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Preface

These guidelines have been developed to support the implementation of Queensland Remote Chemotherapy Supervision (QReCS) model across the state. The QReCS guidelines are intended to enable the safe administration of low-risk chemotherapy regimens closer to home for patients from rural and remote areas utilising telehealth technologies.

Most medical and nursing elements of the guidelines are based on published studies and abstracts. Primarily, the QReCS model has been developed to address the impracticality of having specialist oncology nurses, oncologists and oncology pharmacists available personally in rural and remote locations to deliver chemotherapy. Instead, the QReCS approach sees oncology professionals across medical, nursing and pharmacy streams at larger centres harnessing telehealth technology to supervise chemotherapy administration remotely. It relies on rural generalist pharmacists, nurses and medical teams having formally developed working knowledge of the critical safety and quality issues affecting patients undergoing chemotherapy. As training requirements are moderate, QReCS is responsive to the wide range of clinical activities carried out in rural and remote health facilities, as well as the sometimes high turnover of clinical staff in such locations. In short, QReCS maximises the potential for patients to receive cancer treatment closer to their homes where there is insufficient demand for speciality cancer services.

Note: The publication of these guidelines does not mandate that the QReCS model is adopted universally. The guidelines simply provide health professionals and managers with assistance in cases where the administration of chemotherapy medications is considered a valuable and feasible way to enhance the accessibility of treatment services among rural and remote residents affected by cancer.
Queensland Remote Chemotherapy Supervision (QReCS)

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Queensland Remote Chemotherapy Supervision (QReCS) Guide

Introduction

The Rural and Remote Health Services Plan 2013 recognises the need to explore innovative ways to bring sustainable and equitable care to Queenslanders. The Blueprint for better healthcare in Queensland also identifies the need for health services in rural and remote communities to be improved. The Blueprint makes a commitment to eliminating longer waiting times for diagnosis and treatment for residents of these areas, by linking with the best hospitals in Queensland through telehealth.

In relation to cancer, telehealth has the potential to bring both consultative and treatment services to smaller communities, significantly reducing the stress, family and lifestyle disruption and economic consequences of accessing expertise and treatment for cancer. It can help address current low rates of chemotherapy utilisation in remote areas and boost equity of access to safe, quality cancer treatments.

Purpose

The Queensland Remote Chemotherapy Supervision (QReCS) model provides guidance on the essential requirements for administering chemotherapy medications close to home for rural and remote people affected by cancer.

Adopting the approach set out in QReCS is intended to maximise the scope and safety of the administration of chemotherapy medications at rural and remote facilities. It also aims to assist health service managers to identify prerequisite and associated procedures.

The QReCS approach assumes a service model where support and supervision for the administration of chemotherapy medications is provided to generalist doctors and nurses in rural and remote facilities by specialist cancer clinicians from regional and tertiary hospitals for both patients and staff. The Guide adopts the hierarchy of health services included in the Rural and Remote Health Services Plan 2013. The range of facilities to which this document applies is shown in Figure 1 below.

Figure 1. Health Service Network

![Health Service Network Diagram](image)

CSCF = Clinical Services Capability Framework
**Context**

Current face-to-face and outreach models for oncology treatment, including the administration of chemotherapy medications, do not generally extend to hospitals that operate below level four of the Clinical Services Capability Framework v3.1 (CSCF). Additionally, nurses involved in the administration of chemotherapy medications are currently required to undertake extensive education programs over many months. This investment in training is often considered too burdensome for generalist nurses, who provide a wide range of care in smaller or more remote facilities. COSA has also identified chemotherapy-competent nurses may live in rural areas but do not practice their skills due to a lack of quality support infrastructure. As a result, there are usually no chemotherapy competent nurses working in these hospitals. This eliminates the potential for chemotherapy medications to be administered in rural or remote communities. As a consequence, patients have to travel or relocate to larger centres to access cancer services for the period of their treatment.

To increase access to safe, local cancer care services for patients living in less populated areas, these barriers need to be overcome. A different approach is needed to enable rural and remote nurses to administer chemotherapy medications in a supported arrangement that reflects the nature of their workload, low patient volumes and the needs of people affected by cancer. To prove this concept, the Townsville Cancer Centre has shown it to be feasible to establish an effective model of remote chemotherapy supervision.¹

Studies evaluating the Townsville tele-oncology network reported:

- these medical models are acceptable to patients and welcomed by rural health professionals²
- it seems safe for medical oncologists to remotely supervise chemotherapy delivery at receiving sites³
- the Townsville model saves money to the health system.⁴

The enhanced use of telehealth technology presents an enormous opportunity to harness the cancer clinical expertise in regional and tertiary facilities to increase access to cancer care services in rural and remote areas.

Specifically, telehealth services need to be expanded for:

- medical consultations

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- supervision of nurses administering chemotherapy
- nurse support and education
- allied health assessments and interventions
- allied health support and education
- training, including the Antineoplastic Drug Administration Course (ADAC).

A key factor in the success of the QReCS approach is the engagement of staff at both recipient and provider facilities to ensure they are committed to the process of enhancing health services through telehealth and that they understand the core requirements and logistical factors that need to be considered to enable the safe, sustainable access to cancer clinical expertise for the delivery of chemotherapy.

**Figure 2: Queensland Remote Chemotherapy Supervision (QReCS) model**

![Queensland Remote Chemotherapy Supervision Model](image)

**Implementation requirements**

There are ten key implementation requirements that will ensure provider and recipient facilities are prepared for the safe and sustainable administration of chemotherapy medications in rural and remote locations. Hospitals enthusiastic about harnessing telehealth to enhance the quality and range of cancer services in small communities should ensure they consider all the requirements set out below before committing to provide, or to support the provision of, chemotherapy. Some requirements will take significant time and effort to achieve; as such, allowing an adequate lead time prior to the commencement of services is critical to ensuring safety and managing patient expectations.
1. Strategy and governance

Provider and recipient facilities need to ensure that investment in telehealth services is undertaken in accordance with a coherent strategy for the development of cancer services within the relevant Hospital and Health Service (HHS) or group of HHSs. This will ensure:

- the investment contributes to achieving the service’s vision
- an analysis of the financial impact of an increase in telehealth services is undertaken
- any location-specific risks are identified and mitigated
- the role of telehealth is tied into the model for service integration.

