

# Queensland remote chemotherapy supervision guide (QReCS)

February 2019



## Queensland remote parenteral antineoplastic agents supervision guide

The 2014 document was developed on behalf of the statewide Rural and Remote and Cancer Clinical Networks by staff from:

- Central Integrated Regional Cancer Service (CIRCS)
- Townsville and Cairns Cancer Centres

The following are also acknowledged for their support:

- Rural and Remote Network
- Statewide Cancer Clinical Network (SCaCN)

The consultation process secured the input of a significant number of people and has improved the comprehensiveness of the document. Their time and expert opinion is greatly appreciated.

## Queensland remote parenteral antineoplastic agents supervision guide

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**Please refer to Page 6 for important disclaimer**

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## Foreword - Professor Keith McNeil

The Australian community has been clear about what it expects from healthcare services today and in the future. They want a health system that puts people first – better coordination of care, a reduction in the rate of hospital admissions and improved access to digital health services for the community as a whole. Regardless of location, ensuring Queenslanders receive clinical care within an appropriate timeframe is a key measure of success in Queensland Health’s 10-year strategy *My health, Queensland’s future: Advancing health 2026*<sup>1</sup>.

The challenge for the healthcare system in Australia has always been about how we can improve equity of access to specialist services for patients in rural and remote areas. For cancer, the challenges for those undergoing treatment are compounded when they reside in areas with insufficient local demand for specialty services - every aspect of control has a gradient of poorer outcomes the further people live from major treatment facilities. We have an opportunity to significantly improve the outcome of patients by developing a platform that will enable a delivery of cancer care that’s world class.

The digital agenda over the next 3-5 years puts Queensland in a unique position to work at both a population and individual health level to change the way care is delivered. The goal is precision medicine – knowing what we need to prescribe for therapy and diagnostics for every patient. Delivering a single, integrated record across the State is the end point.

Digital technology enables clinical innovation and continual improvements in service delivery. The **Queensland remote chemotherapy supervision (QReCS) guide 2014** was developed to support Hospital and Health Services to safely and sustainably administer parenteral antineoplastic agents closer to home for patients in rural and remote areas using mobile Telehealth technologies. A multidisciplinary steering committee with representatives from various regions across Queensland oversaw the development and revision of the guide. The requirements developed built on partnerships with Townsville and Cairns Cancer Centres, Central Integrated Regional Cancer Service (CIRCS), Rural Generalists (RGs) and General Practitioners (GPs).

The enhanced use of Telehealth technology presents an enormous opportunity to harness the cancer clinical expertise that exists in regional and tertiary facilities. It will enable patients to access medical consultations, parenteral antineoplastic agents and supportive therapies closer to home, reducing their time and monetary burden, whilst improving workforce capability through support and education.

Together, improved access to Telehealth and the revised publication of this guide will provide additional resources with which our Hospital and Health Services can contribute to improving outcomes for cancer patients living in regional, rural and remote areas of Queensland.

### **Professor Keith McNeil**

Assistant Deputy Director-General and Chief Clinical Information Officer  
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## Summary of the QReCS model and the guide

The guide has been developed to support the implementation of the QReCS model and is supported by evidence from a number of studies on Teleoncology. It is intended to support safe and sustainable shared care closer to home for patients from rural and remote areas.<sup>2</sup>

The initial steps when considering implementing the QReCS model include:

- Agreement between provider and recipient facilities, management and clinical teams
- Allocation of 3 - 6 months preparation time to implement the guide requirements

## Queensland remote chemotherapy supervision (QReCS) model



CSCF = Clinical Services Capability Framework<sup>3</sup> (Cancer Services)

To implement this model, the following 10 requirements are recommended:

1. Strategy and governance
2. Financial considerations
3. Workforce
4. Oncology systemic therapies management
5. Telehealth readiness
6. Oncology systemic therapies readiness
7. Digital Health
8. Hazardous chemicals legislation and special considerations
9. Education and training
10. Documentation and discharge

## Important disclaimer

This guide provides general implementation guidance for health professionals and managers where the administration of systemic cancer therapy/parenteral antineoplastic agents is considered a valuable and feasible way to enhance the accessibility of treatment close to home. Alternative models may be considered if oncology systemic therapy proficient nurses are located in rural facilities.

The guide does not, and is not intended to, address all operational requirements. Clinical and operational governance must ensure that any proposed services fit the local context and are affordable and safe.

The guide sets out suggested minimum requirements for the remote supervision of systemic cancer therapy/parenteral antineoplastic agents. It does not eliminate the need for a designated medical oncologist or haematologist to guide the care of the patient in conjunction with the local supervising medical practitioner. More rigorous or additional requirements may be applied by relevant clinical or operational management if desired. Hospital and Health Services (HHSs) should also consider requirements outlined in the *Clinical Services Capability Framework 2014<sup>3</sup>* (CSCF) for public and licensed private health facilities prior to deciding to implement or upgrade cancer services.

The QReCS guide and any part thereof does not, and is not intended to, substitute the advice of a qualified health practitioner and the implementation of any guidance set out herein should not be relied upon to replace the same. It is the responsibility of the relevant qualified health practitioners, support staff and healthcare decision makers to implement any of the guidance set out herein in accordance with relevant legislation, regulation, standards, codes of practice, professional and clinical standards, protocols, administrative and procedural requirements, and government policies as applicable.

The guide does not, and is not intended to, provide an exhaustive set of relevant or applicable requirements (legislative, regulatory, professional, administrative, best practice or otherwise) for the implementation of the model.

The content presented in the guide is made available by the Queensland Government as an information source only. The State of Queensland makes no statements, representations or warranties about the accuracy, completeness or reliability of any information contained in the guide. The State of Queensland disclaims all responsibility and all liability (including without limitation for liability in negligence) for all expenses, losses, damages and costs you might incur as a result of the information being inaccurate or incomplete in any way, and reliance for any reason on such information.

