients and families are partners in planning and preparing for transition to another service or setting.**



Client-centred  
Services



22.1

Clients and families are actively engaged in planning and preparing for transitions in care.

### Guidelines

Clients and families are involved in all transition planning. The team, client and family discuss the client's care plan, goals, and preferences; the care provided; outstanding issues, clinical or otherwise; what to expect during transition; follow-up appointments; exercise and nutrition plans, where applicable; contact information for the team members and details on when they should be contacted.

Continuity of care is improved when clients participate in transition planning and preparation and have comprehensive information about transitions and end of service.

Examples of key transition moments include rounds, shift changes, handoffs, moving in or out of an organization, to another community provider or at end of service.

Talking with the client and family about transitions helps them understand the process and provides an opportunity to ask any questions. It also helps ensure all information is accurate and complete, and that the client's wishes are respected.



Client-centred  
Services

22.2

The client's physical and psychosocial readiness for transition, including their capacity to self-manage their health, is assessed.

### Guidelines

This assessment happens as early as possible within the care process. Instances where self-management would benefit the client are determined. Capacity to self-manage is influenced by factors such as access to a support network, community care options, cognitive and physical ability, and literacy level.



Client-centred  
Services

22.3

Clients are empowered to self-manage conditions by receiving education, tools, and resources, where applicable.

**Guidelines**

Education that promotes empowerment and helps clients self-manage chronic conditions may include action planning; modeling behaviors and problem solving strategies; reinterpreting symptoms; and social persuasion through group support and guidance for individual efforts. Self-management training topics should include exercise; nutrition; symptom management techniques; risk factor management; fatigue and sleep management; use of medications; managing emotions; cognitive and memory changes; training in communication with health professionals and other individuals; and health-related problem solving and decision making.

Tools and resources made available to help clients to self-manage and are tailored to each client's needs. For example, tools and resources can be modified based on level of understanding, literacy, language, disability, and culture.



Continuity

## 22.4

Appropriate follow-up services for the client, where applicable, are coordinated in collaboration with the client, family, other teams, and organizations.

**Guidelines**

Responsibility for the client's care continues until service has ended or the client has been transferred to another team, service, or organization.

Follow-up services may include primary care, home and community services, community-based rehabilitation, psychological counselling services, and recommendations for ongoing care. Working together to establish proper placement for the client helps ensure the client receives the most appropriate services in the most appropriate setting, and minimizes temporary solutions or unnecessary transfers.

To ensure clients receive seamless and continuous care, placement and follow up includes a process for when transitions do not go as planned.



Client-centred  
Services

- 22.5 Survivorship planning is incorporated into the transition plans in partnership with clients and families.

#### Guidelines

A survivorship care plan (SCP) supports the transition of care from oncology to primary care by improving communication between providers; empowering clients with information about their care; and enabling clients to be active participants in the next phase of their cancer journey.

The SCP includes diagnostic tests completed and results, tumor characteristics, dates of treatment initiation and completion, therapies provided, key providers information, and a follow-up care plan which includes any recommended next steps, surveillance, signs of recurrence, treatments, or testing.



Continuity

- 22.6 Responsibility for follow-up care is determined in partnership with the client, family, and primary care provider.

#### Guidelines

Clarity regarding who is responsible for surveillance, other cancer screenings, and preventative health care is important when clients with cancer transition from one service to another.



Continuity

- 22.7 The transition plan is documented in the client record.



Continuity



- 22.8 Transition plans include a summary of the medical treatment plan.



Safety



22.9

**REQUIRED ORGANIZATIONAL PRACTICE:** Information relevant to the care of the client is communicated effectively during care transitions.

### Guidelines

Effective communication is the accurate and timely exchange of information that minimizes misunderstanding.

Information relevant to the care of the client will depend on the nature of the care transition. It usually includes, at minimum, the client's full name and other identifiers, contact information for responsible providers, reason for transition, safety concerns, and client goals. Depending on the setting, information about allergies, medications, diagnoses, test results, procedures, and advance directives may also be relevant.

Using documentation tools and communication strategies (such as SBAR [Situation, Background, Assessment, Recommendation], checklists, discharge teaching materials and follow-up instructions, read-back, and teach-back) support effective communication, as does standardizing relevant information, and tools and strategies across the organization. The degree of standardization will depend on organizational size and complexity. Electronic medical records are helpful but not a substitute for effective communication tools and strategies.