Additionally, appropriate governance arrangements need to be established to ensure telehealth is meeting its strategic objectives and that services are effective, sustainable, supported and affordable. Governance arrangements should reinforce integration between telehealth and ‘traditional’ parts of the service. As such, a separate governance body is not recommended; instead, senior officers responsible for telehealth would ideally be brought into the appropriate existing management committee.

In cases where telehealth services are provided by a different HHS than that receiving them, it would be prudent for the HHSs to negotiate a service level agreement, setting out the expectations and respective responsibilities of each. This may include such considerations as:

- staff and equipment expectations
- financial arrangements (including sharing of MBS and private patient billing)
- performance metrics, monitoring and reporting
- approach to resolving issues.

In relation to chemotherapy, a key element of governance relates to the agreement of medications for administration at recipient facilities. Initial agreement and subsequent changes need to be considered and approved by the relevant clinical governance committees at both provider and recipient facilities.

2. Financial considerations

Medicare Benefit Schedule (MBS) items can currently be billed by both the provider and recipient sites for telehealth consultations. MBS billing for chemotherapy administration is attributable to the oncology specialist who is responsible for that treatment. The capacity to claim MBS reimbursement for health services is contingent on a range of conditions being met. As such, provider and recipient facilities will need to agree on measures that ensure all requirements of the relevant legislation, guidelines and Department of Health revenue policies are met. MBS rules can be found at www.mbs.gov.au.

Recipient and provider sites may currently also count telehealth consultations as occasions of service under the current Activity Based Funding (ABF) model. Recipient sites may additionally count chemotherapy administration as an ABF occasion of service.

Most chemotherapy medications are reimbursed by the Pharmaceutical Benefit Scheme (PBS) and therefore would not be expected to increase the overall cost of drugs incurred at recipient sites.
Where QReCS is adopted without the support of dedicated funding (e.g. through a site specific or special purpose grant etc), a service level agreement between provider and recipient facilities will assist clarify arrangements regarding funding, billing and sharing of revenue for services delivered.

### 3. Workforce

The minimum workforce required to support the QReCS model is shown in the table below.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Medical</th>
<th>Nursing</th>
<th>Pharmacy</th>
<th>Allied health</th>
<th>Admin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Medical oncologist</td>
<td>Chemotherapy administration competent nurse</td>
<td>Oncology pharmacy or experience handling chemotherapy</td>
<td>Allied health professional experienced with management of cancer patients i.e lymphedema, mucocitis, (discipline as required)</td>
<td>Admin officer Telehealth coordination</td>
</tr>
<tr>
<td>Recipient</td>
<td>Any medical officers</td>
<td>Chemotherapy administration aware nurse</td>
<td>Hospital or community pharmacy</td>
<td>Allied health professional (discipline as required)</td>
<td>Admin officer Telehealth coordination</td>
</tr>
</tbody>
</table>

These officers are not required concurrently every time a patient undergoes a consultation or treatment that is supported by telehealth. However, it is critical that there are identified staff within each profession who are responsible for, and understand the nature of their role in, supporting the delivery of cancer services at provider and recipient facilities.

A key enabler in the successful implementation of QReCS is the engagement of enthusiastic staff at both the provider and recipient facilities, whose telehealth-related work is buttressed by endorsement from executive and senior administration staff.

A key contact for telehealth coordination is essential at both the provider and recipient sites. This ensures minimum disruption of workflow and maximum confidence in the effectiveness of telehealth by:

- coordinating bookings and clinician availability
- ensuring equipment is functioning properly
• advance testing of the interoperability of provider/recipient telehealth equipment\(^5\)

It may be useful for contact details for all staff providing services or support of QReCS be collated into an accessible directory to facilitate easy communication.

4. Complexity of medications

QReCS is limited to chemotherapy medications where the likelihood or consequences of hypersensitivity reactions and extravasations are minimal. Shelf life also needs to be considered when identifying chemotherapy medications appropriate for administration in regional and rural facilities. Requirements around refrigerated transportation of chemotherapy medications and supportive therapies (e.g. packed red blood cells (PRBS), platelets (plts)) need to be mapped and confirmed prior to offering care in rural and remote facilities. Planning should take into consideration that the first dose will be given at the provider facility to assess patient hypersensitivity reaction risk and for demonstrating clinical activities to the remote site via videoconference.

Various drugs can be added to the list of agreed medications based on medical, nursing and pharmacy confidence at recipient sites. A process must be agreed between each provider and recipient site for advancing from one phase to the next. The process must be approved by the relevant clinical governance committees at each facility before being put into practice.

Factors influencing chemotherapy medication complexity include:

• resource allocation to administer treatments (e.g. equipment, staff, space etc)
• waste management.
• pharmacy and supply and physio-chemical stability of treatments
• risk of infusion-related reaction
• confidence of staff (medical, nursing and pharmacy)
• training
• complexity of the patient and intent of treatment
• complexity of regimen

The link [http://qheps.health.qld.gov.au/circs/](http://qheps.health.qld.gov.au/circs/) groups various chemotherapy medications into levels of risk, all or none of which may be suitable for administration in rural or remote facilities at a given time. As noted above, decisions as to the appropriateness of administering chemotherapy medications at any phase need to be made jointly by the provider and recipient facilities and require the joint agreement of the appropriate clinical governance committees.

The medication list at [http://qheps.health.qld.gov.au/circs/](http://qheps.health.qld.gov.au/circs/) is not exhaustive, rather an indicator to inform discussions between provider and recipient sites. The factors outlined above will influence the decision to move between the phases.