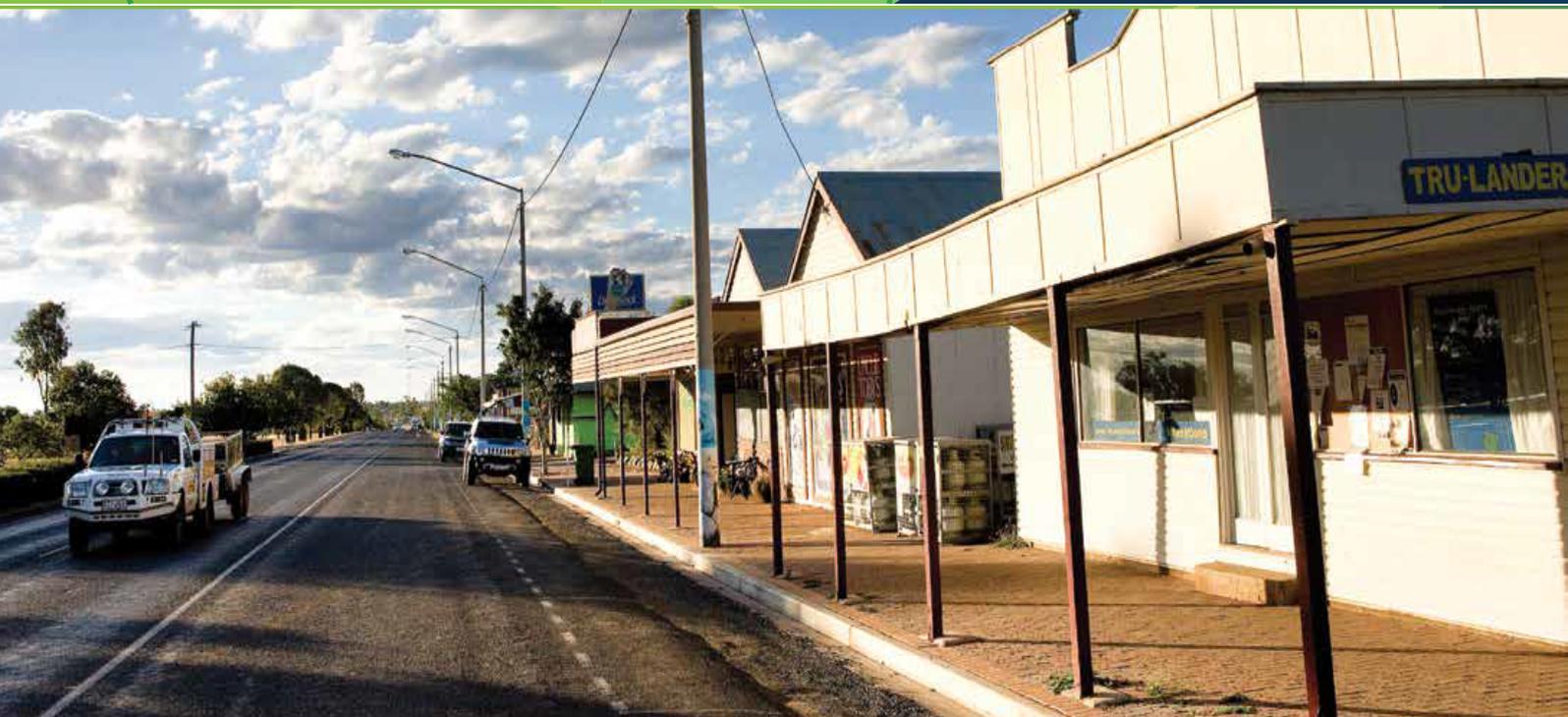
## 2018 review synopsis

Key modifications to the revised QReCS guide include, but are not limited to:

- Updated language to reflect the modern clinical practice of oncology and align with the 2018 Medical Benefits Schedule (MBS) review.
- Addition of adverse event descriptor examples for antineoplastic agents.
- Revised education matrix to support the latest module releases from eviQ Education.
- Inclusion of a Rapid Access Request form.
- Updated references and web addresses.

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## Introduction

The *Queensland Rural and Remote Health Services Framework 2014*<sup>4</sup> recognises the need to explore innovative ways to bring sustainable and equitable healthcare to Queenslanders living in rural and remote communities across the state. Queensland Health's *My health, Queensland's future: Advancing health 2026*<sup>1</sup> identifies improving access to quality and safe care in its different forms and settings as the core business of the health system, with the strategy making a commitment to increase the proportion of outpatient care delivered via Telehealth models of care by 2026.

In relation to cancer, current face-to-face and outreach models for treatment do not generally extend to hospitals that operate below Level 4 of the CSCF.<sup>3</sup> Health Professionals and Nurses involved in the management, administration and supportive care of people affected by cancer are currently required to undertake extensive training, an investment often considered too burdensome for generalist health professionals in remote areas. The Clinical Oncology Society of Australia (COSA) identified that Health Professionals and Nurses in these areas may be capable of management and administration of parenteral antineoplastic agents, however do not practice this skillset due to a lack of quality support infrastructure.<sup>5</sup> These barriers force patients to travel long distances from home to receive the specialist care required, often causing distress and considerable economic consequences. Telehealth technology has the potential to significantly reduce these hurdles.

Evaluation studies have reported positive findings<sup>6</sup>, including:

- high rates of satisfaction of Telehealth models among patients and rural health professionals;
- safety of parenteral antineoplastic agents supervision remotely; and
- cost savings to the health systems.

In addition to specialist consultations, QReCS is a model of remote parenteral antineoplastic drugs/agents supervision that incorporates treatment services (Telenursing and Telepharmacy) via Telehealth. Staff who have a formally developed working knowledge of the critical safety and quality issues relating to parenteral antineoplastic drugs/agents will have an opportunity to develop their skillset in a supported arrangement that reflects their workload. As training requirements are tailored, the model is responsive to the wide range of clinical services and transitional workforce often found in rural and remote health facilities.

Telehealth technology is applicable to all fields of oncology and all health professionals. The QReCS model not only facilitates the provision of services closer to home, but also expands the rural scope of practice and enhances service capability at rural centres. QReCS is endorsed by Queensland Health for statewide implementation.

To meet the guide's requirements, it is expected a minimum lead time of three to six months would be required.

'Achieving health equality for all Australians, regardless of race, income and place of residence, has been identified as one of the greatest health challenges Australia faces.' To effectively address this challenge, the extent of health inequalities needs to be quantified, as was recommended by the *World Health Organization Commission on the Social Determinants of Health*. Specifically, an understanding of spatial patterns of cancer helps health planners, service providers, other health professionals and the general public to assess the current needs and understand the relative health burdens caused by each type of cancer.<sup>7</sup>

An example of a Teleoncology consultation is illustrated in the YouTube video *Royal Australasian College of Physicians (RACP): Introduction to Telehealth*.<sup>8</sup>

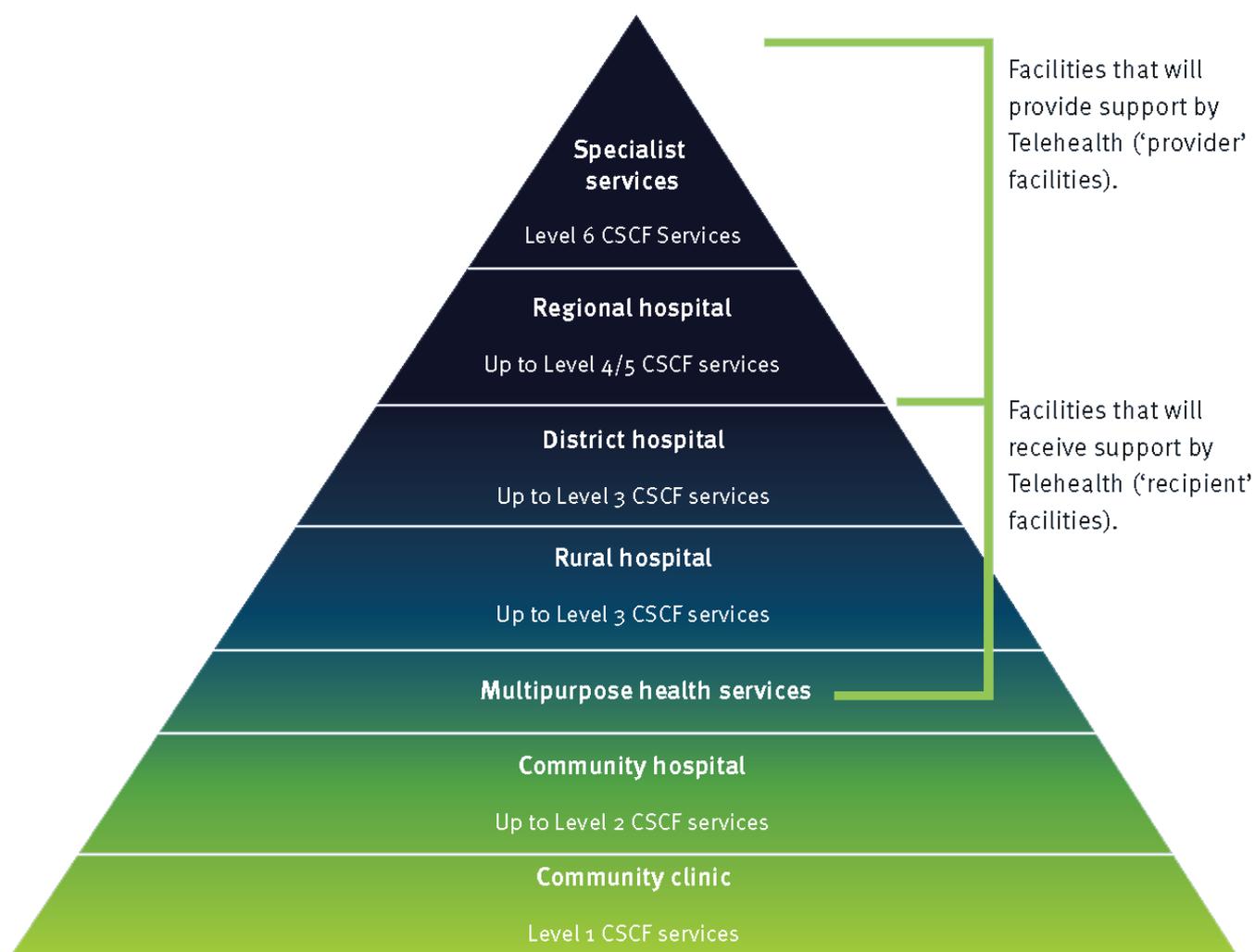
# Purpose

The QReCS guide provides guidance on the minimum requirements for the management and administration of parenteral antineoplastic agents close to home for rural and remote people affected by cancer within an ambulatory care setting.