Effective communication reduces the need for clients and families to repeat information. Clients and families need information to prepare for and improve care transitions; this may include written information or instructions, action plans, goals, signs or symptoms of declining health status, and contact information for the team.

### Test(s) for Compliance

**Major**

22.9.1 The information that is required to be shared at care transitions is defined and standardized for care transitions where clients experience a change in team membership or location: admission, handover, transfer, and discharge.

<b>Major</b>	22.9.2	Documentation tools and communication strategies are used to standardize information transfer at care transitions.
<b>Major</b>	22.9.3	During care transitions, clients and families are given information that they need to make decisions and support their own care.
<b>Major</b>	22.9.4	Information shared at care transitions is documented.
<b>Minor</b>	22.9.5	<p>The effectiveness of communication is evaluated and improvements are made based on feedback received. Evaluation mechanisms may include:</p> <ul style="list-style-type: none"> <li>• Using an audit tool (direct observation or review of client records) to measure compliance with standardized processes and the quality of information transfer</li> <li>• Asking clients, families, and service providers if they received the information they needed</li> <li>• Evaluating safety incidents related to information transfer (e.g., from the patient safety incident management system).</li> </ul>

22.10 A client's wish to end or limit services, transfer to another service, or transition home, is respected.

**Guidelines**

Shared decision making regarding a client's transition takes place in consultation with the family or substitute decision maker, when required, and takes the client's decision-making capacity into consideration. The risks of the transition are discussed with the client and family, as well as other community-based services that are available to them after the transition.

An ethical or values-based decision making framework is used when working with clients who have chosen options against the team's recommendation. In the event the client wishes to continue service against the team's recommendation or beyond the capacity of the organization, an ethical or value-based decision making framework is used to ensure a fair and equitable outcome for the client and the organization.



Client-centred  
Services



Client-centred  
Services



22.11

The client's risk of readmission is assessed, where applicable, and appropriate follow-up is coordinated.

#### Guidelines

Where need for follow up has been identified, the appropriate type and method is determined. This includes the responsibilities of the team such as following up on testing, providing a referral to a partner organization, setting timelines for client contact, or reminding the client of an appointment. It also includes client responsibilities such as following up with other care providers (e.g., primary care or a community health centre), reporting worsening or changing symptoms, and taking medications as prescribed.

A standardized assessment tool (e.g., the LACE Index Scoring Tool). is used to assess risk of readmission after the end of service.



Appropriateness

22.12

The effectiveness of transitions is evaluated and the information is used to improve transition planning, with input from clients and families.

#### Guidelines

At regular intervals, a sample of clients, families, or referral organizations is contacted to determine the effectiveness of the transition or end of service, monitor client perspectives and concerns after the transition, and monitor follow-up plans. Evaluating transitions is an opportunity to verify that client and family needs were met and concerns or questions addressed.

Client feedback and the overall results of the evaluation are shared with the organization's leaders and the governing body and the information is used to improve transitions.

## MAINTAINING ACCESSIBLE AND EFFICIENT INFORMATION SYSTEMS



Appropriateness



- 23.0**      **Client records are kept accurate, up-to-date, and secure.**
- 23.1      An accurate, up-to-date, and complete record is maintained for each client, in partnership with the client and family.

**Guidelines**

Client records are accessible and up-to-date. Information is easy to find and identify, and is organized for ease of use. The record includes the dates of service, is signed by the appropriate authority, and is legible.

Only recognized abbreviations are used in the record, and critical client information is prominently displayed.

The client record is updated whenever there is a change in health status, the care plan, the client's medications, or when the client is transitioned to another level of care or service.

Organizational and professional standards are followed when determining what information is needed for the client record to be considered complete. These include significant changes in condition, diagnostic results, alert notations, progress notes, significant events or patient safety incidents, and others.

Clients and families are involved in providing and documenting information, and ensuring the information captured is accurate and complete. The team may partner with the client and family in various ways depending on the service setting and individual circumstances. For example, in community settings or primary care, documentation can often be completed in the room, with the client and family. This is not always possible in all care settings, particularly if the client record is maintained in a central location, concurrent documentation detracts from the care or service being delivered, or urgent care is being delivered.

