Key Definitions for the Oncology Self Assessment

Key definitions are designated throughout the self assessment with **SMALL CAPITAL LETTERS.**

ACRONYM
An abbreviation formed from the first letter of each major word in a phrase (e.g., ISMP stands for Institute for Safe Medication Practices).

ACTUAL WEIGHT
See **WEIGHT**.

ADJUSTED WEIGHT
See **WEIGHT**.

AREA UNDER THE CURVE (AUC)
The amount of drug exposure or total drug concentration in plasma over a period of time, with the target **AUC** usually ranging from 2 to 7.5 mg/mL x minutes. The **AUC** is used primarily to determine the dose of **CARBO**platin to be administered based on the target **AUC** and the patient's renal function.

AUTHORITATIVE COMMITTEE
A committee empowered to make decisions related to patient medication therapy and clinical practice policies related to medication use (e.g., Pharmacy and Therapeutics Committee).

BATCH
The preparation of multiple units of the same drug with the same concentration in the same diluent and final volume – at one time – that can be used for multiple patients.

BEHAVIORAL CHOICES
Refers to *intentional* acts that are undertaken by the free exercise of one's judgment. Unlike human error, which is *unintentional* behavior, **BEHAVIORAL CHOICE** represents the purposeful behavior we intentionally employ while engaging in our day-to-day activities.

BIOLOGIC SAFETY CABINET (BSC)
A ventilated cabinet for the compounding of sterile preparations, providing protection for personnel, the product, and the environment. It has an open front with inward airflow for personnel protection from hazardous drug exposure, downward high-efficiency particulate air (HEPA)-filtered laminar airflow for the maintenance of product sterility, and HEPA-filtered exhausted air for environmental protection.[1] (See related term – **ISOLATOR**.)

BOARD OF TRUSTEES/DIRECTORS
A governing body of elected or appointed individuals who have oversight over the organization.

BODY SURFACE AREA (BSA)
The total surface of the human body based on height and weight that is used to calculate many chemotherapy drug doses. It is expressed as meters squared (m^2).

CATASTROPHIC STOP
Clinical alert in electronic systems (e.g., infusion pumps, order entry systems) that notifies the user that something is out of range or incorrect and prevents them from continuing. The alert cannot be overridden and the user has to start the process over from the beginning. (See also **HARD STOP**.)

CLOSED SYSTEM TRANSFER DEVICE
A drug transfer device that mechanically prohibits the transfer of environmental contaminants into the system and the escape of hazardous drug or vapor concentrations outside the system; a device that does not exchange unfiltered air or contaminants with the adjacent environment (e.g., Spiros, Onguard, PhaSeal). (http://www.pppmag.com/documents/V6N5/p28_29_30_31.pdf)

[1] Definitions, USP Chapter ‹797› Pharmaceutical Compounding — Sterile Preparations, Revision Bulletin, 2008

Key Definitions for the Oncology Self Assessment (continued)

COMPUTER SYSTEM
Refers to any electronic system into which medication orders are entered, such as computerized prescriber order entry (CPOE) systems into which medical staff enter medication orders, pharmacy computer systems into which pharmacy staff enter or validate medication orders, and nursing computer systems into which nurses document patient care activities and medication administration.

CONTINUOUS INTRAVENOUS INFUSION
Intravenous administration of a sterile fluid without interruption, over a defined period of time.

CYCLE
A dose of chemotherapy/biotherapy that is repeated at regular intervals (a cycle may also be known as a "course" or a "course of therapy"). Several chemotherapy/biotherapy cycles may make up a total treatment protocol. For example, the CHOP chemotherapy protocol may consist of six cycles of treatment given every three weeks.

ENCOUNTER
Any time a patient is provided with services from the organization/practice setting (e.g., a hospital admission, an office visit, a clinic visit for treatment).

HARD STOP
A forcing function in the computer system, intravenous infusion device, or other technology that will not allow the practitioner to continue operation without re-entering the information. (See also CATASTROPHIC STOP.)

HEALTHCARE PRACTITIONER
An individual with formal training who is authorized to perform specific healthcare related tasks (e.g., physician, nurse, pharmacist, pharmacy technician, healthcare aide).

HEALTHCARE TEAM
An interdisciplinary group (e.g., physician, nurse, pharmacist, pharmacy technician, social worker, etc.) that collaborates to deliver and monitor patient care.

IDEAL WEIGHT
See WEIGHT.

INDEPENDENT DOUBLE CHECK
A procedure in which two individuals, preferably two licensed practitioners, separately check each component of the work process. An example would be one person calculating a medication dose for a specific patient and a second individual independently performing the same calculation (not just verifying the calculation) and matching results.

INSTITUTIONAL REVIEW BOARD (IRB)
An interdisciplinary group that has been formally designated to review and monitor biomedical research involving human subjects. An IRB has the authority to approve, require modifications in, or disapprove research. The purpose of an IRB review is to assure that appropriate steps are taken to protect the rights and welfare of human subjects participating in the research. An organization can have an internal IRB, or contract with an external IRB (may also be called a Research Ethics Board [REB]).

INTERMITTENT INTRAVENOUS INFUSION
Intravenous administration of a sterile fluid for a defined duration that is repeated at defined intervals.