Adopting the approach set out in this guide enables shared care and is intended to maximise the scope and safety for the management and administration of parenteral antineoplastic agents at rural and remote facilities. It also aims to assist health service managers to identify prerequisite and associated procedures.

The guide assumes a service model where support and supervision for the management and administration of parenteral antineoplastic agents is provided to doctors, nurses and allied health staff in rural and remote facilities by cancer care specialists from facilities operating at Levels 4, 5 and 6 of the CSCF.<sup>3</sup> The guide adopts the hierarchy of health services included in the *Rural and Remote Health Services Framework 2014*.<sup>4</sup> The range of facilities to which this document applies is shown in Figure 1.

## Figure 1 - Health Service network





## Queensland remote chemotherapy supervision (QReCS) model



CSCF = Clinical Services Capability Framework<sup>3</sup> (Cancer Services)

### Implementation requirements

There are ten minimum implementation requirements recommended to ensure provider and recipient facilities are prepared for the safe and sustainable management and administration of parenteral antineoplastic drugs/agents in rural and remote locations.

Hospitals enthusiastic about harnessing Telehealth to enhance cancer services in small communities should ensure they consider all of these requirements prior to committing to provide or support the provision of parenteral antineoplastic drugs/agents. Some requirements will take significant time and effort to achieve and as such, allowing adequate time prior to the commencement of services is critical to ensuring optimal safety and managing patient expectations.



# 1. Strategy and governance

Provider and recipient facilities need to ensure investment in Telehealth services is consistent with a coherent strategy for the development of cancer services in the relevant HHS or group of HHSs in accordance with the CSCF.<sup>3</sup>

This will ensure:

- the investment contributes to achieving the service’s vision;
- an analysis is undertaken of the financial impact of an increase in Telehealth services;
- any location-specific risks are identified and mitigated; and
- the role of Telehealth is incorporated 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 safe, effective, sustainable, supported and affordable.

Governance should reinforce integration between Telehealth and ‘traditional’ parts of the service. As such, a separate governance committee is not recommended. Instead, it is recommended that senior officers responsible for Telehealth should be brought onto 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 Medicare Benefits Schedule (MBS) revenue, private patient billing and Pharmaceutical Benefits Scheme (PBS) claims; and
- performance metrics, monitoring and reporting the approach to resolving issues.

In relation to parenteral antineoplastic agents, a key element of governance relates to the agreement of drugs/agents 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. In general, both provider and recipient facilities may claim MBS items for Telehealth consultations.

## 2. Financial considerations

MBS billing for parenteral antineoplastic agents administration is attributable to the cancer specialist who is responsible for that treatment. The capacity to claim MBS reimbursement for health services is contingent on meeting a range of conditions. 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.mbsonline.gov.au](http://www.mbsonline.gov.au)

Recipient and provider facilities may both count Telehealth consultations as occasions of service under the activity based funding (ABF) model. Recipient facilities may additionally count parenteral antineoplastic agents administration as an ABF occasion of service.

Most parenteral antineoplastic agents are reimbursed by the PBS and therefore would not be expected to increase the overall cost of drugs/agents incurred at recipient sites. Recipient facilities need to refer to [www.pbs.gov.au](http://www.pbs.gov.au) to verify reimbursement can be claimed for the indication for which parenteral antineoplastic agents are prescribed.

A service level agreement between provider and recipient facilities will help clarify arrangements regarding funding, billing and sharing of revenue for services delivered.

## 3. Workforce

While it demands the same standards of safety and quality of care, the QReCS model requires different workforce arrangements than those which usually provide cancer care. This section outlines the key workforce needs in both provider and recipient facilities.

To be successful, the Telehealth model requires both the provider and recipient sites to be fully engaged and committed. Recipient facilities will need to support additional local education to meet these requirements before QReCS-based services commence. All staff involved in the management and handling of parenteral antineoplastic drugs/agents must have access to applicable information, education and network support, whether it be via videoconferencing, seminars or in-services. As treatment modalities change, recipient sites need to adjust to the new requirements.

A local registered medical practitioner must be identified as responsible for the overall continuity of care of the patient. The local registered medical practitioner must also be available 24 hours for management of any complications. During administration, a registered medical practitioner must also be present onsite to deal with any administration issues, including local reactions as well as allergic reactions, hypersensitivities and anaphylaxis.

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



It is recommended that pharmacists undertake the SHPA ClinCAT cancer competency. ClinCAT is the clinical competency assessment tool developed by the Society of Hospital Pharmacists of Australia (SHPA).<sup>9</sup>

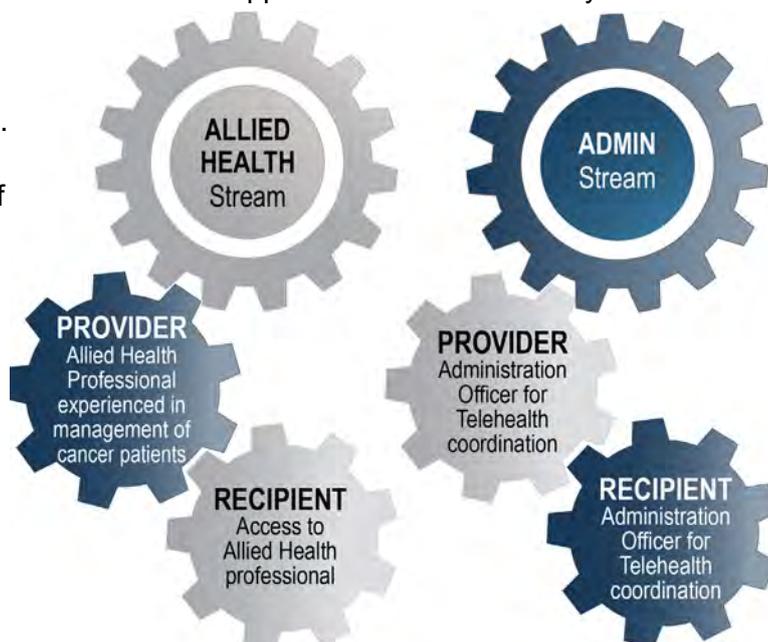
The QReCS model does not displace the need for health professionals to comply with their obligations to maintain a training record and to work within their skill set and defined scope of practice.

Various combinations of the workforce described above are required at various points during a patient's care (further details can be found in Section 7.2). Fundamentally, however, there must at all times be identified health professionals within each profession who are responsible for and understand their role in supporting the delivery of cancer care at provider and recipient facilities.

A key enabler in the successful implementation of the QReCS model is the engagement of staff at both the provider and recipient facilities whose Telehealth-related work is supported and understood by executive and senior administration staff.<sup>10</sup>

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; and
- advance testing the interoperability of provider/recipient Telehealth equipment.



## 4. Oncology systemic therapies management

The QReCS model relates to parenteral antineoplastic agents, monoclonal antibodies (mAbs), tyrosine kinase inhibitors (TKIs) and other therapies where the likelihood or consequence of hypersensitivity, adverse drug reactions and extravasations are minimal or manageable. The shelf life of any prepared products also needs to be considered when identifying parenteral antineoplastic agents appropriate for administration in rural and remote facilities. The ability to meet refrigeration and safe transport requirements for parenteral antineoplastic agents and supportive therapies (some of which are classified as dangerous goods) needs to be considered before offering care in rural and remote facilities. Planning should take into consideration that at least the first dose will be given at the provider facility to assess adverse drug reaction risk and for demonstrating clinical activities to the remote site via Telehealth.