When documenting in the client record with the client and family is not possible, the team works to include the client and family in the process as much as possible (e.g., taking notes with them, confirming information) to ensure that what is documented is accurate and reflects the nature of the service provided, intervention, or conversation.



Appropriateness

23.2

A standardized set of health information is collected to ensure client records are consistent and comparable.

**Guidelines**

Collecting standardized information applies whether the client records are paper-based or electronic.

The nature of the health information collected will vary depending on the type of organization and the services provided. Standards for data collection may be set out in provincial/territorial or national guidelines. Standardized data elements can be found through the Canadian Institute for Health Information, as well as provincial platforms for electronic records (e.g., e-Health Ontario). Where information is not available, the organization works with partner organizations and/or the health region to determine what information to collect for each client.



Appropriateness



23.3

Policies and procedures to securely collect, document, access, and use client information are followed.

**Guidelines**

Policies outlining authorized access to client information are available to the team, including how, when, and what information they may access. Only team members who are actively involved in a client's care have access to the client record.

The team is aware of and knows how to comply with applicable legislation to protect the privacy and confidentiality of client information. Applicable legislation may be provincial, territorial, or federal.

Client-centred  
Services

23.4

Clients are able to access information in their records, including electronic medical/health records, in a routine, client-centred, and timely way.

**Guidelines**

Client access to their records is facilitated in a proactive way, according to the organization's policy and applicable legislation. The processes to access records are client-centred and support clients to access their information. Clients have opportunities to discuss the information, ask questions, provide feedback.



Client-centred Services

23.5 Information is documented in the client's record in partnership with the client and family.

**Guidelines**

Clients are the owners of their health information. They are included in the process of documenting information in their record and can provide input on the information being documented. Clients are given the right to read and comment on information that is recorded. The charting or documentation process may be conducted in partnership with the client as part of their care, or access to their records may be provided electronically.



Appropriateness



23.6 Policies and procedures for securely storing, retaining, and destroying client records are followed.

**Guidelines**

Relevant legislation, including the federal Privacy Act and the federal Personal Information Protection and Electronic Documents Act, are followed, where applicable. Each province and territory refers to their respective privacy laws, and laws governing health information protection, where relevant.



Efficiency



23.7 There is a policy regarding cancer care record retention.

**Guidelines**

Cancer care records are maintained so that if a client requires re-treatment, treatment plans can be shared with other organizations or oncology specialists.



Continuity

23.8

The flow of client information is coordinated among team members and other organizations, in partnership with the client and in accordance with legislation.

**Guidelines**

While respecting the client's right to privacy and with the client's consent, information is shared as required to facilitate a client-centred approach to service delivery. Effective information sharing helps the team better meet the needs of clients and reduces duplication in obtaining client information. The team obtains client consent to share information.

Clients are involved in sharing information (e.g., maintaining and sharing a current list of medications, or providing a discharge summary to appropriate providers).



Appropriateness



23.9

There is a process to monitor and evaluate record-keeping practices, designed with input from clients and families, and the information is used to make improvements.

**Guidelines**

Record-keeping may be paper-based and/or electronic. The monitoring and evaluation process meets any applicable legislation or requirements. The process examines privacy breaches, as well as accuracy and effectiveness of practices.

Evaluation may be done for a sample of records on an irregular or regular basis. Where record-keeping is electronic, evaluation can be triggered based on certain events, such as unusual activity, attempt to retrieve certain data, or unmasking of data.

All electronic activities are linked to a unique user identifier, date and time stamped, and an activity log is maintained to ensure practices can be appropriately monitored.

**24.0 Health information is managed to support the effective delivery of services.**

**24.1 Training and education about legislation to protect client privacy and appropriately use client information are provided.**

**Guidelines**

Training is provided to all team members and may be formal or informal. Further training or education is provided when there are changes to legislation or after an extended period of time.

**24.2 Policies on the use of electronic communications and technologies are developed and followed, with input from clients and families.**



Appropriateness



Appropriateness

**Guidelines**

Policies regarding the use of electronic mail, texting, web applications and social media are determined using the perspectives of clients and families. This may include inter-team communication, communication with clients, or communication with partners and potential clients.

