Patient safety in cancer care - Sweden

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Mirjam Ekstedt, RN, Ass. Prof.
Systems safety research
KTH, Royal Institute of Technology, Stockholm
mirj@kth.se
Sweden

Population: 9.6 million
24 habitants/km²

National government
**21 counties** - 7 regions, 9 university hospitals, 70 county hospitals, 1000 primary care centres
**290 municipalities** – home care, social care

National initiatives to: reduce waiting times, reduce regional disparities, increase patients' satisfaction

- National cancer strategy – national programs
- 6 Regional Cancer Centers
  - 30 national quality registers in cancer care
  - Regimen libraries for anti-cancer drugs
  - Policies for patient participation
National register data used to:

Analyze improvements and brittleness in the organization

Median time from diagnosis to treatment – Breast cancer at Karolinska Hospital

Analyze regional differences

Q1, median och Q3. Grå staplar i bakgrunden markerar 2011, 2012 och 2013
Structured patient safety work – a case

At the Karolinska Hospital, Stockholm - 170 cytotoxic treatments / day

The problem:
Hazards at the sharp end produced the same incident reports over and over again.
Low professional satisfaction, high turnover.

Participatory design and mixed methods:

1. Listening to the professionals’ worries about safety issues
   (Focus group interviews / walk arounds / observations)

2. All errors reported were analyzed in detail.
   (Review of incident reports and charts)

3. Risk analysis of the treatment process - from decision to administration of the drug.
   (Root cause and FRAM analysis)

4. Several interventions for quality improvement

5. Ongoing evaluation
   (Outcome measures: Safety culture measurements, register data, surveys)

Analysis of charts and incident reports

Top-10 risks

1. Missing or incorrect prescription of antiemetics
2. Incorrect prescription of cytotoxic drug
3. Drug not prescribed and/or ordered from pharmacy
4. Incorrect administration
5. Patient not taken the prescribed premedication or antiemetics
6. Incorrect dose verification
7. Regimen missed or incomplete
8. Errors related to the electronic prescription software
9. Leakage from the infusion bags/pumps
10. Prescriptions both manually and electronic (not matching)

24% of the reported errors were related to medication

62% of those (n=178) involved cytotoxic drugs (or premedication to cytotoxic drugs).

Sharp (in press) 2014
Risk analyses of hazards related to cytotoxic drugs

Well-educated experienced personnel

Resources

Administration just in time

Time

Administration of potent drugs

Preconditions

Risk of an adverse event

Control

Patients come for their treatments

Blood tests
Multi-professional team consultation
Decisions about treatment
Patient informed
Updated list of drugs
Correct delivery from the pharmacy
Clear drug prescription

Policies, routines “licenses” for equipment

Ekstedt & Ödegård, 2014
Unsafe transitions and unclear responsibility across professional and institutional borders

Transfers of patients between oncology dept. and other clinics

Patients’ care trajectories

VAL database (Health Care Register data at hospital and department level)
“It's like handing over the stick, not knowing that there is someone who receives it”
Actions undertaken to address the risks

- Top-10 risks
  - Standardized protocol for the delivery of cytotoxic drugs
  - Electronic prescription software
  - Automatic medication dispensers
  - New routines for documentation and ordination
  - Quiet zones for medication and preparation of cytotoxic drugs
  - Patient involvement
  - Extended accountability across professional institutional borders
  - New routines for documentation and ordination
  - Top-10 risks

Bridging gaps in the continuity of care

An active and informed patient (or family caregiver) acts as a buffer against medication errors and adverse events
On-going evaluation shows:
- increased number of reports among all professional groups,
- improvement in patient safety culture (Hospital Survey),
- improvement in the proportion of correct prescriptions,
- challenges - to get all staff to follow the new protocols.
Discussion

- What safety problems have been identified in cancer care in your country?

- Any successful attempts to improve patient safety?

- What should be the main focus in order to improve patient safety in cancer care?

- Can safety improvement in cancer care benefit from a shared international action – if so, what should be done?
Thank You!

Interested in collaboration?

Contact:
Sweden: mirj@kth.se

Norway: einar@hannisdal.net

Denmark: hlz@cancer.dk

- looking forward to hearing from you!