\(^5\) RACGP Implementation guidelines for video consultations in general practice Sept 2012
An example of a phased approach is below:

**Phase 1:**
- 5FU, cyclophosphamide, Methotrexate IM/SC
- Bevacizumab, Trastuzumab,
- Denosumab, Zelodronic acid

**Phase 2:**
- Pemetrexed, weekly Irinotecan, Paclitaxel, weekly Paclitaxel

**Phase 3:**
- Cisplatin (<50mg/m2) with Gemzar, Paclitaxel and , combination of drugs in phase 1 and 2

**Phase 4:**
- Others

NB: Arrangements will need to be agreed in relation to the delivery of medications between provider and recipient sites. Options include having medications delivered directly to recipient facilities from external suppliers and having the provider site manage ordering and delivery of medication.

5. **Telehealth Readiness**

5.1. **Telehealth service processes**

A number of organisations have produced detailed guidelines to help health providers ensure their facilities are well configured for the provision of telehealth services. Of particular note is the Rural Health Education Foundation (www.rhef.com.au), which has collated an array of printable telehealth-related resources onto a single DVD.

The Australian College of Rural and Remote Medicine has produced a practical set of resources that will assist plan effectively for telehealth consultations (www.ehealth.acrrm.org.au). The resources cover such issues as:

- Connectivity and bandwidth
- Lighting, sound and contrast
- Eye contact and body language
- Patient consent and privacy.

The Department of Health Integrated Telecoms team have developed a range of useful resources that would be helpful. These can be found at http://qheps.health.qld.gov.au/telehealth/html/clinical-use.htm.

The Royal Australian College of General Practitioners and Nursing and Midwifery Telehealth Consortia have published telehealth standards for their members. These are accessible at:

• Nurses and midwives:  

Provider and recipient facilities should review this material to ensure they understand the benefits and limits of telehealth and how they can influence the success of services delivered through this mode.

5.2. Videoconferencing equipment

Real-time videoconferencing technology is essential for the success of the QReCS model. Although the Department of Health prefers traditional videoconferencing technology, web-based systems can be alternatives. Decisions about the appropriate equipment and platforms for use in particular cases must be made collaboratively by the provider and recipient facilities.

Standard video equipment used for videoconferencing will generally be adequate for supporting the administration of chemotherapy. For assessing reactions, however, video or web cameras used at the recipient site need to have the capacity to zoom in and retain good resolution. Equipment that is attached to small mobile trolleys or stands will greatly assist in achieving the ideal level of manoeuvrability.

Clinical staff should be able to operate videoconferencing equipment with reasonable skill. This is essential for the efficiency and safety of QReCS. It makes sense for any staff who will be participating in telehealth consultations or treatment to undertake basic training, most likely delivered by the telehealth provider site. In addition, a good relationship with the IT support team at the relevant facility will be useful for maintenance and major trouble shooting.

6. Chemotherapy administration readiness

6.1. Chemotherapy administration area

An area in which chemotherapy medications are administered needs to be clean, adequately ventilated and well lit. Day surgery recovery areas in rural and remote facilities will often provide a suitable location for chemotherapy provision.

Other factors to consider when identifying whether an appropriate area exists are:

• The area is restricted to authorised personnel and is not used as a short cut to other areas of the facility
• There is sufficient room to perform tasks safely
• The area is tidy and free from obstacles
• Telehealth equipment can be easily manoeuvred around the patient bed or chair without disproportionate risk of tripping or entanglement with other equipment
• There is ready access to a shower in the event of personal contamination by chemotherapy medications
- There is an appropriate storage area for chemotherapy medications, encompassing both non-refrigerated and refrigerated items
- Staff eating and drinking are restricted where chemotherapy medications are administered.

The Australasian Health Facility Guidelines, developed by NSW Health and the Australasian Health Infrastructure Alliance, provide further details of the ideal configuration for an ambulatory care unit. These are accessible at www.healthfacilityguidelines.com.au. While it is not expected that recipient facilities will meet every aspect of those Guidelines, it is important that the place chosen to administer chemotherapy medications does not expose patients or health workers to unnecessary risk.

6.2. Personal protective equipment

Some personal protective equipment (PPE) is essential for particular tasks associated with administering chemotherapy medications. The following list is mandatory for use by any staff administering intravenous chemotherapy medications:

Provision of appropriate PPE related to specific tasks:

- Impermeable long sleeved gown with knitted cuffs
- Purpose-manufactured gloves or two pairs (double layer) of surgical latex gloves
- Protective eyewear
- Respiratory protective equipment (N95)

A further list of essential equipment and consumables is accessible at http://qheps.health.qld.gov.au/circs/.

6.3. Other equipment

As noted above, a full list of essential equipment and consumables to enable the safe administration of chemotherapy medications is accessible at http://qheps.health.qld.gov.au/circs/.

7. Information technology and support

7.1. Patient information management system

Since QReCS generally forms part of a larger network of cancer treatment services within or between HHSs, it is ideal that provider and recipient sites share the same oncology information management system (OIMS) for prescription, administration and documentation. If each facility operates using a different OIMS, patient information will need to be manually transferred in line with existing policies. Sufficient lead time will need to be allowed to ensure all relevant patient information is available at the respective sites before consultations are conducted or chemotherapy medications are administered. A single OIMS is the cornerstone to the Townsville Cancer Centre telehealth service. In Townsville’s case, the application in use is MOSAIQ™.
7.2. Logistics and administration support

Given the need to coordinate medical and nursing staff across at least two different sites, it is essential that clinical and administration officers properly consider the logistical and support needs for the remote provision of medical consultations and supervision of chemotherapy.

This section provides a list of core requirements for each of the services that are within the scope of the QReCS model. It is intended this will assist identify potential hurdles that need to be addressed before a facility is ready to provide a safe sustainable chemotherapy administration service.