When determining what electronic communications and technologies to use, considerations are made for how to manage issues of privacy, professionalism, security of information, client communication preferences, and legislation. Technologies may be used to assist in service provision or care, (e.g., demonstrating procedures on a tablet).



Appropriateness

24.3

Policies and procedures for disclosing health information for secondary use are developed and followed.

**Guidelines**

Secondary use refers to using health information for a purpose other than direct service provision, such as clinical program management, health system management, public health surveillance, and research.

Policies and procedures cover the appropriate circumstances in which to disclose the data and how to ensure client privacy is maintained (e.g., by de-identifying or aggregating data prior to disclosure). Where identifiable or re-identifiable data is requested, the team follows an ethics approval process and assesses risk prior to disclosure.



Continuity

24.4

Technologies, systems, and software are interoperable.

**Guidelines**

Computer systems and treatment technology used by the oncology teams are compatible with one another. Interoperable systems facilitate communication between and among teams. Oncology teams must also keep abreast of technology advances and ensure that their systems and software are current.



## MONITORING QUALITY AND ACHIEVING POSITIVE OUTCOMES

### 25.0 **Current research, evidence-informed guidelines, and best practice information is used to improve the quality of services.**



Appropriateness



25.1 There is a standardized procedure to select evidence-informed guidelines that are appropriate for the services offered.

#### **Guidelines**

Guidelines may be selected by a committee, council, or individual who makes recommendations to the team on which guidelines to use and how they can be integrated into service delivery.

Guidelines from other organizations or associations can be adopted by the team. The process for selecting guidelines is standardized and formalized. It may include using content experts; a consensus panel; Grades of Recommendation Assessment, Development and Evaluation (GRADE); or the Appraisal of Guidelines Research and Evaluation (AGREE) II instrument, which allows organizations to evaluate the methodological development of clinical practice guidelines from six perspectives: scope and purpose, stakeholder involvement, rigour of development, clarity and presentation, applicability, and editorial independence.



Client-centred  
Services

25.2 The procedure to select evidence-informed guidelines is reviewed, with input from clients and families, teams, and partners.

**Guidelines**

A collaborative approach is used to select guidelines that are appropriately linked to improved client experience and outcomes.

Organizations will use a comprehensive procedure to select evidence-informed guidelines. Depending on the scope of the project, this may include a comprehensive literature review, an environmental scan, consulting other organizations about their practices, and an evaluation with partners and stakeholders.

As with any activity that affects client care and experience, organizations gather and consider input from clients and families when reviewing the procedure to select evidence-informed guidelines. Although clients and families may not be involved in a technical or scientific review, their perspectives on clients' experiences of care are valuable. Client and family perspectives can be gathered through their attendance at procedural review committees, their review of procedural documents, and by shadowing the use or implementation of the procedure in practice.



Appropriateness



25.3

There is a standardized process, developed with input from clients and families, to decide among conflicting evidence-informed guidelines.

**Guidelines**

Comprehensive documents that synthesize the evidence from several guidelines may be used. For example, the Cochrane Collaboration conducts systematic reviews of the available evidence that can help teams and organizations with their review process.

Clients and families are consulted to determine whether the method of deciding among guidelines follows a client-centred approach (e.g., helping to determine which guideline is more client-centred, reviewing whether a guideline was developed with the client perspective).



Appropriateness



25.4

Protocols and procedures for reducing unnecessary variation in service delivery are developed, with input from clients and families.

**Guidelines**

Selected guidelines and evidence are used to develop procedures and protocols to improve service delivery and provide standardized care to clients. The procedures and protocols may enhance patient safety, improve inter-team collaboration, increase efficiency, and minimize variation in service delivery. Client and family perspectives are considered when evaluating improvements. As the recipients of care, clients and families are often best positioned to help identify unnecessary variations or duplications in service.

Research knowledge is adapted and applied to each unique care setting.



Appropriateness



25.5

Guidelines and protocols are regularly reviewed, with input from clients and families.

**Guidelines**

The review process includes accessing the most up-to-date research and information and determining its relevance (e.g., through literature reviews, content experts, or national organizations or associations). Research information may include intervention research, program evaluations, or clinical trials.

The review process informs the procedure to select evidence-informed guidelines.

Although clients and families may not be involved in a technical or scientific review, their perspectives on clients' experiences while receiving care driven by guidelines and protocols are valuable to the review process.



