NCEPOD For better, for worse? Data comparison tool.

Hospital Number _____

Decision to treat

Recommendations	Data collection tool	Response		Action required
NCEPOD supports the Manual for Cancer Services standard that initial clinical management plans for all cancer patients should be formulated within a multidisciplinary team meeting. The MDT should be responsible for agreeing clinical care pathways, including appropriate chemotherapy regimens, doses and treatment durations.	Q4a – Was this course of SACT agreed at an MDT meeting? Q4b – If NOT, why not?	Yes	No Refer to audit tool	
The decision whether or not to advise SACT should be undertaken by a consultant oncologist/haemato-oncologist after a comprehensive clinical review of the patient.	Q8a – In your opinion, was SACT management appropriate for this patient? Q8b – If NO, please indicate the reason: Q5 – What was the grade of doctor who initiated this course of SACT? Q6 – What was the grade of doctor who prescribed this course of SACT? Q7 – What was the specialty of the clinician who advised SACT?	Yes Cons Cons Onc/ Haem-onc	No Refer to audit tool Other Other Other	
The decision whether to accept treatment should be made by the patient after they have been fully informed of the potential benefits and toxicities and have had sufficient time to consider their decision and discuss it with their family and carers.	Q9a – Is there evidence in the available casenotes that the patient received information to assist them in their decision to accept treatment? Q9b – If YES, please select all that apply: Q10a – Based on the casenotes, did the patient receive sufficient information to give informed consent to treatment?	Yes Yes	No Refer to audit tool No	

	Q10b – If NO, please expand on your answer	Refer to audit tool		
There should be greater standardisation of the consent form. The name and grade of doctor taking consent should always be stated on the consent form?	Q11a – Was there a signed consent form in the notes for this course of SACT?	Yes	No	
	Q11b – If YES, was the grade of the doctor obtaining consent stated on the consent form?	Yes	No	
	Q11c – If YES, was the name of the doctor obtaining consent stated on the consent form?	Yes	No	
Consent must only be taken by a clinician sufficiently experienced to judge that the patient's decision has been made after consideration of the potential risks and benefits of treatment, and that treatment is in the patient's best interest.	Q11a – Was there a signed consent form in the notes for this course of SACT?	Yes	No	
	Q11d – If YES, did it include information on potential toxicity?	Refer to audit tool		
	Q11e – If YES, what was recorded on the side effects section of the consent form?	Refer to audit tool		
	Q12 – In your opinion, was the clinician taking consent experienced enough to judge whether the patient's decision had been made after consideration of the risks and benefits of treatment?	Yes	No	
Giving palliative SACT to poor performance status patients grade 3 or 4 should be done so with caution and having been discussed at a MDT meeting?	Q13 – What was the patient's performance score immediately prior to the most recent course of SACT?	Refer to audit tool		
	Q14 – If the performance score was 3 or 4, was this patient discussed at an MDT meeting prior to palliative SACT commencing?	Yes	No	

SACT prescriptions and administration

Recommendations	Data collection tool	Response		Action required
Junior medical staff at FY1, FY2, ST1 and ST2 grade should not be authorised to initiate SACT.	Q5 – What was the grade of doctor who initiated this course of SACT?	Other	FY1/FY2/ ST1/ST2	
The results of pre-treatment full blood count and renal and liver function tests should be assessed before each cycle of chemotherapy.	Q15 – Before each cycle of SACT were the following assessed? a) Full blood count b) Urea and electrolytes c) Liver function tests	 Yes Yes Yes	 No No No	
Toxicity checklists should be developed to assist record keeping and aid the process of care in prescribing SACT.	Q16 – Is there evidence in the casenotes of an assessment of toxicity since the previous cycle of SACT? Q17 – Is there evidence in the casenotes that a toxicity checklist was used?	Yes Yes	No No	
Assessment of tumour response to treatment should be undertaken and recorded at appropriate intervals depending on the treatment intent and SACT regimen used.	Q18 – Is there evidence in the casenotes of an assessment of response to treatment during this course of SACT?	Yes	No	
All SACT prescriptions should be checked by a pharmacist who has undergone specialist training, demonstrated their competence and are locally authorised/accredited for the task. This applies to oral as well as parenteral treatments.	Q19 – Is there evidence in the casenotes that the SACT prescription was checked by a pharmacist?	Yes	No	
Pharmacists should sign the SACT prescription to indicate that it has been verified and validated for the intended patient and that all safety checks have been undertaken.	Q20 – Was the SACT prescription signed by a pharmacist?	Yes	No	

Safety of SACT

Recommendations	Data collection tool	Response	Action required
If the patient had suffered clinically significant grade 3/4 toxicity with the previous cycle of SACT, a dose reduction or the use of prophylactic GCSF should be considered depending on the treatment intent.	Q21a – Did the patient suffer any grade 3/4event during the previous cycle of SACT? Q21b – If YES, was a dose reduction or the use of prophylactic GCSF considered? Q21c – Please expand on your answer Q21d – Was this appropriate? Q21e – If NO, please expand on your answer	Refer to audit tool Yes No Refer to audit tool Yes No Refer to audit tool	
Consultants should follow good clinical practice and consider: • Reducing the dose of SACT in patients o That have received a number of previous courses of treatment o That have poor performance status o That have significant comorbidity • Reducing the dose or omitting drugs excreted via the kidney, if the patient has impaired renal function • Reducing the dose or omitting drugs excreted via the liver, if the patient has impaired liver function	Q22a – Is there evidence in the casenotes of a dose reduction with this cycle of SACT? Q22b – If YES, please specify why the dose was reduced. Q22c – If NO, do you think there should have been a dose reduction? Q22d – If YES, please expand on your answer	Refer to audit tool Refer to audit tool Yes No Refer to audit tool	

End of life care

Recommendations	Data collection tool	Response		Action required
A pro-active rather than reactive approach should be adopted to ensure that palliative care treatments or referrals are initiated early and appropriately. Oncologists should enquire at an appropriate time, about any advance decisions the patient might wish to make should they lose the capacity to make their own decisions in the future.	Q23 – Is there evidence in the casenotes that a palliative care team was involved?	Yes	No	
	Q24 – Is there evidence in the casenotes that all appropriate supportive care medicines were prescribed?	Yes	No	
	Q25 – Is there evidence of any of the following; an advanced directive, a Preferred Place of Care certificate, or an End of Life Pathway?	Yes	No	
All deaths within 30 days of SACT should be considered at a morbidity and mortality or a clinical governance meeting.	SQ26 – Was the patient's death discussed at an audit or morbidity and mortality meeting?	Yes	No	