Usually protocols with a relatively low to medium risk of complications, including those not normally expected to produce hypersensitivity and vesicant reactions, can be administered under the QReCS model unless a rural site is staffed by a chemotherapy competent nurse. In a study published in the *Journal of Oncology Practice*<sup>2</sup>, administration of various single and combination agents including paclitaxel and immunotherapy agents were found to be feasible and safe in North Queensland.

There must also be documented procedures within the recipient HHS for overnight and/or emergency admission of patients if required.

The QReCS model allows the supply of parenteral antineoplastic agents for administration to be undertaken by a pharmacist at either the provider or recipient facility. The sites supplying the agents must have Medicare approval to supply PBS subsidised medicine in accordance with Section 90 of the *National Health Act 1953*.<sup>11</sup>

Where the recipient hospital has a pharmacist onsite, the clinical screening, ordering and dispensing of parenteral antineoplastic agents and mAbs may be undertaken by the pharmacist. The pharmacist should be responsible for all other medication reconciliation tasks including recording of adverse drug reaction, medication history, issue of Consumer Medicines Information (CMI) and provision of supportive drugs to take at home. They should refer to eviQ guidelines and be familiar with information sources and the following standards of practice:

- *COSA Guidelines for the safe prescribing, dispensing and administration of system cancer therapy*<sup>12</sup>
- *SHPA Standards of Practice for the Provision of Clinical Oncology Pharmacy Services*<sup>13</sup>
- *SHPA Oncology and Haematology and Compounding Services - Handling and Transport of Cytotoxics Guideline 2018-2019*<sup>14</sup>

Support and close liaison from a cancer pharmacist at the provider site is essential to help build the required competency in practice.

- If a recipient facility does not have a pharmacist and is supplied using outreach services from provider hospitals, the supply of parenteral antineoplastic agents may be undertaken in accordance with existing arrangements provided the above standards and relevant legal requirements are met.

For recipient sites without access to a pharmacist, parenteral antineoplastic agents, mAbs and TKIs may be managed as described below:

- a provider site pharmacist clinically validates orders and dispenses parenteral antineoplastic agents and all supportive drugs;
- a pharmacist at the provider facility performs relevant medication reconciliation tasks;

- parenteral antineoplastic drugs/agents are manufactured on site at the provider facility using a Cytotoxic Drug Safety Cabinet (CDSC) or Pharmaceutical Isolator;
- parenteral antineoplastic drugs/agents are packaged in a dedicated container for that patient and sent by courier; and
- parenteral antineoplastic drugs/agents are received by the antineoplastic supervised or capable nurse at the recipient site and stored correctly until required for administration.

The parenteral antineoplastic drugs/agents may be obtained in a 'ready to administer' format from a TGA-registered provider. All Queensland Health facilities are required to purchase all manufactured parenteral antineoplastic drugs/agents from applicable standing offer arrangements, including an agreed pricing structure. The provider or recipient site should make arrangements with the supplier to supply the drugs/agents and agree on processes for ordering and delivery including schedules and costs. It is important to note that these suppliers act as manufacturers and not pharmacies and hence do not replace the need for clinical verification of parenteral antineoplastic drugs/agents by a registered pharmacist.

Funding arrangements for treatment should be agreed between provider and recipient. The dispensing site will be responsible for claiming PBS payment for drugs used. The use of drugs not listed for PBS reimbursement need to be agreed by the provider and recipient sites, as costs will be borne by the dispensing facility.

For drugs subject to the *PBS Revised Arrangements for the Efficient Funding of Chemotherapy Drugs & Streamlined Authority Data Capture*<sup>15</sup>, dispensing facilities that have onsite pharmacy services must be able to undertake paperless dispensing and online claiming through iPharmacy. The dispensing facility must also be licensed to supply PBS drugs from a public hospital. Drugs listed under *The National Health Highly Specialised Drugs (HSD) Program*<sup>16</sup>, or Section 100 drugs, require written prescriptions and the ability to submit a PBS claim.

Paper prescriptions are required for non-public hospital PBS dispensing of parenteral antineoplastic drugs/agents. It is the responsibility of the provider site medical officer to ensure the appropriate prescriptions are written to support the reimbursement process. Pharmacists at the site responsible for claiming the PBS reimbursement should liaise with the oncologist/haematologist to ensure appropriate authorities are obtained and prescriptions generated.

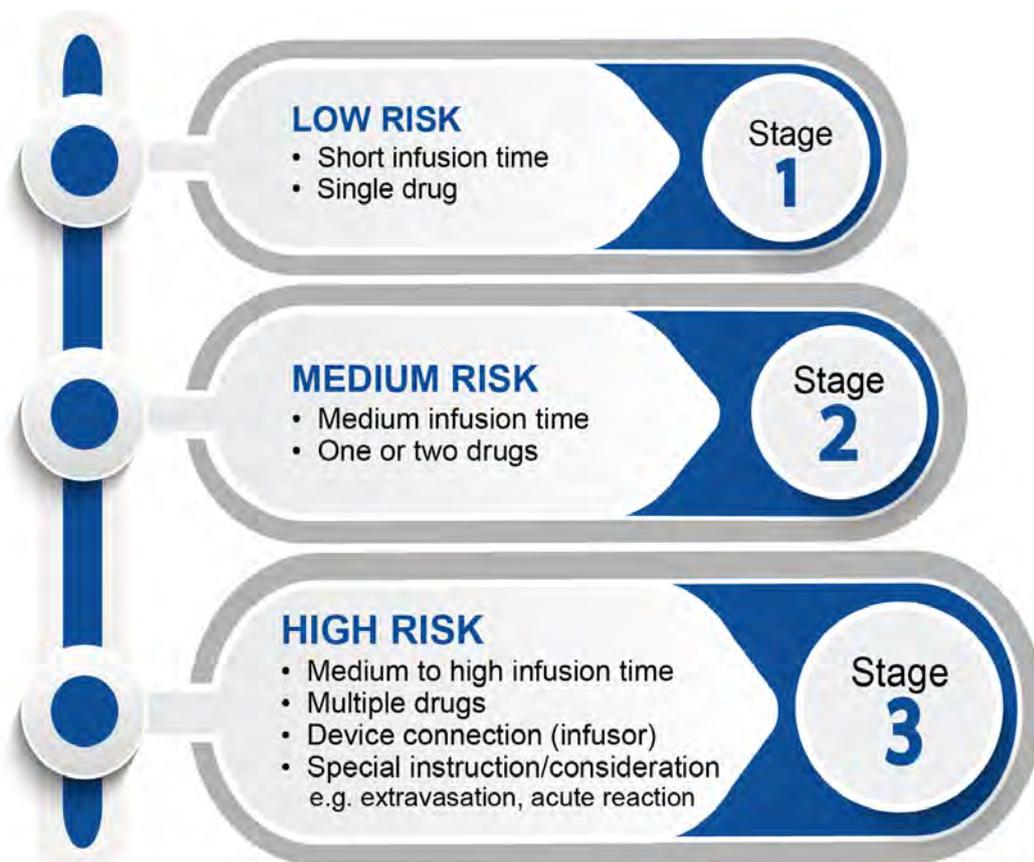
Rather than the provision of numerous treatments upon adoption of the QReCS model, the range of treatments provided at each recipient facility should increase gradually. Antineoplastic drugs/agents can be added by way of a staged approach as medical, nursing and pharmacy confidence and experience develops with the QReCS model. A process must be agreed between each provider and recipient site for increasing the range of available treatments by way of a staged approach, with final endorsement required from both sites. The process must be approved by the relevant clinical governance committees at each facility prior to being put into practice.

Factors influencing the ability to deliver parenteral antineoplastic drugs/agents include:

- resource requirements to administer treatments (e.g. equipment, staff, space etc.);
- requirements for cytotoxic waste management;
- the ability to obtain supply of necessary drugs/agents;
- drug/agent stability and storage;
- risk of infusion-related reaction and protocols for management of reactions;
- competency and confidence, training, knowledge and skill of staff (medical, nursing and pharmacy);
- complexity of the patient and intent of treatment; and
- complexity of regimen.

