

Questionnaire

OECEI Quality standards

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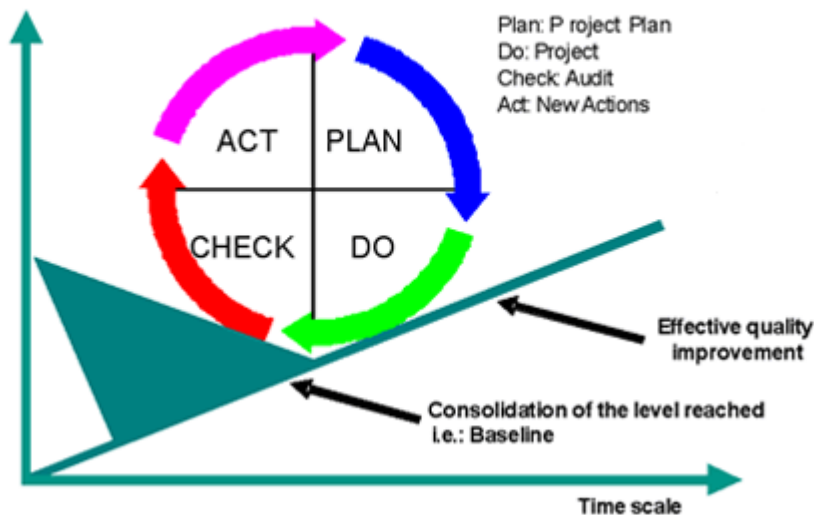
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Centres give a score to each item of the standard. The score is an indicator for the stage of implementation of each item of the standard. The scoring system is based on the Plan-Do-Check-Act-circle or Deming-circle.

The Deming Cycle

Continuous quality control and consolidation



These four stages of implementation are translated in the following possible answers:

- **Yes** means that the indicator of the standard has been implemented on a wide scale in the cancer institute and the Deming-cycle is completed at least twice (> in third cycle),
- **Mostly** means that the indicator has been implemented in most of the critical places in the cancer institute and the Deming-cycle is completed at least once (> in second cycle),

- **Partially** means that the indicator is implemented on project bases or on a modest scale in the cancer institute or the Deming-cycle has not been completed,
- **No** means that the indicator does not get attention or there are plans to start working on the indicator,
- **Not applicable** means that the indicator is not applicable in the cancer institute.

As well as giving a score the centre is required to support the score with a note and/or document. In the e-tool it is possible to add these documents and notes (See User Manual Appendix). As well as identifying improvement point for items that are scored with no or partially.



1. General Standards, Strategic Plan and General Management

1.1. Policy and organization

1.1.1. Oncology policy plan and general report

1.1.1.1.

		Yes	Mostly	Partially	No	not applicable
1.1.1.1.1.	The board and/or the management of the cancer centre has an official recent plan (not older than five years)					
1.1.1.1.2.	The vision on care in the field of oncology care is explained in the plan					
1.1.1.1.3.	The policy and the goals to be achieved are defined in the plan					
1.1.1.1.4.	The annual plan or multi-year plan contains actions to achieve the goals					
1.1.1.1.5.	The cancer centre has concrete annual or multi-year plans on the level of the main services or clusters					
1.1.1.1.6.	The plan is evaluated in later annual reports					
1.1.1.1.7.	Improvement activities of the cancer centre (logistics, research, education, multidisciplinary teams) are part of the annual report					

1.1.2. Cooperation with universities

1.1.2.1.

The cancer centre has formal cooperation or agreement with at least one university for:

		Yes	Mostly	Partially	No	not applicable
1.1.2.1.1.	care activities					
1.1.2.1.2.	educational activities					
1.1.2.1.3.	research activities					

1.1.3. Cooperation with external partners

Have agreements been reached, about the allocation of tasks, such as a hospital or radio therapeutic institute in the case of referrals?

1.1.3.1.

		Yes	Mostly	Partially	No	not applicable
1.1.3.1.1.	Cooperation arrangements with other cancer centres are clearly documented in (written) agreements covering the goals of the co-operation, tasks, responsibilities and competences of the cancer centre and the co-operating partners					
1.1.3.1.2.	There are (written) agreements with home care organisations					
1.1.3.1.3.	There are (written) defined and documented cooperation arrangements with general practitioners.					
1.1.3.1.4.	There are (written) agreements with nursing home, rest house, palliative care institutions, etc.					
1.1.3.1.5.	There are (written) agreements with special cancer care service providers such as radiotherapy centre, pathology laboratory, specialized surgery unit etc.					

1.1.4. Cancer data registration (institutional level)

Are the data on the patients' types of cancers recorded in an institutional cancer database?

1.1.4.1.

		Yes	Mostly	Partially	No	not applicable
1.1.4.1.1.	The number of new oncology patients is known at an institutional level					
1.1.4.1.2.	The number of new cases for each type of cancer is known at an institutional level					
1.1.4.1.3.	There are diagnostic, treatment and outcome data on patients with cancer available annually at an institutional level					
1.1.4.1.4.	The data are reported and analysed by multidisciplinary group with recommendations for improvement of care					

1.1.5. Complications registry

Have agreements been reached concerning keeping and discussing a complications registry?

1.1.5.1.

