Haematology / Oncology

DAY OF TREATMENT LOG SHEET

ID NUMBER .....

SURNAME .....

GIVEN NAMES .....

DATE OF BIRTH .....

Please fill in if no patient label available

Patient/treatment details

Diagnosis		Reason for admission		Allergy	Y	N	
Treatment regimen		Cycle No: of Day Date					

Blood examination and biochemistry (checked? Please select NA / Y / N and record level if required)

Haemaglobin	N/A	Y	N		White cell count	N/A	Y	N		Neutrophils	N/A	Y	N	
Platelet	N/A	Y	N		Random BSL	N/A	Y	N		Urinalysis	N/A	Y	N	
Sodium	N/A	Y	N		Potassium	N/A	Y	N		Magnesium	N/A	Y	N	
Phosphate	N/A	Y	N		Calcium	N/A	Y	N		Albumin	N/A	Y	N	
Urea	N/A	Y	N		Creatinine	N/A	Y	N		eGFR	N/A	Y	N	
Cortisol	N/A	Y	N		LDH	N/A	Y	N		T3,T4,TSH	N/A	Y	N	
ALT	N/A	Y	N		AST	N/A	Y	N		Bilirubin	N/A	Y	N	
Other:					Other:					Other:				

If "N" selected for any of the above record reason and action:

Other investigations (undertaken/required? Please select NA / Y / N)

CEA	N/A	Y	N	CA 125	N/A	Y	N	CA 19.9	N/A	Y	N	CA 15.3	N/A	Y	N	PSA	N/A	Y	N
Echo	N/A	Y	N	ECG	N/A	Y	N	LVEF	N/A	Y	N	Bone scan	N/A	Y	N	Lung function	N/A	Y	N
X-ray	N/A	Y	N	CT	N/A	Y	N	Ultrasound	N/A	Y	N	MRI	N/A	Y	N	PET	N/A	Y	N
Other:																			

Observations (please record)

Pulse		Blood pressure		Temperature		Resp rate		0_2 sats	
Weight (baseline)		Weight (last)		Weight (current)		Height		BSA	

Other checks

Possibility of pregnancy?	Unsure	Y	N	Last Menses		Infectious status/screen	Y	N

Has the patient been admitted to hospital or seen their GP since last treatment was prescribed? Yes ☐ No ☐

If Yes record reason and alert senior nursing/medical staff prior to treatment:

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Toxicity assessment

	Nil toxicities reported					
Toxicity / grade	**0**	**1**	**2**	**3**	**4**	Other:
Performance status						
Fever						
Chest pain						
Dyspnoea/SOB						
Diarrhoea						
Constipation						
Urinary disorder						
Infection						
Nausea						
Vomiting						
Mucositis / stomatitis						
Anorexia						
Pain						
Neuropathy/sensor						
Cognitive disturbance						
Fatigue						
Rash						
Bleeding						
Bruising						
Ocular/eye problems						
Palmar-plantar syndrome						
Extravasation						

Proceed with treatment

Review by senior nursing/medical staff

Must be SEEN and reviewed by senior nursing/medical staff prior to treatment

Other: e.g. menopausal symptoms

Have abnormal results been discussed with the initiating consultant? Yes ☐ No ☐

Have amber and red toxicities been escalated and investigated by the appropriate staff? Yes ☐ No ☐

Record action taken and outcome:

Dose reduction? No ☐ Yes ☐ Why? .....

Change of anti-emetic? No ☐ Yes ☐ Details? .....

Delay? No ☐ Yes ☐ Why? .....

Other changes:

Central venous access device assessment

Please refer to local policy / guideline for CVAD Care

ID NUMBER .....

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GIVEN NAMES .....

DATE OF BIRTH .....