As noted previously, decisions as to the appropriateness of administering parenteral antineoplastic drugs/agents at any stage need to be made jointly by the provider and recipient facilities and require the agreement of the appropriate clinical governance committees. The factors outlined previously will influence the decision to move between the stages.

## Considerations



## Antineoplastic drug/agent adverse event descriptors

Utilising the Common Terminology Criteria for Adverse Events<sup>17</sup> (CTCAE), the table below may assist in the assessment of drugs/agents for patients receiving care at the recipient facility based on their toxicity profile.

Adverse event example	CTCAE Grade		
	2	3	4
<b>Infusion site extravasation</b>	Moderate; minimal, local or noninvasive intervention indicated; limiting age-appropriate instrumental ADL*	Severe or medically significant but not immediately life-threatening; hospitalization or prolongation of hospitalization indicated; disabling; limiting self care ADL**	Life-threatening consequences; urgent intervention indicated
<b>Allergic reaction</b>	Erythema with associated symptoms (e.g. edema, pain, induration, phlebitis)	Ulceration or necrosis; severe tissue damage; operative intervention indicated	Life-threatening consequences; urgent intervention indicated
<b>Peripheral motor neuropathy</b>	Intervention or infusion interruption indicated; responds promptly to symptomatic treatment (e.g. antihistamines, NSAIDs, narcotics); prophylactic medications indicated for <=24 hrs	Prolonged (e.g. not rapidly responsive to symptomatic medication and/or brief interruption of infusion); recurrence of symptoms following initial improvement; hospitalization indicated for clinical sequelae (e.g. renal impairment, pulmonary infiltrates)	Life-threatening consequences; urgent intervention indicated
<b>Nausea</b>	Moderate symptoms; limiting instrumental ADL	Severe symptoms; limiting self care ADL; assistive device indicated	Life-threatening consequences; urgent intervention indicated
	Oral intake decreased without significant weight loss, dehydration or malnutrition	Inadequate oral caloric or fluid intake; tube feeding, TPN, or hospitalization indicated	-

\*Instrumental ADL refer to preparing meals, shopping for groceries or clothes, using the telephone, managing money, etc.  
 \*\*Self care ADL refer to bathing, dressing and undressing, feeding self, using the toilet, taking medications, and not bedridden.

Arrangements will need to be agreed in relation to the shipment of drugs/agents between provider and recipient sites. Options include:

- having drugs/agents delivered directly to recipient facilities from external suppliers; and
- having the provider site pharmacist oversee clinical assessment/review and logistics for ordering and shipment of drugs/agents.

All parenteral antineoplastic agents are prescribed by the provider cancer care oncologist. Appropriate arrangements need to be in place between the provider and recipient for claiming reimbursement through the PBS. Days of delivery of service must be considered, as well as lead time for delivery from order to physical possession. A logistical path for supply must be written, taking both provider and recipient facilities into account. This should also cover compassionate use items that come direct from the manufacturer. Any cost is borne by provider site.



## 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.

The Australian College of Rural and Remote Medicine and the Royal Australasian College of Physicians have produced practical resources that will assist in effectively planning for Telehealth consultations.<sup>18,19</sup>

The resources cover such planning as:

- connectivity and bandwidth;
- lighting, sound and contrast;
- eye contact and body language;
- social media guidelines; and
- patient consent and privacy.

Queensland Health has one of the largest managed Telehealth networks in Australia, coordinated by the Telehealth Support Unit whose team have also developed an expansive range of useful resources<sup>20</sup>.

The Royal Australian College of General Practitioners have developed *Standards for general practices offering video consultations*<sup>21</sup> and The Australian Nursing Federation have published *Telehealth professional practice standards: Registered Nurses*<sup>22</sup> for their members.

Provider and recipient facilities should review this material to ensure they understand the benefits and limitations of Telehealth and how they can influence the success of services delivered through this model.

## 5.2 Videoconferencing equipment

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 parenteral antineoplastic drugs/agents. For assessing reactions, however, video or web cameras used at the recipient site need to have the capacity to zoom in while retaining good resolution. Equipment that is attached to small mobile trolleys or stands will greatly assist in achieving the ideal level of maneuverability.

Clinical staff should be able to operate videoconferencing equipment with minimal skill. This ability is essential for the efficiency and safety of the QReCS model. It is recommended for staff who will be participating in Telehealth consultations or treatment to undertake basic training. Telehealth coordinators at provider and recipient sites could facilitate this. In addition, a good relationship with the IT support team at each facility will be useful for maintenance and major trouble shooting.

To ensure effective infection control, the videoconferencing equipment should be included in routine cleaning if it forms part of the patient environment. The equipment manufacturer should be consulted as to what products are safe to use.



## 6. Oncology systemic therapies readiness

### 6.1 Parenteral antineoplastic drug/agent administration area

The area in which antineoplastic drugs/agents are administered needs to be clean, adequately ventilated and well lit. Day surgery recovery areas in rural and remote facilities may provide a suitable location for parenteral antineoplastic drug/agent management and administration.

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 parts of the facility;
- there is sufficient room to perform tasks safely;
- the area is tidy and free from obstacles;
- all equipment can be easily moved 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 antineoplastic agents;
- there is an appropriate storage area for antineoplastic drugs/agents, encompassing both non-refrigerated and refrigerated items (any fridges in which antineoplastic drugs/agents are stored need to be electronically monitored and alarmed with the capacity to separate antineoplastic drugs/agents from other drugs in rigid walled containers); and
- staff eating and drinking and the storage of food are restricted where parenteral antineoplastic drugs/agents are administered.

The *Australasian Health Facility Guidelines*<sup>23</sup> developed by NSW Health and the Australasian Health Infrastructure Alliance, provide further details of the ideal configuration for an ambulatory care unit. While it is not expected that recipient facilities will meet every aspect of those guidelines, it is important the area chosen to administer antineoplastic drugs/agents does not expose the general public or health workers to unnecessary risk.

## 6.2 Personal protective equipment

Personal protective equipment (PPE) is essential for particular tasks associated with administering antineoplastic agents and waste management.<sup>24</sup>

The following list is mandatory for use by any staff administering parenteral antineoplastic agents:

- impermeable long sleeved gown with knitted cuffs;
- purpose-manufactured gloves or two pairs (double layer) of surgical latex powder free gloves;
- protective eyewear; and
- respiratory protective equipment (N95).

A further list of essential equipment and consumables is accessible via Queensland Health intranet (<http://qheps.health.qld.gov.au/circs>).

## 6.3 Supportive care

Antineoplastic drugs/agents must only be delivered if appropriate supportive care structures are in place to deal with predicted or common complications during or after administration. These supportive care requirements must be in line with those set out in the medical oncology and haematology malignancy services sections of the CSCF<sup>3</sup>, including:

- documented processes for overnight and emergency admission of patients if required;
- documentation (by standard operating procedures) of local policies and procedures for management of commonly expected parenteral antineoplastic agent-related complications, including (but not limited to) febrile neutropenia guidelines and transfusion guidelines;
- access to Level 3 pathology services, such that routine haematology and biochemistry test results available on the same day of collection (e.g. full blood count, coagulation studies and ELFT results) and that a same day transfusion service including access to cross matched blood is available locally;
- for treatment of some specific cancer types, including Hodgkin's lymphoma and chronic lymphocytic leukaemia (treated with fludarabine-based therapy), access to irradiated blood products must be available as part of the local transfusion service; and
- access to Level 2 medical imaging service, including availability of 24-hour X-ray services and non-complex ultrasound investigations.

## 6.4 Medical staff requirements

A local registered medical practitioner must be identified as responsible for the overall continuity of care of the patient. The local registered medical practitioner must also be available 24 hours for management of any complications. During administration, a registered medical practitioner must also be present onsite to deal with any administration issues, including local reactions as well as allergic reactions and anaphylaxis.

## 6.5 Other equipment

As noted above, a list of essential equipment and consumables is accessible internally only via Queensland Health intranet (<http://qheps.health.qld.gov.au/circs>).



## 7. Digital Health

### 7.1 Patient information management system

As the QReCS model will generally form 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 patient information for managing prescriptions, administration and documentation.