		Yes	Mostly	Partially	No	not applicable
1.1.5.1.1.	There are specific protocols for reporting and recording of complications					
1.1.5.1.2.	The data are analysed at an institutional level					
1.1.5.1.3.	After analysis, improvement measures are developed and action plans implemented in agreement with the departments concerned					



1.3. Resources and materials

1.3.1. Cytostatic drugs, prescription, preparation and distribution

Have agreements been reached concerning the prescription, preparation and distribution of cytostatic drugs?

1.3.1.1.

		Yes	Mostly	Partially	No	not applicable
1.3.1.1.1.	A written procedure concerning prescription of anti-cancer drugs is available					
1.3.1.1.2.	A written procedure concerning preparation of anti-cancer drugs is available					
1.3.1.1.3.	A written procedure concerning distribution of anti-cancer drugs is available					
1.3.1.1.4.	The anti-cancer drugs are prepared in a centralized unit					
1.3.1.1.5.	The anti-cancer drugs are prepared under the direct supervision of a pharmacist					

1.3.2. Administration of cytostatic drugs

Are there protocols for the administration of cytostatic drugs?

1.3.2.1.

		Yes	Mostly	Partially	No	not applicable
1.3.2.1.1.	The cancer centre has described procedures or guidelines on the administration of anti-cancer drugs					
1.3.2.1.2.	The anti-cancer drugs are as much as possible be administrated in specialized wards (e.g., administration of anti-cancer drugs takes only place in some well defined wards (medical oncology ward...))					
1.3.2.1.3.	There is a dedicated day-care unit for the administration of anti-cancer drugs					

1.4. Process control

1.4.1. Continuity of care within the cancer centre

Have agreements been reached concerning the continuity of care, and replacement of nursing, medical, paramedical, and support staff associated with oncology? Is the care covered 7 days a week by specialized staff?

1.4.1.1.

		Yes	Mostly	Partially	No	not applicable
1.4.1.1.1.	Continuity of specialized care is warranted 24 hours a day on the medical, paramedical, nursing and supportive levels. This can, among other things, be achieved by planning continuity of care during nights, week-ends, holidays, illness, attendance at conferences or other reasons for absence, within each discipline					
1.4.1.1.2.	Patients are informed about all the aspects of the continuity of care and eventually referred to another hospital					
1.4.1.1.3.	The patient receives information about the contact person for medical and nursing oncology matters					

1.4.2. Waiting and throughput times

Have norms, standards been defined concerning the maximum waiting and throughput times for oncology patients with regard to first outpatients visit, admission, and tests/treatment?

1.4.2.1.

There are guidelines (for different types of tumours) for the (maximum) waiting times between:

		Yes	Mostly	Partially	No	not applicable
1.4.2.1.1.	referral by the general practitioner or referring specialist and the first visit to the outpatient's clinic or the admission into the cancer centre					
1.4.2.1.2.	first visit and the time of definitive diagnosis					
1.4.2.1.3.	definitive diagnosis and first treatment					
1.4.2.1.4.	There is a record of those waiting times					
1.4.2.1.5.	There is continuous measurement and analysis of those waiting times leading to improvements when needed					

1.4.2.1.6.	There is a clear definition of the roles of each category of staff on those issues					
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1.4.3. Compliance with guidelines

Have agreements been reached concerning the use of guidelines relating to diagnosis, treatment, follow up and research?

1.4.3.1.

		Yes	Mostly	Partially	No	not applicable
1.4.3.1.1.	The medical specialists and the employees of the cancer centre apply the (local/regional/national/international) guidelines on diagnostics, treatment, follow up and research					
1.4.3.1.2.	The guidelines are easily accessible					
1.4.3.1.3.	The guidelines are updated on a regular basis depending on medical developments					
1.4.3.1.4.	Each decision that differs from the guidelines is recorded in the file of the patient					

1.4.4. Compliance with guidelines

Do you report the compliance with guidelines multidisciplinary?

1.4.4.1.

		Yes	Mostly	Partially	No	not applicable
1.4.4.1.1.	Compliance with guidelines is measured through the registration of the patients' cancer data					
1.4.4.1.2.	Deviations from guidelines are analyzed					
1.4.4.1.3.	Deviations from guidelines are discussed					
1.4.4.1.4.	Deviations from guidelines are reported annually					

1.4.5. Tasks and responsibilities of the (oncology) nurses

Have agreements been reached concerning the tasks and responsibilities of nurses working at the oncology department?

1.4.5.1.

		Yes	Mostly	Partially	No	not applicable
1.4.5.1.1.	For each technical, clinical or outpatient's department where patients with cancer are treated, there are nurses trained in oncology					
1.4.5.1.2.	Anti-cancer drugs are administered by specially educated (oncology) nurses					
1.4.5.1.3.	The cancer centre has nurses with expertise with regard to the tumours treated (e.g.: breast-, colo-rectal-, head and neck, gynaecological cancer)					
1.4.5.1.4.	There are procedures describing the tasks and responsibilities of (oncology) nurses					
1.4.5.1.5.	Roles and responsibilities of nurses with different expertises (oncology, palliative care,...) are described regarding special involvement in oncology care					
1.4.5.1.6.	The nursing discipline has one staff member as contact person for oncology care					

1.4.6. Roles and tasks of the members of the supportive care staff

Have agreements been reached concerning the roles and tasks of the supportive care staff?