Medical consultations

- Clinic room or office (both ends), equipped with compatible videoconferencing equipment
- Concurrent availability of both oncology specialist (provider) and general medical officer (recipient), plus a time allowance for overrunning (for staff and facilities) at both ends
- Access in both locations to patient chart, inclusive of all pathology and radiology investigations and results (ideally through single oncology information management system (OIMS))
- Patient

Nursing consultations

- Clinic room or office (both ends), equipped with compatible videoconferencing equipment
- Concurrent availability of chemotherapy competent nurses at provider and recipient facilities, plus a time allowance for overrunning (for staff and facilities) at both ends
- Access in both locations to patient chart, inclusive of all pathology and radiology investigations and results (ideally through single oncology information management system (OIMS))

Pharmacy handover

- Telephone or videoconferencing equipment
- Copies of chemotherapy and supportive care prescriptions
- Copies of patient medication history
- Concurrent availability of dedicated / experienced oncology pharmacist (provider) and general / community pharmacist (recipient)
- A time allowance for overrunning (for staff and facilities) at both ends

Chemotherapy administration

- Videoconferencing equipment (ideally on a small, mobile stand at recipient facility)
- Access at both locations to all equipment and consumables (accessible at http://qheps.health.qld.gov.au/circs/)
• Access in both locations to patient chart, inclusive of all pathology and radiology investigations and results (ideally through single oncology information management system (OIMS))
• Supervising nurse at provider facility appropriately scheduled (i.e. one chair booked in regional or tertiary centre day oncology unit to account for remote supervision activity)
• Chemotherapy competent nurse at recipient facility appropriately scheduled
• Access to appropriate space at recipient facility for administration of chemotherapy
• A time allowance for overrunning (for staff and facilities) at both ends
• Medical and nursing consultations have occurred before chemotherapy administration
• Pharmacy handover has occurred before chemotherapy administration
• Medical officer available at recipient site during chemotherapy administration
• Patient

Allied health consultation or treatment

• Clinic room or office (consultations) or treatment room (treatment) in both locations, equipped with compatible videoconferencing equipment
• Concurrent availability of both specialist oncology allied health (provider) and general allied health (recipient) professionals
• A time allowance for overrunning (for staff and facilities) at both ends
• Access in both locations to patient chart, inclusive of all pathology and radiology investigations and results (ideally through single oncology information management system (OIMS))
• Patient.

8. Legislation and special considerations

Legislation related to the management of hazardous chemicals, including chemotherapy medications, imposes obligations on healthcare providers to ensure that workers, visitors and the environment are not exposed to health and safety risks. The relevant legislation requires procedures to be developed and readily accessible to all workers that comply with regulation and best practice.

All staff who handle chemotherapy or chemotherapy-related waste must have access to appropriate education and reference documents to reduce the risk of exposure for workers, visitors and the environment.

Facilities must identify and coordinate relevant training that is individualised to the chemotherapy-related responsibilities of particular groups of workers. Educational content and delivery methods will differ depending on the role of each worker. The completion of a structured risk assessment will assist to identify staff who should undertake relevant training.

For further advice on the cytotoxic safety training requirements for common roles, please contact the Central Integrated Regional Cancer Service by email (circs@health.qld.gov.au).
Comprehensive records must be kept in relation to cytotoxic safety training. Records must include:

- Session date
- Session topic
- Name of person who conducted the session
- Names of participants.

Additional detail is provided in Appendix 1.

9. Education and training

9.1. Medical staff
The QReCS guidelines impose no formal chemotherapy-specific education requirements for medical officers at the recipient facility. The handbook for junior cancer care medical staff would be available for reference by medical staff at the recipient facility if requested.

The oncology specialist will provide the recipient facility medical officer with an overview of the prescribed chemotherapy regimen and side effects during the telehealth consultation.

9.2. Nurses administering chemotherapy

Nurses administering chemotherapy must complete the Antineoplastic Drug Administration Course (ADAC), developed by the Cancer Institute of NSW. ADAC is accessible through iLearn (https://ilearn.health.qld.gov.au/login/index.php). Nurse managers and educators at rural and remote facilities should consult with the Central Integrated Regional Cancer Service (CIRCS) (circs@health.qld.gov.au) to agree the best approach for nurses to complete practical aspects of ADAC. In many cases, it will be appropriate for some competency-based assessments to be undertaken by videoconference.

It is expected that nurses administering chemotherapy will have completed their annual mandatory requisites such as Advanced Life Support (ALS).

9.2.1. Recipient
Chemotherapy awareness is the minimum requirement for nurses who administer chemotherapy medications to patients at recipient facilities.

To achieve chemotherapy awareness, recipient site nurses will:

- Enrol in ADAC through iLearn and successfully complete all e-quizzes and competencies for:
  - Handling antineoplastic drugs and related waste safely
  - Administering oral antineoplastic drugs

NB: The above competencies can be undertaken through simulation via videoconferencing
• Complete a CVAD learning package / workshop as determined by provider site
  o CVAD workshops maybe offered through simulated videoconferencing
• Attend a two day clinical practice placement at the provider facility

Arrangements for supervised clinical practice will need to be negotiated between the relevant facilities. Provider and recipient facility nurse managers should request a copy of the ADAC certificate before scheduling clinical practice attendance by nurses from recipient sites.

9.2.2. Provider

Nurses supervising the administration of chemotherapy by nurses at recipient facilities must be chemotherapy competent.

Nurses from the provider site will:

• Enrol in ADAC through iLearn and successfully complete all e-quizzes and competencies for
  o Handling antineoplastic drugs and related waste safely
  o Administering oral antineoplastic drugs
  o Understanding how antineoplastic drugs work
  o Reviewing prescriptions and protocols
  o Assessing patients
  o Educating patient and carer
  o Administering IV antineoplastic drugs
  o Preventing and managing extravasation of antineoplastic drugs
  o Skills development workshop – administering, delivering, assessing and educating

Successful completion of all ADAC requirements, including supervised clinical practice and skills development workshop, will lead to a nurse being deemed chemotherapy competent. This is the minimum level of competency required to administer chemotherapy.

The link http://qheps.health.qld.gov.au/circs/ contains a full list of clinical practice prerequisites, including those acquired through ADAC. This link also provides the suggested program for the two days of supervised clinical practice required for the achievement of chemotherapy competence.

9.3. Nurses required to prepare monoclonal antibodies (MABs)

Nurses required to prepare monoclonal antibodies (MABs) must complete a formal education program related to preparation and associated safe handling practices. The precise content of such education will depend on the context in which a nurse will work with MABs.
Training may be provided by a local nurse educator, pharmacist or experienced workplace health and safety educator. Sites can discuss their needs and processes in relation to nurses preparing monoclonal antibodies with CIRCS (circs@health.qld.gov.au).