Please fill in if no patient label available

CVAD insertion

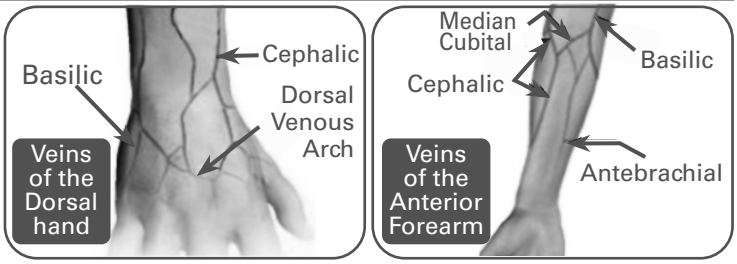
Cannulation attempts (unsuccessful)

No. of attempts: .....

Location/s: .....

.....

Sign: ..... Date: .....



Please mark with a **X** the number of cannulation attempts on the diagram

Successful cannulation Sign: ..... Date: .....

CVAD type: ☐ CICC ☐ t-CICC ☐ Other ☐ PICC ☐ TIVAD ☐ tc-CICC ☐ FICC ☐ tc-A-CICC ☐ A-CICC

Location: ☐ Left ☐ Right ☐ Other ☐ Chest ☐ Neck ☐ Groin ☐ Arm

External catheter length (cm):

No. of lumens: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other

TIVAD non-coring needle ..... mm .....

CVAD removal

Removal date:

Signature:

Reason: ☐ No longer required ☐ Occlusion ☐ Thrombosis ☐ Systemic CVAD infection ☐ Suspected CVAD ☐ Catheter migration ☐ Local infection ☐ Accidental removal ☐ Skin impairment ☐ Device failure ☐ Catheter tip malposition ☐ Other

CVAD assessment

Is the **CVAD** still required?	Y	N	Is the **dressing** clean dry and intact?	Y	N
Is the **exit site** clean & no inflammation?	Y	N	Is the **skin** intact & no inflammation?	Y	N
Is the catheter **secure**, without obvious signs of migration?	Y	N	Is each lumen or the CVAD **patent**?	Y	N
Are **needleless connectors** on each lumen?	Y	N	Are needleless connectors **clean, secure**?	Y	N
Are the IV lines **labelled, secure**?	Y	N			

If 'N' is selected for any of the above, refer to local policy and record action taken:

CVAD procedures

Dressing changed/applied? Y/N Date: Time: Type of dressing applied:

Catheter exit site free from inflammation, exudate?	Y	N	Skin under dressing free from irritation or injury?	Y	N
External catheter length same as time of insertion?	Y	N	Catheter secured?	Y	N
Lumen/s – easy aspiration and injection?	Y	N	Needleless connector/s replaced?	Y	N
All dressing materials replaced?	Y	N			

If 'N' is selected for any of the above, refer to local policy and record action taken:

TIVAD needle replaced? Y/N Date: Time:

Needle site free from inflammation, exudate?	Y	N	Skin under dressing free from irritation or injury?	Y	N
Patency - easy aspiration and injection?	Y	N	Needleless connector/s replaced?	Y	N
Dressing applied and needle secured?	Y	N	Comment:		

IV administration line change completed? Y/N Date: Time:

IV filters replaced? Y/N Date: Time:

Screening, assessments, referrals and appointments

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Nutrition screen

Has a validated tool been used to conduct a malnutrition assessment?	Yes ☐ No ☐
Notes/outcome:	

Malnutrition screening tool

Have you/the patient lost weight recently without trying?	Yes (see scoring below)			Unsure (2)
If yes, how much weight (kg) have you lost?	0.5 - 5kg (1)	>5 - 10kg (2)	10 - 15kg (3)	> 15kg (4)
Have you been eating poorly because of decreased appetite?	No (0)	Yes (1)		
TOTAL MST SCORE (add above scores together):				(If the MST score is > 2 refer to dietetics)
Referral required: Yes ☐ No ☐	Patient: Consented ☐	Declined ☐	Referred to:	