1.4.6.1.

		Yes	Mostly	Partially	No	not applicable
1.4.6.1.1.	Roles and responsibilities for each of the paramedical disciplines are described regarding the involvement in oncology care					
1.4.6.1.2.	Roles and responsibilities for each of the supportive disciplines are described regarding the involvement in oncology care					
1.4.6.1.3.	Each of the paramedical discipline has one staff-member as the contact person (referent) for oncology care					
1.4.6.1.4.	Each of the supportive disciplines has one staff-member as the contact person (referent) for oncology care					

1.4.7. Communication between the members of the supportive care staff

What is the focus of the communication between nursing, paramedic and supportive disciplines?

1.4.7.1.

Communication amongst members of the supportive care staff (nursing, paramedical and supportive disciplines) occurs through :

		Yes	Mostly	Partially	No	not applicable
1.4.7.1.1.	Consultation					
1.4.7.1.2.	Data transmission					
1.4.7.1.3.	Transfer of knowledge					
1.4.7.1.4.	Information and implementation of guidelines					

1.4.8. Referral of patients to paramedical and supportive disciplines

Have agreements been reached within the cancer centre concerning who is authorized to refer patients to paramedical and/or support disciplines, and under what circumstances?

1.4.8.1.

		Yes	Mostly	Partially	No	not applicable
1.4.8.1.1.	It is made clear for which problems related to cancer and at which moment paramedical disciplines should be consulted					

1.4.8.1.2.	It is made clear for which problems related to cancer and at which moment supportive disciplines should be consulted					
1.4.8.1.3.	There are written procedures on the circumstances for calling on and referral to paramedical disciplines					
1.4.8.1.4.	There are written procedures on the circumstances for calling on and referral to supportive disciplines					

1.4.9. Multidisciplinary harmonization / integrated care

Have agreements been reached on the harmonization of integrated care, between the various disciplines involved in the diagnosis, treatment and counselling of oncology patients?

1.4.9.1.

		Yes	Mostly	Partially	No	not applicable
1.4.9.1.1.	The responsibilities of the different disciplines involved in the diagnosis of the patient in the cancer centre are described					
1.4.9.1.2.	The responsibilities of the different disciplines involved in the treatment of the patient in the cancer centre are described					
1.4.9.1.3.	The responsibilities of the different disciplines involved in the follow-up of the patient in the cancer centre are described					
1.4.9.1.4.	The multidisciplinary team advises on the inclusion of patients in clinical trials					
1.4.9.1.5.	The name of the physician responsible for the coordination of the care of the patient is defined and communicated to the patient					

1.4.10. Selection criteria for the oncology team meeting

Are the selection criteria concerning which patient should be discussed in the multidisciplinary setting clear and documented?

1.4.10.1.

		Yes	Mostly	Partially	No	not applicable
1.4.10.1.1.	Criteria are defined for the selection of patients to be discussed in the multidisciplinary team meetings					
1.4.10.1.2.	These selection criteria are clear, documented and based on a consensus between the different disciplines					

1.4.11. Procedure for the oncology multidisciplinary team meetings

Is there a procedure for the oncology multidisciplinary team meetings?

1.4.11.1.

There are procedures describing how the regular multidisciplinary team meetings apply following criteria :

		Yes	Mostly	Partially	No	not applicable
1.4.11.1.1.	One of the specialist in charge of the care of the patient is present during the discussion of the patient					
1.4.11.1.2.	During the presentation of patients, diagnostic results and examination results are available					
1.4.11.1.3.	The necessary facilities to show diagnostic and examination results are available					
1.4.11.1.4.	Conclusions and advices resulting from the multidisciplinary team meeting are documented in the patient's medical record					
1.4.11.1.5.	There is a clear description of the way to inform all the members of the multidisciplinary team about which patients will be discussed					
1.4.11.1.6.	There is a clear description of the communication of the advice resulting from the discussion to all the physicians and other disciplines involved in the care of the given patients					

1.4.11.1.7.	There is a clear description of the communication of the advice resulting from the discussion to the concerned patients					
1.4.11.1.8.	Each final decision about care of the patient that differs from the advice and conclusions of the multidisciplinary team is documented and recorded in the patient's medical record					
1.4.11.1.9.	There is a procedure describing how the conclusions and advice from the multidisciplinary meeting will be evaluated and by whom					

1.4.12. Registration and evaluation of the recommendations of the multidisciplinary team meeting

Have agreements been reached concerning the registration and evaluation of recommendations that emerge from the multidisciplinary team meeting?

1.4.12.1.

		Yes	Mostly	Partially	No	not applicable
1.4.12.1.1.	Conclusions and advices resulting from the multidisciplinary team meeting are documented in the patient's medical record					
1.4.12.1.2.	Deviations from conclusions and advices are documented and motivated in the patient's medical record					
1.4.12.1.3.	There is a procedure described on how the conclusions and advices from the multidisciplinary meeting will be evaluated and by whom.					

1.5. Safeguarding the quality system

1.5.1. Quality and risk management and safety requirements

Does the cancer centre have a global policy for quality and risk management and safety requirements?

1.5.1.1.