9.4. Pharmacy staff

Under the QReCS guidelines, a hospital or community pharmacist from the recipient facility is supported and mentored as required by an oncology pharmacist from the provider facility on a drug-by-drug basis. Alternatively, the pharmacist at the rural or remote facility may choose to undertake more comprehensive oncology pharmacy education.

10. Documentation and discharge

Documentation, management of post-chemotherapy side effects and discharge planning will be the same as for the current face-to-face and telehealth models. Chemotherapy competent nurses at the provider site will support chemotherapy-aware nurses at rural and remote facilities in relation to side effect and discharge management.

It is likely that nurses at the recipient facility will become the default contact person for rural or remote patients. This will need to be taken into consideration by nursing and facility managers when evaluating the workload arising from the QReCS model.

Once a patient has received their final dose of prescribed chemotherapy medication, the specialist oncologist will determine the appropriate frequency of review consultations. In most cases where the patient has coped well with their treatment, review consultations will be provided by telehealth. However, arrangements for each patient will be determined jointly by the specialist and patient.
Reference list

The following documents are useful resources that will support the implementation of the QReCS guidelines in provider and recipient facilities.

*Work Health and Safety Act 2011 (Qld)*

*Work Health and Safety Regulation 2011 (Qld)*


Appendix 1 – Chemotherapy legislation logistics

Safety Data Sheets (SDSs)

- ChemAlert Stock Holding Report and Hazardous Substances Register must have a register/inventory list of all hazardous medications that are stocked and administered throughout facility
- Current SDSs must be available for all workers:
- All workers must have access to ChemAlert (http://qheps.health.qld.gov.au/safety/hazards/chemalert.htm)
- All workers must possess the skills required to access ChemAlert for required information.

Risk assessments


Spill management

- Spill kits to be available where antineoplastic medications and related waste are handled, stored, transported and disposed of
- Store spill kits in appropriate locations
- Sign locations where spill kits are housed
- Provide a dedicated mop and bucket that is labelled appropriately for spills.

Waste management

Cytotoxic waste may be stored for extended periods of time, provided all precautions are taken to ensure that there is no environmental nuisance or risk created through the storage of this material (Department of Environment and Heritage Protection).

Waste is to be stored in a secure dedicated area:

- Area to be appropriately signed to identify antineoplastic waste from general and clinical waste
- Area to be well ventilated
- Area to have sufficient light
- Area to have appropriate odour control
- If all waste stored in one area, cytotoxic waste is to be separated from other types of waste within the area.
Waste receptacles

Waste bins, sharps bins and linen bags need to comply with Department of Environment and Heritage Protection:

- Containers and bags must be purple (lilac P23)
- Containers must have a white label that states ‘cytotoxic waste’
- Containers must have a symbol of the cell in telophase.

Laundry

- Require a system to ensure that linen contaminated by cytotoxic waste is isolated from other linen
- Facility may decide to dispose of cytotoxic contaminated laundry if required laundry processes are not practicable.

Chemotherapy supply

Ordered directly from pharmacist at recipient site with support from pharmacist at provider site or entire process co-ordinated and managed by provider site.
Complexity of chemotherapy medications


The provision of chemotherapy treatments utilising the proposed QReCS guidelines is ideally underpinned by an Oncology Information Management System (OIMS) that enables all care providers to view clinical notes and prescriptions (e.g. MOSAIQ). Treatments should be considered according to the level of risk associated with the administration of the medication in the recipient facility.

The initial administration of chemotherapy medications to a patient should be undertaken by chemotherapy competent staff at the provider facility (level four, five or six) site. Subsequent cycles may be given based on the QReCS guidelines.

Recipient facilities implementing the QReCS model that have onsite pharmacy services will require the capability to undertake paperless dispensing through iPharmacy. If paper PBS prescriptions are required, it is the responsibility of the pharmacist at the recipient site to contact the oncologist for the necessary paperwork.

Recipient sites that have their pharmacy services coordinated by the provider facility will have their PBS requirements managed by the provider.

Cisplatin may be considered at doses < 30mg/m² as a weekly dose; however it is unlikely to fit the criteria for rural and remote administration.

Treatments should be introduced gradually with low risk single agent therapies until confidence and experience is gained.

The following table is not exhaustive, but identifies chemotherapy and supportive medications according to their ease of administration, stability, and risk of infusion reactions and toxicities.

...
### Low

<table>
<thead>
<tr>
<th>Drug</th>
<th>Shelf life after mixing (Fresenius) in days stored at 2-8°C</th>
<th>Infusion related reaction risk after successful 1st cycle</th>
<th>Extravasation risk</th>
<th>Other issues to be considered in rural sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bevacizumab</td>
<td>21</td>
<td>Low</td>
<td>Neutral</td>
<td>Monitoring for proteinuria and BP required</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Delayed wound healing</td>
</tr>
<tr>
<td>Bortezomib</td>
<td>35</td>
<td>Low</td>
<td>Irritant</td>
<td>Also subcutaneous route available</td>
</tr>
<tr>
<td>Cyclophosphamide</td>
<td>28</td>
<td>Low</td>
<td>?Irritant</td>
<td></td>
</tr>
<tr>
<td>Denosumab</td>
<td>n/a</td>
<td>Low</td>
<td>Skin irritant</td>
<td></td>
</tr>
<tr>
<td>Etoposide Phosphate</td>
<td>60</td>
<td>Low</td>
<td>Irritant with vesicant properties</td>
<td></td>
</tr>
<tr>
<td>Fluorouracil</td>
<td>90</td>
<td>Low</td>
<td>Irritant</td>
<td></td>
</tr>
<tr>
<td>Fluorouracil mechanical infusor (Baxter)</td>
<td>42</td>
<td>Low</td>
<td>Irritant</td>
<td>CVAD maintenance / monitoring</td>
</tr>
<tr>
<td>Gemcitabine</td>
<td>90</td>
<td>Low</td>
<td>? Irritant</td>
<td></td>
</tr>
<tr>
<td>Irinotecan</td>
<td>60</td>
<td>Low</td>
<td>Irritant</td>
<td>Pre-medication required</td>
</tr>
<tr>
<td>Methotrexate</td>
<td>90</td>
<td>Low</td>
<td>Irritant</td>
<td>≤ 60mg/m²</td>
</tr>
<tr>
<td>Pemetrexed</td>
<td>28</td>
<td>Low</td>
<td>? Irritant</td>
<td></td>
</tr>
<tr>
<td>Trastuzumab</td>
<td>43</td>
<td>Low</td>
<td>Neutral</td>
<td>3 mthly cardiac echo required</td>
</tr>
<tr>
<td>Topotecan</td>
<td>28</td>
<td>Low</td>
<td>? Irritant</td>
<td></td>
</tr>
<tr>
<td>Zoledronic Acid</td>
<td>n/a</td>
<td>Low</td>
<td></td>
<td>Osteonecrosis of the jaw (ONJ)</td>
</tr>
</tbody>
</table>