INTRAVENOUS PUSH
Intravenous administration of a small volume of sterile fluid over a short period of time, usually via a syringe.

Key Definitions for the Oncology Self Assessment (continued)

ISOLATOR
A specifically designed cabinet for compounding sterile preparations, providing protection for personnel from hazardous drug exposure, maintenance of product sterility, and protection of environmental chemical contamination. Air exchange into the isolator from the surrounding environment should not occur unless the air has first passed through a microbial retentive filter (HEPA minimum). Many isolators are sealed units whereby personnel prepare products by working through sealed portals with integral gloves attached to the portals. These sealed units may also be known as glove boxes. Some types of isolators require all materials inside to be gas sterilized. (See related term **BIOLOGIC SAFETY CABINET**.)

JUST CULTURE
Refers to a safety-supportive model of shared accountability where healthcare institutions are accountable for the systems they design, for supporting the safe behavior choices of patients, visitors, and staff, and for responding to staff behaviors in a fair and just manner. In turn, staff are accountable for the quality of their **BEHAVIORAL CHOICES** (human error is not a **BEHAVIORAL CHOICE**) and for reporting errors and system vulnerabilities.

LICENSED HEALTHCARE PRACTITIONER
An individual permitted by law to provide health care, treatment, or services without direct supervision.

MAXIMUM DOSE
The dose of a medication that represents the upper limit that is normally found in the literature, protocol, and/or manufacturer recommendations. **MAXIMUM DOSES** may vary according to age, weight, diagnosis, or co-morbidity.

ORDER SET
An ordering template, either pre-printed or electronic, that contains predefined information that is derived from evidence-based best practice guidelines.

PERSONAL PROTECTIVE EQUIPMENT (PPE)
PPE is equipment worn by those who handle, prepare, and administer chemotherapy/biotherapy and who handle excreta from patients who have received chemotherapy/biotherapy to minimize exposure. Examples of PPE include gloves, gowns, and eye protection.

PRESCRIBER
A healthcare practitioner who is legally permitted to prescribe care, treatment, and services without direct supervision as authorized by your organization.

PROACTIVE RISK ASSESSMENT
A quality improvement method that is based on the analysis of possible failures in the process, the possible consequences of the failure, and associated risk factors that may lead to the failure. Examples of **PROACTIVE RISK ASSESSMENT** tools include Failure Mode and Effects Analysis (FMEA) as well as self assessments such as this one.

PROTOCOL
A defined regimen for managing a particular treatment for a specific diagnosis (includes chemotherapy/biotherapy medications and dosing guidelines, supportive treatments, and required monitoring).

Key Definitions for the Oncology Self Assessment (continued)

PULLBACK METHOD
A method used during drug preparation in which the drug is drawn into a syringe, injected into an infusion bag/container, and then the syringe plunger is "drawn back" to demonstrate the volume that was added to the container for a second individual to verify the preparation. (This is not a recommended method to verify final drug preparation.)

REDUNDANT (REDUNDANCIES)
Repetitive steps that are intentionally added to a process to help detect errors.

ROOT CAUSE ANALYSIS (RCA)
A team-based retrospective process for identifying the underlying causal factors that may have led to a preventable adverse event.

SOFT STOPS
Clinical alerts that notify the user that something should be checked or confirmed before continuing. However, the user can easily override the alert and continue the process.

SPECIAL ACCESS DRUGS
Drugs that are provided by a supplier/vendor through a restricted distribution process, often requiring government or regulatory intervention.

STRUCTURED PROCESS
A defined systematic and standardized process with clearly defined steps and expected endpoints that have been agreed upon by the organization and all staff have been educated to follow.

SYSTEM DESIGN/REDESIGN
Refers to the design/redesign of processes, procedures, equipment, interfaces, overall structure, and the environment or conditions under which staff work, for the purpose of satisfying specific requirements, such as patient safety. The design of a system dictates how reliable it is in terms of satisfying specific requirements.

TALL MAN LETTERING
Refers to the use of mixed case letters to help draw attention to the dissimilarities of certain look-alike drug name pairs e.g., vin**CRIS**tine and vin**BLAS**tine. A list of look-alike drug names with recommended **TALL MAN LETTERING** can be found at: http://www.ismp.org/Tools/tallmanletters.pdf.

TIME-OUT
A formal process by which, immediately prior to a procedure, healthcare providers pause to review a standardized checklist to confirm the drug to be administered and the procedure to be performed for the patient (e.g., confirming the right patient, drug, dose, diluent, route, site, rate of administration).

TRANSITION OF CARE
The movement of a patient from one level or area of care to another (e.g., moving from an intensive care unit to a general hospital unit; transferring from a hospital to a nursing home).

TRIGGERS
Critical indicators (e.g., laboratory values, patient symptoms, use of antidotes for medications administered) that alert practitioners to the need for evaluation of a potential adverse event.

WEIGHT
- **ACTUAL WEIGHT**
  The **ACTUAL WEIGHT** of a patient without shoes or heavy clothing.
- **ADJUSTED WEIGHT**
  A calculated weight based on a standard formula that considers the lipid distribution characteristics of the patient.
- **IDEAL WEIGHT**
  The lean body weight of a patient, calculated using a standard formula based on height and gender.