In accordance with existing policies, if each facility operates using a different ieMR, patient information will need to be transferred between facilities. Sufficient lead time will need to be allowed to ensure all relevant patient information is available at the respective sites prior to consultations being conducted or Antineoplastic systemic therapies drugs/agents being administered.

The ieMR used should have the relevant functionality needed to ensure safe and appropriate prescribing, supply and administration of parenteral antineoplastic agents. This should include entry and retrieval of patient information from Queensland Health systems such as Patient Administration System (PAS) (including patient Unit Record) and adverse drug alerts. Clinical information (e.g. drugs and protocols) and calculations (e.g. Body Surface Area, dosages) should be supported, validated and subject to a regular review process.

This is of particular importance where staff in recipient sites may not have the expertise to identify errors that may occur as part of a system error (e.g. dose miscalculation, prescribing of drugs/agents to which a patient has a known adverse drug reaction).

## 7.2 Logistics and administration support

Given the need to coordinate medical and nursing staff across at least two different sites, clinical and administration officers need to fully consider the logistical and support needs for the remote provision of medical consultations and supervision of parenteral antineoplastic agents.

This section provides a list of core requirements for each of the HHS services that are within the scope of the QReCS model. It is intended this will assist in identifying potential hurdles that need to be addressed before a facility is ready to provide a safe and sustainable parenteral antineoplastic agent management and administration service.

### Medical consultations

- clinic room or office (at both provider and recipient sites), access to compatible videoconferencing equipment;
- concurrent availability of oncology/haematology specialist (provider) and general medical officer (recipient), plus a time allowance for overrunning (for staff and facilities) at both provider and recipient sites;
- access in both locations to patient information, inclusive of all pathology and radiology investigations and results; and
- attendance of patient.

### Nurse consultations

- clinic room or office (at both provider site and recipient sites), access to compatible videoconferencing equipment;
- concurrent availability of parenteral antineoplastic agent proficient nurse at provider and parenteral antineoplastic agent capable or supervised nurse at recipient facilities, plus a time allowance for overrunning (for staff and facilities) at provider and recipient sites;
- access in both locations to patient information, inclusive of all pathology and radiology investigations and results; and
- attendance of patient.

### Pharmacist discussion

- telephone or videoconferencing equipment;
- access to parenteral antineoplastic agents and supportive care prescriptions;
- access to patient medical records or summary including through integrated electronic medical record (ieMR);
- access to laboratory results;
- concurrent availability of cancer pharmacist (provider) and pharmacist (recipient) - note: in some situations, the pharmacist supporting the recipient site is the outreach pharmacist that is located at the provider site. In these situations the outreach pharmacist (who is located at the provider site) may support the recipient site via Telehealth; and
- a time allowance for overrunning (for staff and facilities) at provider and recipient sites.

## Antineoplastic drug/agent management and administration<sup>25</sup>

- access to iPharmacy with online PBS system or equivalent;
- videoconferencing equipment (ideally on a small, mobile stand at recipient facility);
- access at both locations to all equipment and consumables (list accessible via QHEPS on <http://qheps.health.qld.gov.au/circs>);
- access in both locations to patient information, inclusive of all pathology and radiology investigations and results;
- parenteral antineoplastic agent proficient nurse at provider facility appropriately scheduled (i.e. one chair booked in provider facility day oncology unit to account for remote direct supervision activity);
- parenteral antineoplastic agent capable or supervised nurse at recipient facility appropriately scheduled;
- access to appropriate space at recipient facility for administration of parenteral antineoplastic agents;
- a time allowance for overrunning (for staff and facilities) at both ends;
- medical and nursing consultations have occurred before parenteral antineoplastic agent administration;
- documented pharmacy handover, including adverse drug reaction (ADR) checking and drug reconciliation/history has occurred before parenteral antineoplastic agent administration;
- medical officer available at recipient site during parenteral antineoplastic agent management and administration; and
- attendance of patient.

## Allied Health consultation or treatment

- clinic room or office (consultations) or treatment room (treatment) in both locations, with access to compatible videoconferencing equipment;
- concurrent availability of specialist oncology Allied Health (provider) and general Allied Health (recipient) professionals;
- a time allowance for overrunning (for staff and facilities) at both sites;
- access in both locations to patient information, inclusive of all pathology and radiology investigations and results; and
- attendance of patient.

## 8. Hazardous chemicals legislation and special considerations

Legislation related to the management of hazardous chemicals including parenteral antineoplastic drugs/agents imposes obligations on healthcare providers to ensure workers, visitors and the environment are not exposed to health and safety risks. The legislation requires relevant safe control measures such as procedures, information, instructions and training are provided. These must comply with the legislation and best practice and be readily accessible to all workers to eliminate risks of exposure to hazardous chemicals. <sup>25,26,27,28,29,30,31,32</sup>

All staff who dispense or handle parenteral antineoplastic agent waste must have access to appropriate education and reference documents to reduce the risk of exposure to persons and the environment. <sup>25,26,28,29,33</sup>

Facilities must identify and coordinate relevant training that is individualised to the parenteral antineoplastic agent-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 <http://qheps.health.qld.gov.au/circs>.

Comprehensive records of cytotoxic safety training must be kept. Records must include:

- session date;
- session topic;
- name of person who conducted the session; and
- names of participants.

Additional information is provided via the Queensland Health intranet at <http://qheps.health.qld.gov.au/circs>.

## 9. Education and training

### 9.1 Medical staff

The QReCS guide recommends no specific formal parenteral antineoplastic agent-specific education requirements for medical officers at the recipient facility. The medical oncologist or haematologist at the provider facility should provide the recipient facility medical officer with an overview of the prescribed parenteral antineoplastic agents regimen and side effects during the Telehealth consultation. Ideally, the same medical officer should provide support to the recipient facility medical officers to ensure training is maintained.

The medical officer at the provider facility responsible for the overall continuity of care of the patient is recommended to undertake basic specialty and parenteral antineoplastic agent-specific training. This may include completion of the Australian College of Rural and Remote Medicine cancer education modules for general practitioners (EPICC)<sup>34</sup>, including (but not limited to) febrile neutropenia and transfusion guidelines. Additionally, the local medical practitioner may undertake specific education sessions delivered by the provider Telehealth facility (i.e. the facility at CSCF<sup>3</sup> Level 4,5 or 6) with respect to local diagnostic, management and treatment pathways for the cancer types being managed.

Furthermore, the local medical practitioner must have access to a multi-disciplinary consultation group, including registered specialists with credentials in medical oncology, clinical haematology, radiation oncology and medical radiology and ideally, anatomical pathology for appropriate development of individual patient management strategies.

It is recommended that further knowledge is also attained by the local medical practitioner from various websites, including *COSA Guidelines for the Safe Prescribing, Dispensing and Administration of Systemic Cancer Therapy*<sup>12</sup> and procedure manuals of provider sites.

### 9.2 Nurses administering parenteral antineoplastic drugs/agents<sup>35,36</sup>

Nurses administering parenteral antineoplastic drugs/agents must complete the education requirements outlined below. At a minimum, nurses must:

- be, or have access to a clinician who is, proficient in intravenous cannulation as per your local facility policy and guidelines;
- have completed an appropriate Central Venous Access Devices<sup>37</sup> (CVAD) learning package and competency; and
- have completed the appropriate components of the Cancer Institute NSW eviQ Education Antineoplastic Drug Administration Course<sup>43</sup> (ADAC).

#### 9.2.1 IV cannulation

As parenteral antineoplastic agent administration will regularly require the cannulation of patients who do not have CVADs, it is essential that all nurses delivering parenteral antineoplastic drugs/agents are proficient in IV cannulation or have access to clinical staff who are (e.g. anaesthetist or anaesthetic nurse).