		Yes	Mostly	Partially	No	not applicable
1.5.1.1.1.	There is an identified Quality and Risk Management Direction					
1.5.1.1.2.	The quality Director participates in the executive direction of the cancer centre					
1.5.1.1.3.	There is a written global programme describing the policy for: Quality management, including continuous quality improvement (CQI) certification processes and individual accreditation of physicians					
1.5.1.1.4.	There is a written global programme describing the policy for: Risk management, including a programme for the centralized reporting of undesirable events by health care workers					
1.5.1.1.5.	There is a written global programme describing the policy for: Safety management of the cancer centre and its users					
1.5.1.1.6.	There is a written global programme describing the policy for: Patient safety management, including a systematic centralized reporting of side effects of drugs (current practice)					
1.5.1.1.7.	There is a programme for the systemic analysis of major adverse or undesirable events (e.g. : morbidity and mortality reviews), in each clinical and technical department					
1.5.1.1.8.	Patients or patients' relatives should be part of these organizations					

1.5.2. Quality and risk management and safety requirements

1.5.2.1.

		Yes	Mostly	Partially	No	not applicable

1.5.2.1.1.	There is a patients committee (or association), for consultative advice about quality of care and risk management					
1.5.2.1.2.	There is a preventive maintenance programme for equipment and access to accurate and reliable diagnostic tests					
1.5.2.1.3.	There is a monitoring system for the appropriate use of diagnostic services					
1.5.2.1.4.	There is a monitoring system for the appropriate use of (radio)therapeutic services					
1.5.2.1.5.	There is a regular internal audit system					
1.5.2.1.6.	There is a quality and risk dashboard of the cancer centre, with an annual evaluation of the results and, if necessary, revision of its content					

1.5.3. Accuracy of the diagnostic services

Are the diagnostic services safe, efficient and accurate for workers and patients?

1.5.3.1.

		Yes	Mostly	Partially	No	not applicable
1.5.3.1.1.	Security checking of devices and technical equipment used for diagnosis (biology, pathological anatomy, imaging, functional tests) are part of the maintenance contracts.					
1.5.3.1.2.	Latest security checks have been done on time					
1.5.3.1.3.	Calibration of devices and technical equipment used for diagnosis (biology, pathological anatomy, imaging, functional tests) are part of the maintenance contracts					
1.5.3.1.4.	Latest calibrations have been done on time					
1.5.3.1.5.	Devices and technical equipment used for diagnosis (biology, pathological anatomy, imaging, functional tests) are periodically certified by an authorized company. Expiration date is still valid.					
1.5.3.1.6.	There is a reporting system for near miss accidents during the use of the devices and equipment.					

1.5.4. Quality and risk management of research and new techniques

Are there monitoring systems for quality and risk management associated with the introduction of new techniques / new practice?

1.5.4.1.

		Yes	Mostly	Partially	No	not applicable
1.5.4.1.1.	Identification of any risks associated with the introduction of a new technology or new practice is performed systematically					
1.5.4.1.2.	There is a quality assurance programme for clinical research					
1.5.4.1.3.	There is a procedure for Serious Adverse Events and Sudden Unexpected Serious Adverse Reaction handling and reporting					
1.5.4.1.4.	The SOP's are regularly updated and are accessible					

1.5.5. Quality assurance in all areas

Does the cancer centre promote and develop the practice of quality assurance in all areas?

1.5.5.1.

The quality assurance programmes are included in the global policy for quality and risk management

		Yes	Mostly	Partially	No	not applicable
1.5.5.1.1.	There is one quality assurance programme in each oncology healthcare area (chemotherapy, surgery, radiotherapy) and at risk units (anaesthesiology, critical care, etc)					
1.5.5.1.2.	There is at least one quality assurance programme in areas other than the oncology healthcare area					
1.5.5.1.3.	All activities of cancer centre follow, when applicable, the guidelines of Good clinical Practice, Good laboratory Practice and Good manufacturing Practice					

1.5.6. Quality assurance in all areas (HR)

1.5.6.1.

		Yes	Mostly	Partially	No	not applicable
1.5.6.1.1.	Evaluation of the employees is a part of the human resources (HR) management, from bottom to top, including directors, Chief Officers (heads of departments) and physicians.					
1.5.6.1.2.	The results of evaluation are documented and used for building future strategy of the institution, with alignment of the departments					
1.5.6.1.3.	Relevant training is provided to all staff according to their level of responsibility					
1.5.6.1.4.	HR policy includes a formal individual evaluation at least once/2 years					
1.5.6.1.5.	Training records of all staff are available					
1.5.6.1.6.	Skills, competences and expertises are assessed in case of recruitment at managerial level					
1.5.6.1.7.	Specific psychological support is available to the cancer centre's employees including physicians.					

1.5.7. Privacy, protection of personal data

Are there procedures for privacy, protection of personal data?

1.5.7.1.

		Yes	Mostly	Partially	No	not applicable
1.5.7.1.1.	There is a Patient Charter: an official set of principles, a document defining the commitments of both the cancer centre AND the patient. In this Charter the cancer centre commits itself to respect and to guarantee the patient's privacy					
1.5.7.1.2.	There is a secure procedure for the storage, preservation, consultation and transmission of personal data according to the national/European regulations					
1.5.7.1.3.	Protocols for clinical trials guarantee the protection of the patient's personal data. This point is checked and validated by an Ethical Committee					



2. Screening and primary prevention and health education

2.4. Process control

2.4.1. Availability of screening programmes

In the setting of private health policy, does the cancer centre organise or participate in screening programmes?

