

**POGO Provincial Pediatric Oncology Satellite Program
New Satellite Preparedness Checklist**

Hospital:	Click or tap here to enter text.
Form Completed By:	Click or tap here to enter text.
Title:	Click or tap here to enter text.
Date Completed:	Click or tap here to enter text.

Ambulatory

- Has a proposed ambulatory-dedicated pediatric oncology space been identified? **Please select:**
If NO, please provide further context: **Click or tap here to enter text.**
- Check the box next to **EACH** statement that is true. In the proposed ambulatory-dedicated space:
 - ☐ pediatric resuscitation equipment is (or will be) available.
 - ☐ we can manage allergic reactions and/or anaphylaxis.
 - ☐ isolation rooms are (or will be) available.

Inpatient

If required, can your pediatric inpatient unit accommodate admissions for supportive care? **Please select:** If NO, please provide further context: **Click or tap here to enter text.**

- Check the box next to **EACH** statement that is true. On the inpatient ward:
 - ☐ pediatric resuscitation equipment is (or will be) available.
 - ☐ we can manage allergic reactions and/or anaphylaxis.
 - ☐ isolation rooms are (or will be) available.

Human Resources

- POGO Provincial Pediatric Oncology Satellite Clinics support patients on clinical trials to receive aspects of their care closer to home. A lead physician in the POGO Satellite Clinic will be required to assume the role of Designated Satellite Investigator and will be asked to complete general ethics and protocol-specific training requirements for conduct of research. Has a lead physician been identified? **Please select:**
If YES, please provide the name of the lead physician: **Click or tap here to enter text.**
- The POGO Satellite Clinic must have an experienced Satellite Nurse Coordinator with specific training in pediatric oncology. This individual will also have ongoing educational exposure and familiarity with oncology issues. This individual will also be primarily responsible for oversight of the delivery of nursing care in the satellite context. Optimally, there will be 1 or more backup nurses with an articulated interest in pediatric oncology who would have the opportunity for education exposure on an ongoing basis. Have you identified who this nurse/nurses will be? **Please select:**
If YES, please provide the name of the lead physician: **Click or tap here to enter text.**
- Do you have a list of key contacts throughout the hospital that will support the activities of the Satellite clinic (e.g., Research Office, Pharmacy, Blood Bank, Laboratory, Diagnostic Imaging)? **Please select:**
Note: When available, please share this list with POGO.

Education

- POGO will support the coordination and delivery of a locally-relevant adaptation of the Association of Pediatric Hematology/Oncology Nurses (APHON's) Pediatric Chemotherapy and Biotherapy Provider Course for Satellite clinic nurses. The training is delivered in-person or virtually. How many nurses assigned to the Satellite clinic do you propose to participate in this training in advance of the official launch? **Click or tap here to enter text.** How many inpatient nurses do you propose to participate in this training in advance of the official launch? **Click or tap here to enter text.**

8. Has your site identified any pharmacy-specific educational needs? **Please select:**
If YES, please specify: [Click or tap here to enter text.](#)
9. Are there any other educational needs you anticipate that we have not addressed? [Click or tap here to enter text.](#)

Policies and Procedures

10. Please utilize the checkboxes to indicate the status of your institutional policies/procedures for the following components of safe handling of chemotherapy:

	Policy/Procedure is Current and in Effect	Policy/Procedure is Due for Review	Policy/Procedure Needs to be Created
During administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disposal of chemotherapeutic agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Extravasations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Is total parenteral nutrition (TPN) currently administered to pediatric patients in your hospital? **Please select:**
If YES, do you have written TPN policies/procedures? **Please select:**

Venous Access

12. The following skills relate to venous access. Please check the box for all skills currently being used in practice in your hospital:

Skills	Implanted Venous Access Device (Ports)	Hickman/Broviac Catheter	PICC	Pediatric IVs	Insuflon
Access/start	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Draw blood from	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Give medication via	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heparinize (flushing and heparinizing lines)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Apply dressings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage blocked lines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Remove device	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pharmacy

13. Please check the box next to **EACH** anti-infective agent that is in your hospital formulary:
- | | | |
|---|--|--|
| <input type="checkbox"/> meropenem | <input type="checkbox"/> ciprofloxacin | <input type="checkbox"/> piperacillin/tazobactam |
| <input type="checkbox"/> cotrimoxazole (IV) | <input type="checkbox"/> levofloxacin (IV) | <input type="checkbox"/> amikacin |
| <input type="checkbox"/> acyclovir (IV and PO) | <input type="checkbox"/> levofloxacin (PO) | <input type="checkbox"/> clindamycin |
| <input type="checkbox"/> metronidazole | <input type="checkbox"/> ceftazidime | <input type="checkbox"/> vancomycin |
| <input type="checkbox"/> gentamicin or tobramycin | <input type="checkbox"/> cefepime | <input type="checkbox"/> liposomal amphotericin |
14. Are you able to obtain the anti-infective agents (listed above), which are not in your hospital formulary?
- ☐ Yes, we can obtain all of the anti-infective agents that are not in our formulary
- ☐ Yes, we can obtain some of the anti-infective agents that are not in our formulary
- ☐ No, we cannot obtain some of the anti-infective agents that are not in our formulary

15. Please check the box next to **EACH** anti-emetic that is in your formulary:

- | | | |
|---|---|--|
| <input type="checkbox"/> aprepitant | <input type="checkbox"/> palonosetron | <input type="checkbox"/> dexamethasone |
| <input type="checkbox"/> granisetron | <input type="checkbox"/> olanzapine | <input type="checkbox"/> nabilone |
| <input type="checkbox"/> ondansetron (PO) | <input type="checkbox"/> ondansetron (IV) | |

16. Are you able to obtain the anti-emetic agents (listed above), which are not in your hospital formulary?

- ☐ Yes, we can obtain all of the anti-emetic agents that are not in our formulary
- ☐ Yes, we can obtain some of the anti-emetic agents that are not in our formulary
- ☐ No, we cannot obtain some of the anti-emetic agents that are not in our formulary

17. Please check the box next to **EACH** extravasation agent that is readily available **on site**:

- ☐ DMSO (Dimethyl sulfoxide) topical solution
- ☐ Sodium thiosulfate
- ☐ Hyaluronidase* 1500 units' injection

18. Are you prepared to ensure that **all** extravasation agents (listed above) are readily available on site for the prevention and management of extravasation? **Please select:**

Laboratory

19. Which of the following blood collection methods are practiced at your hospital?

- Pediatric venipuncture **Please select:**
- Capillary **Please select:**
- Central line **Please select:**

20. Does your hospital have pediatric-specific guidelines around blood volume draws? **Please select:**

Blood Bank

21. Can your Blood Bank provide irradiated blood within 24 hours? **Please select:**

Diagnostic Imaging

22. Does your radiology team have expertise in pediatrics? **Please select:**

23. Are CT scans and MRIs performed on pediatric patients in your hospital? **Please select:**