**Supplementary Table 1**

1. Medication Reconciliation completed.
2. Patient education completed prior to care and treatment at each clinic visit and prior to clinic discharge.
3. Documentation completed in a timely manner per policy.
4. Patient documentation included age-appropriate pain assessment each visit, with appropriate intervention, and timely reassessment when pain identified.
5. Patient documentation included psychosocial risk screening, each visit (minimum every 6 months)
6. Patient documentation included functional risk screening each visit (minimum every 6 months)
7. Patient documentation included an abuse risk screening each visit and follow-up if necessary (minimum every 6 months).
8. Patient progress notes documented on the chart used National Cancer Institute Common Terminology Criteria for Adverse Events.
9. All chemotherapy administered has an "okay to give" order documented on the patient chart.
10. All medication administration included documentation of drug, dose, route, and response to medication. Chemotherapy administration included the documentation of blood return before and after administration.  Chemotherapy required a start and stop time, and the signature of the 2 nurses who verify the chemotherapy.
11. Documentation of 1 quality improvement project or evidence-based practice project.
12. Policies up to date.
13. Documentation of the Hematology/Oncology educational needs assessment. Evidence of life-long learning by participating in ongoing educational activities to expand knowledge, enhance role performance, and increase knowledge of professional issues.
14. Documentation of annual influenza vaccine administration to patients who are at least 6 months old.
15. At registration, patients receive an armband with 2 identifiers are used to place the armband.
16. All staff washed hands or hand cleaner before and after patient care.
17. Medications and chemotherapy are safely stored and locked away.
18. Medications prepared by pharmacy and nursing staff are labeled correctly.
19. Prior to all chemotherapy administration:  Appropriate patient assessment is completed; two registered nurses independently calculate drug dosages based on body surface area, verify written order for dosage, route, and mode of administration against protocol and roadmap; look for signed consent, “ok to give”; laboratory tests according to protocol; education of treatment with patient/caregiver completed.
20. All staff used personal protective equipment appropriately when handling cytotoxic therapy.
21. Performed patient identification at patient side with witness prior to chemotherapy administration.
22. Chemotherapy and other support medications administered according to protocol and national standards.
23. Staff aware of the location of chemotherapy spill kit, hazardous materials/chemotherapy are labeled and disposed of properly.
24. Patient/family education and anticipatory guidance about the disease and treatment.  Teaching methods are appropriate to the situation, developmental level, learning needs, language preference, and culture.  Feedback is encouraged and teaching strategies are evaluated.
25. Isolation patients are identifiable.  Isolation supplies available and used appropriately.  Soiled, used, and isolation equipment stored in proper area. Staff aware of how to reduce the risk of infection associated with medical equipment and devices between patient uses.
26. The clinic staff monitored the bacterial and fungal infections in the patient population.
27. The clinic staff monitored central line associated blood stream infections and interventions to reduce the number of incidences.
28. Sink or hand cleaning solution as well as appropriate gloves to perform patient care tasks available in appropriate areas. Chemotherapy approved gloves and gowns in the patient treatment area(s) where chemotherapy is checked.
29. Line care or peripheral intravenous line done within guidelines of national standards.
30. Participation in medical error reporting.
31. Evidence of a process to review the routine immunizations administered.  Evidence of a plan in place to administer immunizations to patients who are not up to date as well as those who may need to be immunized after oncologic treatment.
32. Patient documentation included falls assessment and follow-up for falls precautions if applicable.
33. Patient documentation included nutritional risk screening each visit (minimum every 6 months).
34. Guidelines followed for the care of febrile immunocompromised patients.
35. Hand-off communication documentation completed on transfers of new referrals.
36. Patient Satisfaction scores meet or exceeded the benchmark: Press Ganey standard overall mean score.