Appropriateness



25.6

There is a policy on ethical research practices that outlines when to seek approval, developed with input from clients and families.

**Guidelines**

The need for ethics approval is evaluated and, if necessary, sought, prior to undertaking research or activities (including quality improvement activities), where information is collected.



Safety



## 26.0 Client and team safety is promoted within the service environment.

26.1 A proactive, predictive approach is used to identify risks to client and team safety, with input from clients and families.

### Guidelines

A proactive, predictive approach is designed to address potential issues by mitigating a risk or hazard before it occurs. While it may not be possible to identify all risks in a service setting, a comprehensive process is used to identify the most probable risks.

Through this approach, the team works to address processes that create errors, delays, or inefficiencies and may be viewed as beyond the team's control. These may be small, continuously occurring interruptions to work flow that create significant loss of resources as time goes on (e.g., having to look up commonly used information, having to search for commonly used items).

Information is gathered to determine the causes of potential problems and strategize possible solutions. These activities include conducting audits, talking to clients, talking to team members, monitoring areas for risk, identifying interruptions, participating in safety briefings, and addressing areas where there is a high margin of error.

Regular opportunities to share information about potential problems and actual incidents can reduce risk and the likelihood of an incident occurring or recurring.



Safety



26.2 Strategies are developed and implemented to address identified safety risks, with input from clients and families.

**Guidelines**

The team works together to increase participation in risk mitigation strategies. Client and family perspectives are incorporated in the process of developing and implementing risk mitigation strategies. The strategies are tested on a small scale and results are monitored. Strategies will vary depending on the types of risks identified and may include action planning and working with other team members to address identified risks.



Safety



26.3

Radiotherapy only: There is a radiation therapy quality assurance committee.

**Guidelines**

Due to the unique safety risks associated with radiotherapy and radiotherapy technology and equipment, the organization has a dedicated quality assurance committee for radiotherapy. The committee is comprised of a mix of team members with varying skill sets and experience in delivering radiotherapy to ensure that all areas of care and disciplines are represented.

The committee reviews, develops, and implements policies and procedures for the safe delivery of radiotherapy and is engaged in service planning, equipment selection and acquisitions, quality improvement initiatives, incident prevention, incident review, and monitoring compliance with technical quality control policies and procedures.

The quality assurance committee meets regularly as well as following certain events (e.g., prior to acquiring new equipment, following an emergency or equipment failure, or following a patient safety incident).



Safety



26.4

Radiotherapy only: Radiation exposure is monitored in compliance with regulations to ensure client, team, and public safety.

**Guidelines**

Monitoring radiation exposure allows the organization to design roles that ensure team safety when delivering radiotherapy .

The direct measurement and/or evaluation of radiation doses is performed to ensure compliance with the applicable regulations. Shielding requirements for radiotherapy equipment rooms are approved by the radiation safety officer before construction or renovations are initiated. Verification measurements of the shielding are approved by the radiation safety officer before the first use of the radiotherapy equipment.



Safety



26.5

Verification processes are used to mitigate high-risk activities, with input from clients and families.

**Guidelines**

To identify high-risk activities, the team may review its services and use this information to develop and implement checking systems to reduce the risk of harm to clients and team members.

Across the care continuum, verification systems vary depending on services. Examples may include but are not limited to:

- Repeat back or read back processes for diagnostics or verbal orders
- Checking systems for water temperature, especially for bathing
- Standardized tracking sheets for clients with complex medication management needs
- Automated alert systems for communication of critical test results
- Computer-generated reminders for follow-up testing in high-risk clients
- Two person verification process for blood transfusions
- Independent double checks for dispensing and administering high-risk medications
- Medication bar coding systems for drug dispensing, labeling, and administration
- Decision support software for order entry or drug interaction checking
- Safety monitoring systems for teams in community-based organizations or for clients in high-risk environments
- Standardized protocols to monitor vital signs (e.g., fetal heart rate during medical induction/augmentation of labour, or in high-risk deliveries)
- Systems to monitor vaccine fridge temperatures
- Standardized protocols for the use of restraints
- Standardized screening processes for allergies to contrast media.



Safety



26.6

Safety improvement strategies are evaluated with input from clients and families.

**Guidelines**

Adjustments are made as needed to ensure positive change is sustained.