### Moderate

<table>
<thead>
<tr>
<th>Drug</th>
<th>Shelf life after mixing (Fresenius) in days stored 2-8°C</th>
<th>Infusion related reaction risk after successful 1st cycle</th>
<th>Extravasation risk</th>
<th>Other issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actinomycin D</td>
<td>7 days in syringe (Baxter)</td>
<td>Low</td>
<td>Vescicant</td>
<td>Vesicant precautions Bolus administration</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleomycin</td>
<td>28</td>
<td>Mod-high</td>
<td>Irritant</td>
<td>Consider day 8 and 15 BEP protocol</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Medical air only</td>
</tr>
<tr>
<td>Cabazitaxel</td>
<td>1</td>
<td>Mod</td>
<td>Irritant</td>
<td>Short shelf life restricts use in rural and remote centres</td>
</tr>
<tr>
<td>Drug</td>
<td>Mod</td>
<td>Type</td>
<td>Reaction</td>
<td>Other issues</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----</td>
<td>--------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Carboplatin</td>
<td>60</td>
<td>Mod</td>
<td>Irritant</td>
<td>Most reactions occur when &gt;6 cycles administered</td>
</tr>
<tr>
<td>Cetuximab</td>
<td>2</td>
<td>Mod</td>
<td>Neutral</td>
<td>Short shelf life restricts use in rural and remote areas</td>
</tr>
<tr>
<td>Dacarbazine</td>
<td>1</td>
<td>Low</td>
<td>Irritant</td>
<td>Short shelf life restricts use in rural and remote areas</td>
</tr>
<tr>
<td>Docetaxel</td>
<td>28</td>
<td>Mod-High</td>
<td>Irritant</td>
<td>Consider after 2nd successful cycle</td>
</tr>
<tr>
<td>Doxorubicin</td>
<td>60</td>
<td>Low</td>
<td>Vesicant</td>
<td>-vesicant precautions</td>
</tr>
<tr>
<td>Doxorubicin - Liposomal</td>
<td>1</td>
<td>Mod</td>
<td>Irritant with vesicant properties</td>
<td>Short shelf life restricts use in rural and remote centres</td>
</tr>
<tr>
<td>Epirubicin</td>
<td>56</td>
<td>Low</td>
<td>Vesicant</td>
<td>-vesicant precautions</td>
</tr>
<tr>
<td>Etoposide</td>
<td>7</td>
<td>Mod</td>
<td>Irritant with vesicant properties</td>
<td>Monitor for hypotenion</td>
</tr>
<tr>
<td>Idarubicin</td>
<td>35</td>
<td>Low</td>
<td>Vesicant</td>
<td>-vesicant precautions</td>
</tr>
<tr>
<td>Mitomycin</td>
<td>28</td>
<td>Low</td>
<td>Vesicant</td>
<td>-vesicant precautions</td>
</tr>
<tr>
<td>Mitoxantrone</td>
<td>3</td>
<td>Low</td>
<td>Vesicant</td>
<td>-vesicant precautions</td>
</tr>
<tr>
<td>Oxaliplatin</td>
<td>28</td>
<td>Mod-high</td>
<td>Irritant with vesicant properties</td>
<td>Reactions may occur &gt;8 cycles</td>
</tr>
<tr>
<td>Paclitaxel Weekly</td>
<td>21</td>
<td>Mod</td>
<td>Irritant</td>
<td>Consider after 2nd cycle</td>
</tr>
<tr>
<td>Paclitaxel 3 weekly</td>
<td>21</td>
<td>Mod-High</td>
<td>Irritant</td>
<td>Consider after 2nd cycle</td>
</tr>
<tr>
<td>Paclitaxel-Albumin bound</td>
<td>2</td>
<td>Low</td>
<td>Irritant</td>
<td>Short shelf life restricts use in rural and remote areas</td>
</tr>
<tr>
<td>Rituximab</td>
<td>14</td>
<td>Mod</td>
<td>Neutral</td>
<td>Consider after 2nd cycle Incremental administration required</td>
</tr>
<tr>
<td>Vincristine</td>
<td>56</td>
<td>Low</td>
<td>Vesicant</td>
<td>-vesicant precautions</td>
</tr>
<tr>
<td>Vinorelbine</td>
<td>28</td>
<td>Low</td>
<td>Vesicant</td>
<td>-vesicant precautions</td>
</tr>
</tbody>
</table>

**High**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Shelf life after mixing (Fresenius) in days stored 2-8°C</th>
<th>Infusion related reaction risk after successful 1st cycle</th>
<th>Extravasation risk</th>
<th>Other issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alemtuzumab</td>
<td>1 High</td>
<td>Neutral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asparaginase</td>
<td>1 High</td>
<td>Neutral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carmustine</td>
<td>2 Low</td>
<td>Irritant</td>
<td></td>
<td>Pulmonary toxicity</td>
</tr>
<tr>
<td>Cisplatin</td>
<td>60 High</td>
<td>Irritant</td>
<td></td>
<td>Complex hydration regimen, fractionated regimen may be considered in certain centres, nephrotoxic</td>
</tr>
<tr>
<td>High/ Multi dose cyclophosphamide</td>
<td>56 Low</td>
<td>? Irritant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cytarabine</td>
<td>90 High</td>
<td>Neutral</td>
<td></td>
<td>Neurotoxic</td>
</tr>
<tr>
<td>Ifosfamide</td>
<td>42 High</td>
<td>Irritant</td>
<td></td>
<td>Neurotoxic</td>
</tr>
<tr>
<td>Ipilimumab</td>
<td>1 Low</td>
<td>Neutral</td>
<td></td>
<td>Reconstitution onsite</td>
</tr>
<tr>
<td>HD Methotrexate</td>
<td>90 High</td>
<td>Irritant</td>
<td></td>
<td>Complex monitoring and</td>
</tr>
</tbody>
</table>
Equipment and consumables specific to administering chemotherapy