2.4.1.1.

		Yes	Mostly	Partially	No	not applicable
2.4.1.1.1.	The cancer centre participates in structured regional (province/county) screening programmes.					
2.4.1.1.2.	The cancer centre participates in structured national screening programmes.					
2.4.1.1.3.	The cancer centre organises screening programmes.					

2.4.2. Participation in prevention and health education initiatives

Does the cancer centre organise or participate in prevention and health education initiatives that meet the needs of the population?

2.4.2.1.

		Yes	Mostly	Partially	No	not applicable
2.4.2.1.1.	The cancer centre organises prevention programmes.					
2.4.2.1.2.	The cancer centre organises health education initiatives/programmes.					
2.4.2.1.3.	The cancer centre participates in prevention programmes					
2.4.2.1.4.	The cancer centre participates in health education initiatives/programmes.					

2.4.3. Availability of primary prevention clinics

Does the institution have one or more specific primary prevention clinics?

2.4.3.1.

		Yes	Mostly	Partially	No	not applicable

2.4.3.1.1.	The cancer centre has a specific primary prevention clinic or at least one specific primary prevention programme					
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2.4.4. Oncogenetic clinic / outpatient department

Does the institution have an oncogenetic clinic?

2.4.4.1.

		Yes	Mostly	Partially	No	not applicable
2.4.4.1.1.	The cancer centre has an oncogenetic clinic for identifying high-risk individuals by molecular genetics. ((e.g. breast cancer, ovarian cancer, colo-rectal cancer, endocrine tumours)					
2.4.4.1.2.	Formal relationships exist between the cancer centre and reference genetic laboratories					

2.4.5. Smoking control in the cancer centre

Is there a policy for non smoking in the cancer centre?

2.4.5.1.

		Yes	Mostly	Partially	No	not applicable
2.4.5.1.1.	a non-smoking policy is clearly documented					
2.4.5.1.2.	support is provided to workers who decide to quit smoking					
2.4.5.1.3.	any public part of the cancer centre is clearly identified as a smoke-free area					
2.4.5.1.4.	explanations about smoking regulation in the institution are available for patients					
2.4.5.1.5.	patients are encouraged to quit smoking					
2.4.5.1.6.	workers are encouraged to quit smoking					
2.4.5.1.7.	appropriate and specific support is provided to patients who want to quit smoking					
2.4.5.1.8.	smoking is prohibited to patients (possibly with the exception of a restricted smoking-room equipped with an appropriate aspiration device)					
2.4.5.1.9.	the cancer centre is labialized "Smoke-Free"					

3. Care

3.4. Process control

3.4.1. Pain service

Does the cancer centre have a protocol/guideline for pain control?

3.4.1.1.

		Yes	Mostly	Partially	No	not applicable
3.4.1.1.1.	The cancer centre applies / uses guidelines regarding pain treatment for patients with cancer					
3.4.1.1.2.	There is regular staff education on pain management					
3.4.1.1.3.	Patients and their families receive oral and written information about any pain management.					
3.4.1.1.4.	There is a pain score card as part of the guidelines.					
3.4.1.1.5.	The use of the pain score card is regularly assessed					

3.4.2. Palliative/Supportive care team

Does the cancer centre have written agreements for composition and tasks of the palliative / supportive care team? NB: palliative AND/OR supportive care

3.4.2.1.

The palliative/supportive care team

		Yes	Mostly	Partially	No	not applicable
3.4.2.1.1.	intervenes in a timely way to requests from all inpatients departments					
3.4.2.1.2.	replies to out-patient requests with a help line service or consultation					
3.4.2.1.3.	provides education for different disciplinary specialists and patients and families					

3.4.3. Palliative/Supportive and terminal care (guideline)

Are there guidelines to palliative and terminal care? NB: palliative AND/OR supportive care

3.4.3.1.

		Yes	Mostly	Partially	No	not applicable
3.4.3.1.1.	The cancer centre uses guidelines on palliative, supportive and terminal care					
3.4.3.1.2.	Written procedures exist on referral of patients to palliative/terminal care					

3.4.4. Palliative and terminal care

Is the management of the specific needs of patients at the end of their life considered within and outside the cancer centre? NB: palliative AND/OR supportive care

3.4.4.1.

		Yes	Mostly	Partially	No	not applicable
3.4.4.1.1.	All patient cases referred for palliative terminal care are discussed during scheduled meetings with the palliative care team					
3.4.4.1.2.	Agreements exist with other cancer centre(s) for transferring patients at the end of their life, if necessary					
3.4.4.1.3.	Services provided by the cancer centre after patients are discharged are clearly defined					
3.4.4.1.4.	These services are known by terminal patients and relevant workers					

3.4.5. Psycho-oncology service

Does the cancer centre have a psycho-oncology team or department?

3.4.5.1.