Safety



26.7

Patient safety incidents are reported according to the organization's policy and documented in the client and the organization record as applicable.

**Guidelines**

Reporting and recording is done in a timely way. Patient safety incidents include harmful incidents, no harm incidents, and near misses, as per the World Health Organization International Classification for Patient Safety.



Client-centred  
Services



26.8

Patient safety incidents are disclosed to the affected clients and families according to the organization's policy, and support is facilitated if necessary.

**Guidelines**

The Canadian Patient Safety Institute (CPSI) publishes a guide to disclosing patient safety incidents, for health care providers, interdisciplinary teams, organizations, and regulators who are developing and implementing disclosure policies, practices, and training methods.

Support following a patient safety incident is an important part of the process. Support is provided to clients and families as well as team members affected by a patient safety incident.



Safety



26.9

Patient safety incidents are analyzed to help prevent recurrence and make improvements, with input from clients and families.

**Guidelines**

Analyzing patient safety incidents includes determining the contributing factors, taking action to prevent the same situation from recurring, and monitoring the effectiveness of those actions. Organizations use this information when developing strategies to proactively anticipate and address risks to client and team safety.

The Canadian Patient Safety Institute offers a framework for incident management. It provides an in-depth description of the process of analyzing and managing patient safety incidents. An online Incident Analysis Learning Program series is available to assist organizations to apply the principles of incident analysis at [www.patientsafetyinstitute.ca/](http://www.patientsafetyinstitute.ca/).

**27.0 Indicator data is collected and used to guide quality improvement activities.**



27.1 Information and feedback is collected about the quality of services to guide quality improvement initiatives, with input from clients and families, team members, and partners.

**Guidelines**

Information and feedback is collected in a consistent manner from key stakeholders about the quality of services. Feedback can take the form of client and family satisfaction or experience data, complaints, indicators, outcomes, scorecards, incident analysis information, and financial reports. It may be gathered by a variety of methods, including surveys, focus groups, interviews, meetings, or records of complaints.



27.2 The information and feedback gathered is used to identify opportunities for quality improvement initiatives and set priorities, with input from clients and families.

**Guidelines**

Feedback and other forms of information, observation, and experience are used to identify and prioritize areas for quality improvement initiatives. This is done using a standardized process based on criteria such as expressed needs of clients and families, client-reported outcomes, risk, volume, or cost.



27.3 Measurable objectives with specific timeframes for completion are identified for quality improvement initiatives, with input from clients and families.

**Guidelines**

Quality improvement objectives define what the team is trying to achieve and by when. Appropriate quality improvement objectives are typically short term, have targets that exceed current performance, and are usually aligned with longer-term strategic priorities or patient safety areas. The timeframe will vary based on the nature of the objective.

The SMART acronym is a useful tool for setting meaningful objectives. The objectives should be Specific, Measurable, Achievable, Realistic, and Time-bound. The United States Centers for Disease Control and Prevention offers a guide to writing SMART objectives.



Appropriateness

27.4

Indicator(s) that monitor progress for each quality improvement objective are identified, with input from clients and families.

**Guidelines**

Indicators are used to monitor whether the activities resulted in change and if the change is an improvement. Primarily, indicators are selected based on their relevance and whether they can accurately monitor progress. When there are multiple potential indicators, criteria such as scientific validity and feasibility are used to select them.

If there are difficulties selecting indicators, it may mean the quality improvement objective needs clarification.



Appropriateness



27.5

Quality improvement activities are designed and tested to meet objectives.

**Guidelines**

Quality improvement activities are the actions that are undertaken to initiate improvements, and are part of the larger quality improvement plan. Activities are first designed and tested on a small scale to determine their effect prior to implementing them more broadly.

The Getting Started Kit for Improvement Frameworks is a resource created by the Canadian Patient Safety Institute and is based on the Model for Improvement. The Institute for Healthcare Improvement offers a framework to guide quality improvement activities using Plan, Do, Study, Act cycles.



Appropriateness

27.6

New or existing indicator data are used to establish a baseline for each indicator.

**Guidelines**

Establishing a baseline reference point makes it possible to monitor progress towards meeting quality improvement objectives by comparing pre- and post-activity data and noting changes. Establishing a baseline may require one or many data points and occurs over a defined period of time. Once the baseline is established, the team may need to reevaluate its quality improvement objectives to ensure they remain feasible and relevant.



