Patient Safety in Danish Cancer Care. Results from 4 studies

Studies carried out, 2008-11

1. Identification of **physical harm** through record-review (572) Global Trigger Tool in 4 inpatients facilities

2. Identification of cancer-related **adverse event** (2.429), *reported by Health professionals* to the National Patient Safety Database

3. Analyzes of **experienced adverse event** (132) *reported by patients and relatives* to the Danish Cancer Society

Results across the Studies

Most common safety problems

- Related to chemotherapy, radiation therapy, surgery and infections
- Clinical and administrative communication
- Access to diagnostic

Physical harm in 28% of admissions → most temporary harm
5% of AE reports → higher risk of permanent harm (4% vs. 2%)
29% of the patients experienced an error during their journey:
  - physical, psychological and social consequences
  - significantly correlated to number of transitions
  - no follow-up with every 4. patient

Types of safety hazards differ according to health care setting and method

* National Survey of Cancer Patients’ Perspective on Health Care. www.cancer.dk/barometer
**Conclusion and Challenges**

**Conclusion**
- Significant and specific cancer related safety hazards
- Patients provide new information
- No single method can draw a complete picture

**Challenges**
- Address cumulative failures across the continuum of care
- Monitoring; indicators and tools → Create an evidence based platform
- From knowledge to action → Enhanced involvement of physician and leaders in healthcare, and involve patients as partners

Safety needs explicitly to be addressed in cancer care and planning

---

National working group established by the Cancer Society, Clinical Cancer Groups and hospital owners:

Transition Radiotherapy Chemo-therapy Iatrogen infection Patient involvement Monitoring

International collaboration?