(Includes equipment required for central venous access device (CVAD) care)

<table>
<thead>
<tr>
<th>Items for delivery of chemotherapy</th>
<th>FAMMIS codes/ordering information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spill kit chemotherapy</td>
<td>10005680</td>
</tr>
<tr>
<td>Gown, hospital: N/sterile, disposable, impervious, blue, universe</td>
<td>10104274</td>
</tr>
</tbody>
</table>

**Respiratory Protective Equipment (RPE)**

- Mask-shield, Surg: Partic Resp, N95, Small
- Mask-shield, Surg: Partic Resp, N95, Med
- Mask-shield, Surg: Partic Resp, N95, Reg

<table>
<thead>
<tr>
<th>Purpose manufactured gloves (Nitrile)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glove, Exam: Nitrile, N/St, N/Powd, Large</td>
</tr>
<tr>
<td>Glove, Exam: Nitrile, N/St, N/Powd, Med</td>
</tr>
<tr>
<td>Glove, Exam: Nitrile, N/St, N/Powd, Small</td>
</tr>
<tr>
<td>Glove, Exam: Nitrile, N/St, N/Powd, XS</td>
</tr>
<tr>
<td>Glove, Exam: Nitrile, N/St, Flx, Long/Cuff, N/Powd, Small</td>
</tr>
<tr>
<td>Glove, Exam: Nitrile, N/St, Flx, Long/Cuff, N/Powd, Med</td>
</tr>
<tr>
<td>Glove, Exam: Nitrile, N/St, Flx, Long/Cuff, N/Powd, Large</td>
</tr>
</tbody>
</table>

**Waste Receptacles**

- Bag, Waste: Cyto, PE, Lilac, 75L
- Bag, Waste: Cyto, PE, Lilac, 240L (wheelie bin)
- 19 litre sharps (purple)

<table>
<thead>
<tr>
<th>Cytotoxic labels</th>
</tr>
</thead>
<tbody>
<tr>
<td>NB: Special order</td>
</tr>
</tbody>
</table>

Vendor: Mediprint (Contact: 3200 7788)
Vendor Number: 107468 – Product Code: LPB$) Size 400 mm x 10 mm

<table>
<thead>
<tr>
<th>Items for the management of CVADs</th>
<th>FAMMIS codes/ordering information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Port-a-cath needles</td>
<td></td>
</tr>
<tr>
<td>Needle, ACC Port: 90D, Micro, Y Safety, 19 x 25 mm</td>
<td>10247460</td>
</tr>
<tr>
<td>Needle, ACC Port: 90D, Micro, Y Safety, 22 x 19 mm</td>
<td>10247465</td>
</tr>
</tbody>
</table>

**Luer lock syringes:**

- Syringe, Hypo, Inj, L/Lk, 10 ml
- Syringe, Hypo, Inj, L/Lk, 30 ml

<p>| Applicator, Chlorhx Alc Imprg: 2%, swab stic | 10133406 |</p>
<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin prot barrier film: n/alc wipe</td>
<td>10128615</td>
</tr>
<tr>
<td>Securement Dev, Cath-tube: PICC, Adult, FXD</td>
<td>10166112</td>
</tr>
</tbody>
</table>
Clinical placement program prerequisites


1. Proficient in the IV administration of medications
2. Completion of theoretical workshop for central venous access devices (CVADs) common to cancer care:
   a. Peripherally inserted central catheters (PICCs)
   b. Totally implantable central venous catheters (ports)
3. Competent in IV cannulation
4. Completion of the relevant aspects of the Cancer Institute NSW Antineoplastic Drug Administration Course (ADAC):
   a. Handling antineoplastic drugs and related waste safely
      i. eLearning Guide
      ii. 100% grade in eQuiz
      iii. Clinical workplace learning via simulation using videoconferencing teaching model related to module competency
      iv. Successful attainment of competency via simulation using videoconferencing teaching model
   b. Administering oral antineoplastic drugs
      i. eLearning Guide
      ii. 100% grade in eQuiz
      iii. Clinical workplace learning via simulation using videoconferencing teaching model related to module competency
      iv. Successful attainment of competency via simulation using videoconferencing teaching model

Clinical workplace learning for these competencies via simulation using videoconferencing teaching model may be limited. This learning/practice will take place during the clinical placement and should be an aspect of the day 1 visit to the provider site.

5. Clinical placement

Staff attending the provider site will require a program that allows them to perform the skills of administering IV chemotherapy using a direct supervision model. During this time, the staff member is to be supported to practice the skills required for the relevant competencies and they should then be assessed in the relevant competencies using the ADAC competency assessments.
Clinical placement program schedule