Supportive care/Psychosocial screen

Has a supportive care screen been conducted/screening tool offered?	Yes ☐	No ☐	
Comment:			
Referral required: Yes ☐ No ☐	Patient: Consented ☐	Declined ☐	Referred to:
Need for community nursing/services assessed?	Yes ☐	No ☐	
Comment:			
Referral required: Yes ☐ No ☐	Patient: Consented ☐	Declined ☐	Referred to:
Has a psychosocial screen been conducted/screening tool offered?	Yes ☐	No ☐	
Comment:			
Referral required: Yes ☐ No ☐	Patient: Consented ☐	Declined ☐	Referred to:

Other assessments/referrals

			Comment:
Delerium assessment completed?	Y	N	
Wound care assessment completed?	Y	N	
Falls risk assessment completed?	Y	N	
Pressure injury assessment completed?	Y	N	
Skin integrity assessment completed?	Y	N	
Other referrals made:			

Appointments

Next treatment appointment booked?	Y	N	Date:	Time:
Consultant review booked?	Y	N	Date:	Time:
Investigation booked?	Y	N	Date:	Time:

General checks

GP letter sent?	Y	N	Blood test form completed?	Y	N	**Emergency contact information**	Y	N
Other:								

Comments:

Signature: ..... Print name: ..... Designation: ..... Date/Time: .....

Anti-cancer drug administration time out checklist

ID NUMBER .....

SURNAME .....

GIVEN NAMES .....

DATE OF BIRTH .....

Please fill in if no patient label available

Two health professionals (as approved by local policy) to complete **Time out** immediately prior to drug administration. The medical order should be verified and any discrepancies identified should be discussed with the prescribing doctor and the pharmacist prior to drug administration. Please write or circle the appropriate answer as indicated.

Protocol: ..... Date: ..... Cycle: ..... Day: .....

Patient allergies/previous hypersensitivity drug reactions: .....

Action taken: .....

.....

	Drug 1	Drug 2	Drug 3	Drug 4	Drug 5
Drug name					
Time of drug check	am/pm	am/pm	am/pm	am/pm	am/pm
Correct patient	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Relevant laboratory values checked	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Medical authority for treatment to proceed	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Patient consent	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Correct drug, BSA dose and drug expiration *	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Dose reduction	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Correct route (specify)	IV / PO / IM / subcut / intrathecal	IV / PO / IM / subcut / intrathecal	IV / PO / IM / subcut / intrathecal	IV / PO / IM / subcut / intrathecal	IV / PO / IM / subcut / intrathecal
Correct infusion line	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Document infusion line, fluid and filter used					
Correct date and time	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
Venous access patent	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Correct rate and pump program checked	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA	Yes / No / NA
Signatures and designation	RN / MO	RN / MO	RN / MO	RN / MO	RN / MO
Signatures and designation	RN / MO	RN / MO	RN / MO	RN / MO	RN / MO

If any of the above is answered with a No, do not proceed with drug administration. See further advice from medical officer (MO), pharmacist or senior nurse.

* verify that all doses are correct according to protocol and patient parameters e.g. weight, body surface area (BSA), creatinine clearance and that maximum and cumulative doses are not exceeded for the dose or the course according to the protocol. Check any dose reductions are correct according to the protocol, patient parameters and doctor's instructions.

This checklist was developed in response to the 2007 NSW Health Directive Correct Patient, Correct Site Policy PD2007-079. The term "Time out" was originally coined by the World Health Organisation (WHO) in the Safe Surgery Saves Lives Campaign. http:/www.who.int/en/

Comments:

Signature: .....Print name: ..... Designation: ..... Date/Time: .....

Progress notes

ID NUMBER .....

SURNAME .....

GIVEN NAMES .....

DATE OF BIRTH .....

Please fill in if no patient label available

Report documentation guidelines:

1. Confirm/complete patient identification
2. Document in **BLACK INK** only
3. Note date & time of report
4. Identify as medical, nursing, allied health, other
5. Complete report - clear, concise, legible
6. Sign report, print name & professional designation
7. Draw through any blank lines between reports
8. Refer to local medical record documentation policies for specific documentation requirements.

Date /Time	Notes	Signature Print name & designation

PROGRESS NOTES