		Yes	Mostly	Partially	No	not applicable
3.4.5.1.1.	There is a psycho-oncology service with competence in (oncology) psychiatry and psychology					
3.4.5.1.2.	The staff are trained to detect patients with psychological suffering or distress.					
3.4.5.1.3.	Structured screening methods are used to refer patients to the psycho-oncology team					
3.4.5.1.4.	Procedures about how to refer the patients to the psycho-oncology service, including patients in psychological distress, are clearly defined					

3.4.6. Social Counselling

Does the cancer centre have a guideline or policy on the psychosocial counselling of oncology patients?

3.4.6.1.

		Yes	Mostly	Partially	No	not applicable
3.4.6.1.1.	Social counselling, including social workers, is available and accessible to all patients					

3.4.7. Family involvement in care

Is care organized for the patient's family during treatment, the end of life and the immediate bereavement period?

3.4.7.1.

		Yes	Mostly	Partially	No	not applicable
3.4.7.1.1.	In agreement with the healthcare team, the family can participate in certain personal activities (e.g. meals, washing).					
3.4.7.1.2.	Each ward offering palliative/terminal care has a room for meeting the families.					
3.4.7.1.3.	Visiting time restrictions are lifted and arrangements for relatives to stay/sleep as well as for visiting by children are facilitated					

3.4.8. Family involvement in care (children)

Is there special attention paid to children with a parent who is dying?

3.4.8.1.

		Yes	Mostly	Partially	No	not applicable
3.4.8.1.1.	Specific support exists for families with children whose parent is dying (trained staff, guidelines...)					
3.4.8.1.2.	Families are proactively informed on the available support					

3.4.9. Rehabilitation

Is there access to a rehabilitation unit with mono- and multidisciplinary interventions?

3.4.9.1.

		Yes	Mostly	Partially	No	not applicable

3.4.9.1.1.	There is access to a functional rehabilitation department focussed on cancer patients.					
3.4.9.1.2.	The rehabilitation unit manages the psychosocial and physical rehabilitation of the patient, starting at an early stage of the treatment, and continuing during the post therapeutic care period					

3.4.10. Prosthetic surgery

Do patients receive information and advice about the possibilities of prosthetic surgery?

3.4.10.1.

		Yes	Mostly	Partially	No	not applicable
3.4.10.1.1.	The person(s) in charge of providing information on prosthetic surgery are clearly identified					
3.4.10.1.2.	The patient is informed about how to get information					
3.4.10.1.3.	This information includes the potential risks					
3.4.10.1.4.	Prosthetic and reconstructive surgery is available and accessible to all appropriate patients					

4. Research, innovation and development

4.1. Policy and organization

4.1.1. Organizational and hierarchical structure

Is there a description of the organizational and hierarchical structure of the RID organization?

4.1.1.1.

		Yes	Mostly	Partially	No	not applicable
4.1.1.1.1.	There is an organizational and hierarchical structure specifically for research, innovation and development					
4.1.1.1.2.	A Scientific Advisory Board meets on a regular basis and advises the board of the cancer centre on its research activities					
4.1.1.1.3.	The Scientific Advisory Board verifies the quality of the research activities					
4.1.1.1.4.	The Scientific Advisory Board verifies the coherence of the objectives of the different research programmes and the cancer centres' objectives and strategy at least annually					

4.1.2. Research collaboration

4.1.2.1.

		Yes	Mostly	Partially	No	not applicable
4.1.2.1.1.	The cancer centre has a strategy on collaboration and networking					
4.1.2.1.2.	The cancer centre participates in national and international research projects					

4.1.3. Organization of clinical research

4.1.3.1.

		Yes	Mostly	Partially	No	not applicable
4.1.3.1.1.	There is a dedicated clinical research management unit					
4.1.3.1.2.	It is the task of the unit to have a strategy for promoting the conduct of clinical trials					

4.1.3.1.3.	It is the task of the unit to ensure the management that the conduct of clinical trials is according to the clinical trials protocols					
4.1.3.1.4.	It is the task of the unit to ensure administrative, scientific and ethical/legal review and approval of new clinical trials					
4.1.3.1.5.	It is the task of the unit to coordinate the clinical research activities as well as their funding					
4.1.3.1.6.	It is the task of the unit to centralize the collection of the information about the trials and patients included					
4.1.3.1.7.	It is the task of the unit to provide and update information about the trials to all departments and external partners					
4.1.3.1.8.	It is the task of the unit to assist in the conduct and monitoring of clinical trial activities					
4.1.3.1.9.	It is the task of the unit to provide an annual report on clinical trial activities					

4.1.4. Periodical policy review

Is there a periodical research policy review?

4.1.4.1.

		Yes	Mostly	Partially	No	not applicable
4.1.4.1.1.	There is a periodically defined research policy and research strategy plan					
4.1.4.1.2.	The research policy and research strategy plan are integrated into the general activities of the cancer centre					

4.1.5. Scientific interaction and integration

Is there a structure for integrating and stimulating the scientific interaction?

4.1.5.1.

The cancer centre promotes co-operation between researchers and clinicians through:

		Yes	Mostly	Partially	No	not applicable
4.1.5.1.1.	Organized and formalized activities					

4.1.5.1.2.	Regular information and meetings about research activities					
4.1.5.1.3.	Regular information and meetings about research results					
4.1.5.1.4.	Promotion of integration of research activities into clinical activities					
4.1.5.1.5.	Organisation of integration of research activities into clinical activities					

4.1.6. Internal review and evaluation of grant proposals

Is there a procedure in place for internal review of grant proposals before submissions?