### Day One
Date of Program Commencement:

<table>
<thead>
<tr>
<th>Participant Name</th>
<th>Provider Site Program Coordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Participant's Line Manager’s Name</td>
<td>Provider Site and HHS:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Recipient Site and HHS</td>
<td>Resource Nurse’s Name:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>Learning Objectives</th>
<th>Teaching Strategy</th>
<th>Learner Activity</th>
<th>Resources / Aids</th>
</tr>
</thead>
<tbody>
<tr>
<td>0900 - 0945</td>
<td><strong>Orientation to Unit</strong></td>
<td>Resource person to provide a tour of services and introduce nurse from recipient site</td>
<td>Recipient nurse to clarify questions regarding environment or equipment during orientation to unit</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Telehealth Model</strong></td>
<td>Resource person to show the nurse from the recipient nurse how QReCS works in the clinical setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Provide an overview of the telehealth model used in the provider site</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0945 - 1000 <strong>Peripheral Venous Access</strong></td>
<td>Face-to-face discussion</td>
<td>Active participation in discussion</td>
<td>Provider procedure related to cannulation of patient receiving IV chemotherapy</td>
</tr>
<tr>
<td></td>
<td>- Revise the key principles of peripheral venous access for patients receiving IV chemotherapy. For example; most appropriate cannula size and most appropriate vein for the administration of chemotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Demonstrate the skills to cannulate a patient receiving IV chemotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Resource nurse to directly observe recipient nurse cannulating a patient for IV chemotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recipient site nurse cannulates a patient receiving IV chemotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Learning Objectives</td>
<td>Teaching Strategy</td>
<td>Learner Activity</td>
<td>Resources / Aids</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 1000 – 1100 | **Central Venous Access Devices (CVADs)**  
1. Briefly describe the major characteristics of the common CVADs used in cancer care:  
   1. Peripherally Inserted Central Catheters (PICCs)  
   2. Totally Implanted Central Venous Catheter (Port)  
2. Explain the management of PICCs and Port  
3. Summarise the possible complications related to CVADs  
4. Explain the management of possible CVAD complications  
5. Demonstrate how to access a PICC and Port | Face-to-face discussion | Active participation in discussion | Queensland-Cancer Education Program: Module 2 Core Skills in Cancer Care - CVADs in Cancer Care  
Provider procedure related to the management of CVADs |
| 1100 - 1115 | MORNING TEA                                                                          |                                                        |                                                                        |                                                                                                |
| 1115 – 1200 | **Preparation of Monoclonal Antibodies**  
- Demonstrate how to prepare products such as Avastin and Herceptin using control measures such as a closed system and Personal Protective | Resource nurse to demonstrate how to prepare monoclonal antibodies such as Avastin and Herceptin using local procedure  
Resource nurse to directly observe | Recipient nurse to observe resource person preparing monoclonal antibodies such as Avastin and Herceptin using local procedure  
Recipient nurse to prepare | Procedure related to safe preparation of monoclonal antibodies  
Access to required equipment to perform procedure |
<table>
<thead>
<tr>
<th>Time</th>
<th>Learning Objectives</th>
<th>Teaching Strategy</th>
<th>Learner Activity</th>
<th>Resources / Aids</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Equipment</strong></td>
<td>recipient nurse preparing monoclonal antibodies (may be a simulated activity)</td>
<td>monoclonal antibodies such as Avastin and Herceptin (may be a simulated activity)</td>
<td></td>
</tr>
<tr>
<td>1200 – 1300</td>
<td><strong>Competency Assessment Tools</strong></td>
<td>Read through the competency based assessments to explain components of assessments and ascertain if any questions</td>
<td>Recipient nurse to clarify questions regarding competency based assessment process</td>
<td>ADAC competency assessments: 1. Understanding how antineoplastic drugs work 2. Reviewing prescriptions and protocols 3. Assessing patients 4. Educating the patient and carer 5. Administering IV antineoplastic drugs 6. Preventing and managing the extravasation of antineoplastic drugs</td>
</tr>
<tr>
<td>1300 – 1330</td>
<td><strong>LUNCH</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 1330 – 1600 | **Clinical Workplace Demonstration**                                                 | Resource nurse to demonstrate entire process for administering IV chemotherapy in the clinical workplace  
- Utilise ADAC competency assessments | Recipient nurse to observe process for administering IV chemotherapy using the ADAC competency assessments  
Recipient nurse to clarify questions regarding competency based | ADAC competency assessments: 1. Understanding how antineoplastic drugs work 2. Reviewing prescriptions and protocols 3. Assessing patients |
### Learning Objectives

<table>
<thead>
<tr>
<th>Time</th>
<th>Learning Objectives</th>
<th>Teaching Strategy</th>
<th>Learner Activity</th>
<th>Resources / Aids</th>
</tr>
</thead>
<tbody>
<tr>
<td>0900 - 1000</td>
<td><strong>Clinical Demonstration Revision</strong>&lt;br&gt;● Discuss Day 1 clinical demonstration</td>
<td>Face-to-face discussion&lt;br&gt;● Resource person to generate discussion regarding Day 1 clinical demonstration to identify if recipient nurse has any questions or concerns</td>
<td>Recipient nurse to clarify questions regarding Day 1 clinical demonstration</td>
<td>Recipient site nurse administers IV chemotherapy to a patient/s Relevant ADAC competency</td>
</tr>
<tr>
<td>1000 – 1600</td>
<td><strong>Competency Assessment</strong>&lt;br&gt;● Assess the recipient nurse in the IV administration of</td>
<td>Resource nurse to directly observe recipient nurse administering IV</td>
<td>Recipient site nurse administers IV chemotherapy to a patient/s</td>
<td>Access to eviQ Access to relevant hospital procedures</td>
</tr>
</tbody>
</table>

### Day Two

**Date of Program Commencement:**

<table>
<thead>
<tr>
<th>Participant Name:</th>
<th>Provider Site Program Coordinator:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant's Line Manager’s Name:</td>
<td>Provider Site and HHS:</td>
</tr>
<tr>
<td>Recipient Site and HHS:</td>
<td>Resource Nurse’s Name:</td>
</tr>
<tr>
<td>Time</td>
<td>Learning Objectives</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Provide MT and</td>
<td>chemotherapy using relevant ADAC competencies:</td>
</tr>
<tr>
<td>Lunch Break</td>
<td>1. Understanding how antineoplastic drugs work</td>
</tr>
<tr>
<td></td>
<td>2. Reviewing prescriptions and protocols</td>
</tr>
<tr>
<td></td>
<td>3. Assessing patients</td>
</tr>
<tr>
<td></td>
<td>4. Educating the patient and carer</td>
</tr>
<tr>
<td></td>
<td>5. Administering IV antineoplastic drugs</td>
</tr>
<tr>
<td></td>
<td>6. Preventing and managing the extravasation of antineoplastic drugs</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>