Appropriateness

27.7

There is a process to regularly collect indicator data and track progress.

**Guidelines**

How indicator data will be collected and how often is determined. Regularly collecting data allows the team to track its progress and understand the normal variation of values.



Efficiency

27.8

Wait time data are collected for cancer care.

**Guidelines**

The collected wait times data includes the time from referral to consultation, and from decision to treat until treatment initiation. Data are collected for varying types of treatment (e.g., systemic therapy, radiotherapy, surgical services).



Efficiency

27.9

Data are collected on treatment-related toxicity outcomes.



Efficiency

27.10

Radiotherapy only: Data are collected about peer review rates for radiotherapy treatment plans.

**Guidelines**

Peer review by a second independent radiation oncologist should occur prior to the beginning of treatment. When this is not possible, treatment plans are reviewed before 25% of the treatment has been completed. The team tracks data about when this occurs and uses it to implement strategies to increase peer review rates.

Data are reported to relevant provincial and/or federal bodies for benchmarking.

Client-centred  
Services

27.11

Client-reported outcomes are collected and reviewed as part of the cancer program's quality improvement initiatives.



Efficiency

27.12

Data about disease control and survival outcomes are collected.

**Guidelines**

The team completes a periodic audit of relevant clinical outcomes such as disease control and survival outcomes. Disease control and survival outcomes data are collected for clients treated with curative intent.



Efficiency

27.13

Indicator data are compared to available benchmarks.

**Guidelines**

The cancer program compares its indicator data to national and/or provincial benchmarks to evaluate how it compares on relevant clinical data and client outcomes.



Appropriateness



27.14

Indicator data is regularly analyzed to determine the effectiveness of the quality improvement activities.

**Guidelines**

The team compares the intended and actual effects of its quality improvement activities, and, if the objective has not been achieved, adjusts its actions accordingly to meet the objective.

Analyzing data helps identify trends and may reveal areas that could be considered for future quality improvement initiatives. Indicator data can be displayed in a run chart or control chart, both of which are valid means of data analysis.

Safer Healthcare Now! offers Patient Safety Metrics, a web-based tool where organizations can submit data on various interventions, analyze results, and generate reports.

If it is not within the team's capacity to analyze the data, it seeks qualified internal or external assistance.



Appropriateness



27.15

Quality improvement activities that were shown to be effective in the testing phase are implemented broadly throughout the organization.

#### Guidelines

The way in which activities are implemented broadly will vary based on the scope and scale of the team's services and the timeframe (e.g., an effective activity is implemented in more than one area of care and for a longer period of time).

Population  
Focus

27.16

Information about quality improvement activities, results, and learnings is shared with clients, families, teams, organization leaders, and other organizations, as appropriate.

#### Guidelines

Information is tailored to the audience and considers the messaging and language that is appropriate for each audience.

Sharing the results of evaluations and improvements helps familiarize stakeholders with the philosophy and benefits of quality improvement and engage them in the process. It is also a way for organization to spread successful quality improvement activities and demonstrate its commitment to ongoing quality improvement.

Among other benefits, sharing indicator data externally allows for comparisons with organizations offering similar services.



Appropriateness

27.17

Quality improvement initiatives are regularly evaluated for feasibility, relevance, and usefulness, with input from clients and families.

**Guidelines**

The evaluation of quality improvement initiatives includes activities, objectives, and indicators. Results are used to plan future quality improvement initiatives including how and when to sustain or spread existing initiatives.

Outcomes of the quality improvement initiatives are considered with respect to how they align with the organization's overall quality improvement plan, goals and objectives, mission and values, and strategic plan. The team evaluates whether objectives were met within the timeframes and whether the timeframes are still relevant.

Based on the review of the initiatives, objectives and indicators may be added, amended, or removed as appropriate. The rationale for amending or removing them is documented.

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**Feedback: Please indicate the name of the standard, as well as the criterion number in your comments. Please be as specific as possible in your comments.**

*For example: I would like to provide comments on the Long-Term Care Services standards, criterion 3.12. Clients should be included in this process. I suggest you change the wording to "The team engages staff, service providers, and clients in the process to plan services."*

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