4.1.6.1.

		Yes	Mostly	Partially	No	not applicable
4.1.6.1.1.	There is an internal review of grant proposals before submission to the funding organization					
4.1.6.1.2.	There is an internal evaluation of the success of the grant proposals					

4.1.7. (Suspected) scientific misconduct

Is there a procedure in case of (suspected) scientific misconduct?

4.1.7.1.

		Yes	Mostly	Partially	No	not applicable
4.1.7.1.1.	There is a procedure for dealing with scientific misconduct					

4.3. Resources and materials

4.3.1. Means for conducting research activities

Does the cancer centre have the means for conducting its research activities?

4.3.1.1.

		Yes	Mostly	Partially	No	not applicable
4.3.1.1.1.	The budget for cancer research is clearly and yearly defined					
4.3.1.1.2.	The cancer centre provides access to facilities for research activities					
4.3.1.1.3.	The cancer centre provides resources and means for research activities					
4.3.1.1.4.	Funding of research activities follows clearly defined procedures					
4.3.1.1.5.	The use of financial resources and accounting of research activities is controlled, monitored and reported according to rules					

4.3.2. Intellectual property and innovation

Is there a policy for the protection of intellectual property?

4.3.2.1.

		Yes	Mostly	Partially	No	not applicable
4.3.2.1.1.	There is a strategy for innovation					
4.3.2.1.2.	There is support for protection and exploitation of intellectual property					
4.3.2.1.3.	There is support for business development of research projects					
4.3.2.1.4.	There is a technology transfer service available					

4.3.3. Biobank

4.3.3.1.

		Yes	Mostly	Partially	No	not applicable
4.3.3.1.1.	The cancer centre has a policy for biobanking patient related samples					

4.3.3.1.2.	There is a SOP defining the collection, the storage, the registration and the use of the biological samples					
4.3.3.1.3.	There is a centralized registration of the data related to the biological material					



4.4. Process control

4.4.1. Structured scientific programme

Is there a structured scientific exchange programme in the cancer centre? (Colloquia, seminars, theme-specific conferences).

4.4.1.1.

		Yes	Mostly	Partially	No	not applicable
4.4.1.1.1.	There is a structured, documented and up to date scientific programme in the cancer centre through colloquia, seminars or theme-specific conferences.					
4.4.1.1.2.	Scientific programmes are used to guarantee that results from research will be translated into daily practice timely; (e.g.) diagnostic tools, treatment or prevention					

4.4.2. Teaching programme for PhD students

Is there a teaching programme for PhD students?

4.4.2.1.

		Yes	Mostly	Partially	No	not applicable
4.4.2.1.1.	There is a teaching programme for PhD students					

4.4.3. Transfer of new scientific information to clinical practice

Is there a procedure for the transfer of new scientific information to clinical practice?

4.4.3.1.

		Yes	Mostly	Partially	No	not applicable
4.4.3.1.1.	There is a procedure that guarantees that results from research will be translated into daily practice timely. (e.g.) diagnostic tools, treatment or prevention)					

4.5. Safeguarding the quality system

4.5.1. Periodical site visit / review

Is there a periodical site visit/review of the total research organization?

4.5.1.1.

There is a periodical review and/or site visit, with external reviewers, of:

		Yes	Mostly	Partially	No	not applicable
4.5.1.1.1.	the total research organization					
4.5.1.1.2.	each research group/team activities					
4.5.1.1.3.	clinical/translational research					
4.5.1.1.4.	research support facilities					



5. Teaching and continuing education

5.1. Policy and organization

Does the cancer centre analyse the training needs to define an annual or multi-annual programme?

5.1.1. Analyse training needs

5.1.1.1.

		Yes	Mostly	Partially	No	not applicable
5.1.1.1.1.	The cancer centre analyses the training needs regularly					
5.1.1.1.2.	Based on the analysis, the institution defines an annual or multi-annual training / educational programme for physicians					
5.1.1.1.3.	Based on the analysis, the cancer centre defines an annual or multi-annual training / educational programme for researchers					
5.1.1.1.4.	Based on the analysis, the cancer centre defines an annual or multi-annual training / educational programme for nurses					
5.1.1.1.5.	Based on the analysis, the cancer centre defines an annual or multi-annual training / educational programme for paramedics					
5.1.1.1.6.	Based on the analysis, the cancer centre defines an annual or multi-annual training / educational programme for supportive disciplines (psychologists etc.)					
5.1.1.1.7.	Based on the analysis, the cancer centre defines an annual or multi-annual training / educational programme for other disciplines (please specify in the note)					

5.4. Process control

5.4.1. Participation in teaching oncology

Do the physicians, researchers, nurses and psychologists in the cancer centre participate in the teaching of undergraduate theoretical courses in oncology?

5.4.1.1.

Does the cancer centre provide teaching to:

		Yes	Mostly	Partially	No	not applicable
5.4.1.1.1.	physicians					
5.4.1.1.2.	researchers					
5.4.1.1.3.	nurses					
5.4.1.1.4.	psychologists					
5.4.1.1.5.	supportive disciplines (psychologists etc.)					
5.4.1.1.6.	other disciplines (please specify in the note)					

5.4.2. Types of teaching programmes provided

Does the cancer centre participate in teaching for PhD/BSc/MSc degree(s) in oncology nursing?