## 9.2.2 Central Venous Access Devices<sup>37</sup> (CVAD)

Nurses administering parenteral antineoplastic drugs/agents at recipient facilities must have completed an appropriate learning package on the management of Central Venous Access Devices<sup>37</sup> (CVAD) and have attended a CVAD<sup>37</sup> workshop that promotes current evidence-based practice and aligns with Standards 3 and 4 of the *National Safety and Quality Health Service Standards* (NSQHS)<sup>38</sup>, *CNSA eviQ CVAD guidelines*<sup>39</sup> and *Centre for Healthcare Related Infection Surveillance and Prevention (CHRISP), IVD ICARE*.<sup>40</sup>

These workshops may be available locally in some HHSs or staff may access the CVAD<sup>37</sup> Tele-education workshop that is conducted regularly by CIRCS throughout the calendar year. Ideally, recipient facilities will encourage nursing staff to demonstrate CVAD<sup>37</sup> competency via an approved assessment tool<sup>41,42</sup>. Provider site nurses supervising parenteral antineoplastic agents at recipient facilities must be able to demonstrate that they are CVAD<sup>37</sup> proficient.

## 9.2.3 Antineoplastic Drug Administration Course (ADAC)

The main education resource which supports the QReCS model is Antineoplastic Drug Administration Course<sup>43</sup> (ADAC) developed by the Cancer Institute NSW and endorsed for use in Queensland Health. ADAC<sup>43</sup> comprises both theoretical and practical elements, all of which are assessed on a modular basis.

ADAC<sup>43</sup> is accessible through eviQ Education's website and may be available through local Learning Management Systems. Nurse Managers and Educators at rural and remote facilities may consult with CIRCS (<http://qhps.health.qld.gov.au/circs>) to coordinate the best approach for nurses to complete practical aspects of ADAC<sup>43</sup>. In many cases, it will be appropriate for some competency-based assessments to be undertaken by video-conference.

Finally, it is expected that nurses administering parenteral antineoplastic drugs/agents will have completed their annual mandatory requisites, such as Basic Life Support (BLS) as per their local facility policies, procedures and guidelines.

## 9.3 Nursing skill taxonomy

A parenteral antineoplastic supervised nurse is defined as a nurse who has completed the following:

- Proficient in IV cannulation (if nurse is not proficient, access to a proficient clinician is sufficient).
- A CVAD<sup>37</sup> learning package and workshop and is working towards being deemed competent as determined by provider site.
- All required ADAC<sup>43</sup> eQuizzes and supervised clinical practice assessments up to the referred exit point.

A parenteral antineoplastic capable nurse is defined as a nurse who has completed the following:

- Proficient in IV cannulation (if nurse is not proficient, access to a proficient clinician is sufficient).
- A CVAD<sup>37</sup> learning package and workshop as determined by provider site and has been deemed competent via successful completion of a relevant assessment tool.
- All required ADAC<sup>43</sup> eQuizzes and supervised clinical practice assessments up to the referred exit point.

A parenteral antineoplastic proficient nurse is defined as a nurse who has completed the following:

- Proficient in IV cannulation (if nurse is not proficient, access to a proficient clinician is sufficient).
- A CVAD<sup>37</sup> learning package/workshop as determined by provider site and has been deemed competent via successful completion of a relevant assessment tool and has a minimum of three years' experience.
- All required ADAC<sup>43</sup> eQuizzes and supervised clinical practice assessments up to the final exit point.

### 9.3.1 Central Venous Access Devices Course<sup>37</sup> (CVAD)

Category	Minimum recommended requirement
Supervised	➔ Completed a CVAD learning package and workshop, work towards competency as determined by provider site.
Capable	➔ Deemed competent using a competency assessment tool, i.e. local site tool or EdCaN Competency Assessment Tool for management of CVADs or eViQ Education Competency Assessment Tools for CVADs.
Proficient	➔ Deemed competent with a minimum of three years' experience.

### CVAD<sup>37</sup> Course Modules

Module	Completion requirements	Average learning hours
Principles of central venous access devices	<ul style="list-style-type: none"> <li>➔ eLearning guides (2)</li> <li>➔ eQuiz</li> </ul>	1.25
Patient assessment and education	<ul style="list-style-type: none"> <li>➔ eLearning guides (2)</li> <li>➔ eQuiz</li> </ul>	1.25
Care and management of CVADs	<ul style="list-style-type: none"> <li>➔ eLearning guides (4)</li> <li>➔ eQuiz</li> </ul>	2.25

### 9.3.2 Antineoplastic Drug Administration Course<sup>43</sup> (ADAC)

Category	Minimum recommended requirement
Supervised	➔ Completed select ADAC modules and delivers anti-cancer therapies (including chemotherapy) under direct supervision only.
Capable	➔ Completed ADAC in full and regularly delivers anti-cancer therapies (including chemotherapy).
Proficient	➔ Completed ADAC in full and has three years' experience regularly delivering anti-cancer therapies (including chemotherapy).

	Module	Completion requirements	Average learning hours
<b>Supervised</b>	Handling antineoplastic drugs and related waste safely	<ul style="list-style-type: none"> <li>➤ eLearning guide</li> <li>➤ eQuiz</li> </ul>	2.25
		<ul style="list-style-type: none"> <li>➤ Competency assessment</li> <li>➤ Exit point</li> </ul>	Learners pace
<b>Capable</b>	Understanding how antineoplastic drugs work	<ul style="list-style-type: none"> <li>➤ eLearning guide</li> <li>➤ eQuiz</li> </ul>	2.25
	Reviewing protocols and prescriptions	<ul style="list-style-type: none"> <li>➤ eLearning guide</li> <li>➤ eQuiz</li> </ul>	2.25
	Educating the patient and carer	<ul style="list-style-type: none"> <li>➤ eLearning guide</li> <li>➤ eQuiz</li> </ul>	2.25
	Assessing patients	<ul style="list-style-type: none"> <li>➤ eLearning guide</li> <li>➤ eQuiz</li> </ul>	2.25
	Administering oral antineoplastic drugs	<ul style="list-style-type: none"> <li>➤ eLearning guide</li> <li>➤ eQuiz</li> </ul>	2.25
		<ul style="list-style-type: none"> <li>➤ Supervised clinical practice</li> <li>➤ Competency assessment</li> <li>➤ Exit point</li> </ul>	Learners pace Learners pace
<b>Proficient</b>	Administering antineoplastic drugs	<ul style="list-style-type: none"> <li>➤ eLearning guide</li> <li>➤ eQuiz</li> </ul>	2.25
		<ul style="list-style-type: none"> <li>➤ Supervised clinical practice</li> <li>➤ Clinical skills workshop</li> <li>➤ Competency assessment</li> <li>➤ Exit point</li> </ul>	Learners pace

## 9.4 Recipient site requirements

A parenteral antineoplastic supervised or capable nurse is required to manage and administer drugs/agents to patients at recipient facilities.

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 a participant's ADAC<sup>43</sup> certificates of completion prior to scheduling attendance by nurses from recipient sites.

The competencies for 'Handling antineoplastic drugs and related waste safely' and 'Administering oral antineoplastic drugs' can be undertaken through simulation via videoconferencing. This service may be provided by the provider site or by contacting <http://qheps.health.qld.gov.au/circs> (with consultation).

## 9.5 Provider site requirements

A parenteral antineoplastic proficient nurse at the provider site is required to supervise the administration of drugs/agents to patients at recipient facilities.

The competencies for 'Handling antineoplastic drugs and related waste' and 'Administering oral antineoplastic drugs' can be undertaken through simulation via videoconferencing. This service may be provided by the provider site or by contacting <http://qheps.health.qld.gov.au/circs> (with consultation).

Successful completion of all ADAC<sup>43</sup> requirements, including skills development workshop and minimum of three years' experience in the delivery of parenteral antineoplastic drugs/agents will lead to a nurse being deemed parenteral antineoplastic proficient. This is the minimum education and experience level required to supervise the administration of parenteral antineoplastic drugs/agents.

The link <http://qheps.health.qld.gov.au/circs> (Queensland Health intranet site) contains a full list of clinical practice prerequisites, including those acquired through ADAC<sup>43</sup>. This link also provides the suggested program for the three days of supervised clinical practice required for the achievement of chemotherapy competence.