5.4.2.1.

Does the cancer centre provide

		Yes	Mostly	Partially	No	not applicable
5.4.2.1.1.	academic teaching in oncology					
5.4.2.1.2.	continuous medical education (CME)					
5.4.2.1.3.	BSc, MSc and PhD programs related to cancer research					

5.4.3. Types of teaching programmes organized

Does the cancer centre participate in organizing for PhD/BSc/MSc degree(s) in oncology nursing?

5.4.3.1.

Does the cancer centre organize/coordinate:

		Yes	Mostly	Partially	No	not applicable
5.4.3.1.1.	academic teaching in oncology					
5.4.3.1.2.	continuous medical education (CME)					
5.4.3.1.3.	BSc, MSc and PhD programs related to cancer research					



6. Patient related

6.4. Process control

6.4.1. Educational material

Has policy been defined concerning the production, distribution and administration of educational material relating to oncology?

6.4.1.1.

The cancer centre delivers:

		Yes	Mostly	Partially	No	not applicable
6.4.1.1.1.	written information on relevant aspects of oncology to the patients					
6.4.1.1.2.	written information on relevant aspects of oncology to general practitioners					
6.4.1.1.3.	The written information includes information about diagnostic examinations and methods of treatment					
6.4.1.1.4.	The written information includes information about clinical trials					
6.4.1.1.5.	The written information includes information about supportive care, complementary care and palliative care					

6.4.2. Inform patients on admission

Have procedures been established on informing cancer patients about cancer centre admission procedures?

6.4.2.1.

		Yes	Mostly	Partially	No	not applicable
6.4.2.1.1.	There is detailed information about the admission procedure					
6.4.2.1.2.	This information is available and communicated to the patient					
6.4.2.1.3.	The admission procedure is regularly assessed for efficiency					

6.4.2.1.4.	The cancer centre can accept patients during day and night in the event of an emergency, admit them if necessary, or refer them to another institute					
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6.4.3. Informing patients about results, treatment and counselling

Have agreements been reached on informing oncology patients about the results of diagnostic tests, about treatment (and follow up treatment), and about counselling (in terms of how it is done and what it means)?

6.4.3.1.

		Yes	Mostly	Partially	No	not applicable
6.4.3.1.1.	The cancer centre has procedures or guidelines regarding information transfer on diagnostics, treatment, follow-up and supervision of the patient.					
6.4.3.1.2.	Policies are defined about who is informing the patient, relatives and close friends about the result of an examination, further treatment or supervision					
6.4.3.1.3.	Policies are defined about when this information is delivered					
6.4.3.1.4.	Policies are defined about how the transmission of information to the people involved in treatment and patient care is organized					
6.4.3.1.5.	Policies are defined about how the relevant information transferred to the patient is described in the patient's file, such as information about the further treatment that can be expected, the plan of treatment, about requesting a consultation of another medical specialist, the consequence of potential side effects					

6.4.4. Discharge procedure

Does the cancer centre have a discharge procedure?

6.4.4.1.

		Yes	Mostly	Partially	No	not applicable
6.4.4.1.1.	There is a written discharge procedure					

6.4.4.1.2.	This procedure is regularly assessed					
6.4.4.1.3.	At discharge, information is provided to the patients about patients associations					
6.4.4.1.4.	At discharge, information is provided to the patients about self helping groups					
6.4.4.1.5.	At discharge, information is provided to the patients about home care					
6.4.4.1.6.	At discharge, information is provided to the patients about treatment and follow-up plans					
6.4.4.1.7.	At discharge, information is provided to the patients about contact details with cancer centre					



6.5. Safeguarding the quality system

6.5.1. Patient satisfaction / experiences

Does the cancer centre evaluate the patient's satisfaction / experiences related to cancer care?

6.5.1.1.

		Yes	Mostly	Partially	No	not applicable
6.5.1.1.1.	The cancer centre has a survey method for obtaining the patients' opinion about their experiences during consultation					
6.5.1.1.2.	The cancer centre has a survey method for obtaining the patients' opinion about their experiences during day care					
6.5.1.1.3.	The cancer centre has a survey method for obtaining the patients' opinion about their experiences during hospitalisation					
6.5.1.1.4.	The survey is regularly analysed and corrective measures are planned					
6.5.1.1.5.	There is a group of patients representing patients and serving as a link between the cancer centre and the patients for advisory and consultation					

6.5.2. Conciliatory commission for complaints

Does the cancer centre have an identified conciliator (or a conciliatory commission), for complaints related to cancer care?

6.5.2.1.

		Yes	Mostly	Partially	No	not applicable
6.5.2.1.1.	The cancer centre has a clearly identified conciliator or a conciliatory commission (sometimes known as a mediator or mediation service, or as the complaints officer or complaints department)					
6.5.2.1.2.	The role of the conciliator or the conciliatory commission is to reply to any request for information or complaints from the patients or their families.					

6.5.2.1.3.	The actions undertaken by the conciliator are recorded in a file that is used to produce an annual report					
6.5.2.1.4.	The conciliator gives feedback on his/her findings to the professional who is the subject of the complaint.					