### 9.5.1 Nurses required to prepare monoclonal antibodies

Nurses required to prepare monoclonal antibodies (mAbs) and tyrosine kinase inhibitors (TKIs) must complete a formal education program related to the 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 and TKIs and must be in line with the *Australian Consensus Guidelines for the Safe Handling of Monoclonal Antibodies for Cancer Treatment for Healthcare Personnel*.<sup>44</sup>

The Immunotherapies three part online course developed by Cancer Institute NSW, eviQED<sup>45</sup> is an example of an education resource that supports the QReCS model and is endorsed for use in Queensland. The course comprises both theoretical and practical elements, all of which should be completed with relevant competencies as per local policies and procedures for:

Module	Average learning hours
Principles of immunotherapy	2.75
Classes of immunotherapy drugs	1.50
Clinical management	1.50

Training may be provided by a local nurse educator, pharmacist or experienced workplace health and safety educator. Sites requiring advice or guidance in relation to nurses preparing mAbs and TKIs can contact <http://qheps.health.qld.gov.au/circs>.

## 9.6 Pharmacy staff

In the QReCS model, a hospital pharmacist or community pharmacist from the recipient facility is supported by a cancer pharmacist from the provider facility on a patient by patient basis.<sup>26,27,33</sup> The QReCS model does not specify formal education requirements for the pharmacist at the recipient facility, however, the pharmacist may choose to undertake more comprehensive oncology pharmacy education.

It is recommended that further knowledge is also attained from various websites, including *COSA guidelines for the safe prescribing, dispensing and administration of systemic cancer therapy*<sup>12</sup> and procedure manuals of the providing sites.

Pharmacists at the provider facility may undertake professional courses and programmes such as below or equivalent:

- Foundation Clinical Practice for cancer pharmacists – COSA and Cancer Pharmacists Group (CPG)<sup>46</sup>
- Advanced Clinical Practice for cancer pharmacists – COSA and CPG<sup>47</sup>
- Society of Hospital Pharmacists of Australia (SHPA) cancer services Seminars i.e. Foundation or Extension Seminar in Oncology. Refer SHPA website Events Calendar for updates.<sup>48</sup>

The pharmacists at the provider facility may undertake a competency performance assessment with a trained evaluator using a tool such as the SHPA ClinCAT competency assessment tool.<sup>9</sup>

## 9.7 Allied Health professionals

Generalist allied health staff may provide supportive care to parenteral antineoplastic agent patients. Allied health professionals may be at risk of being exposed to cytotoxic waste, via body fluids, and therefore are required to attend appropriate training.

There are no formalised training pathways in cancer care for allied health clinicians. Interested staff may access further training using ADAC<sup>43</sup>, Queensland-Cancer Education Program and the allied health cancer hub page.<sup>49</sup>

Access to experienced allied health clinicians for support and supervision is via the provider site.

## 10. Documentation and discharge

Documentation, management of post-parenteral antineoplastic agent side effects and discharge planning under the QReCS model will be the same as for the current face-to-face and Telehealth models.

Parenteral antineoplastic proficient nurses at the provider site must support parenteral antineoplastic supervised or capable 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.

All supportive post treatment medications (e.g. anti-emetics, anti-diarrhoeal) must be available to the patient to take at home. The patient should be given sufficient supply or instructions on how to obtain further supply.

Written information or access to information on the treatment administered, including expected side effects, precautions to be taken and what to do in the event of adverse effects (e.g. uncontrolled nausea and vomiting, a febrile episode or severe diarrhoea), must be provided.

Once a patient has received their final treatment, the oncologist / haematologist should determine the appropriate frequency of follow-up plan. In most cases where the patient has coped well with their treatment, follow-up consultations may be provided by Telehealth. However, arrangements for each patient must be determined jointly by the oncologist / haematologist, patient and recipient facility medical officer.

### Rapid Access Request form

To enable patients receiving care at a recipient site to access the provider cancer care service, a Rapid Access Request form is now available to facilities that wish to utilise it.

A sample image of this form is included in the Appendix of the guide and is available for download and use at <http://qheps.health.qld.gov.au/circs/qreecs/>.

The design of the form has been based on the Shared Care-Rapid Access Request from Cancer Australia.<sup>50</sup>

# Abbreviations

Abbreviation	Description
<b>ABF</b>	Activity Based Funding
<b>ADAC</b>	Antineoplastic Drug Administration Course
<b>ADR</b>	Adverse drug reaction
<b>ANMAC</b>	Australian Nursing and Midwifery Accreditation Council
<b>BLS</b>	Basic life support
<b>BMT</b>	Bone marrow transplant
<b>CHRISP</b>	Centre for Healthcare Related Infection Surveillance and Protection
<b>CINSW</b>	Cancer Institute New South Wales
<b>CIRCS</b>	Central Integrated Regional Cancer Service
<b>CMI</b>	Consumer Medicines Information
<b>COSA</b>	Clinical Oncology Society of Australia
<b>CNSA</b>	Cancer Nursing Society of Australia
<b>CSCF</b>	Clinical Services Capability Framework
<b>CVAD</b>	Central venous access device
<b>EdCaN</b>	The National Cancer Nursing Education Project
<b>ELFT</b>	Electrolytes liver function test
<b>FBC</b>	Full blood count
<b>HBCIS</b>	The Hospital Based Corporate Information System
<b>HHS</b>	Hospital and Health Service
<b>HSD</b>	Highly specialised drugs
<b>ieMR</b>	Integrated electronic Medical Record
<b>mAb</b>	Monoclonal antibody
<b>MBS</b>	Medicare Benefits Schedule
<b>OIMS</b>	Oncology information management system
<b>PBS</b>	Pharmaceutical Benefits Scheme
<b>PPE</b>	Personal protective equipment
<b>Q-CEP</b>	Queensland-Cancer Education Program
<b>QReCS</b>	Queensland remote chemotherapy supervision
<b>RACGP</b>	The Royal Australian College of General Practitioners
<b>RACP</b>	The Royal Australasian College of Physicians
<b>RBWH</b>	Royal Brisbane and Women's Hospital
<b>SPHA ClinCAT</b>	Society of Hospital Pharmacists of Australia Clinical Competency Assessment Tool
<b>TKI</b>	Tyrosine Kinase Inhibitor
<b>UR</b>	Unit record

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# Appendix - Rapid Access Request form

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 <p><b>Queensland Government</b></p> <p><b>Rapid Access Request</b></p> <p>Facility: .....</p>	<p>(Affix identification label here)</p> <p>URN: .....</p> <p>Family name: .....</p> <p>Given name(s): .....</p> <p>Address: .....</p> <p>Date of birth: ..... Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I</p>
<p><b>The Rapid Access Request is designed to be used when a current patient with a clinical issue requires urgent specialist consultation or advice.</b></p> <p>The Rapid Access Request is <b>not</b> to be used as a substitute for existing referral arrangements between referrers.</p>	
<b>FROM</b>	
Facility: ..... Address: ..... State: ..... Postcode: ..... Phone number: ..... Fax number: ..... Email address: .....	
<b>TO</b>	
Specialist name: ..... Specialty: ..... Address: ..... State: ..... Postcode: ..... Phone number: ..... Fax number: ..... Email address: .....	
<b>PATIENT DETAILS</b>	
Patient name: ..... Date of birth: ..... Address: ..... State: ..... Postcode: ..... Home / Work number: ..... Mobile Number: .....	
Specialist input required <input type="checkbox"/> Urgent consultation <input type="checkbox"/> Urgent advice	
Clinical concerns <i>(description of symptoms and/or test results triggering rapid access request)</i>	
Signature: ..... Date: .....	
<b>OUTCOME OF SPECIALIST CONSULTATION</b>	
Usually to be completed by the specialist, but may be completed by the medical officer / health professional at the time of phone conversation if phone advice only is received.	
Outcome Further action required <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, detail further action: .....	
Continue shared care? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, care transferred to: .....	
Contact option Facility to specialist <input type="checkbox"/> Phone <input type="checkbox"/> Letter <input type="checkbox"/> Fax <input type="checkbox"/> Email Specialist to facility <input type="checkbox"/> Phone <input type="checkbox"/> Letter <input type="checkbox"/> Fax <input type="checkbox"/> Email	
Name: ..... Designation: .....	
Signature: ..... Date: .....	

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**RAPID ACCESS REQUEST**



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