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Optimizing Quality & Safety Systems to Reduce the Risk of Patient Harm

Dr. Sands:
Over the past few decades, increasing attention has been directed on reducing the risk of patient harm within the healthcare system. This includes morbidity and mortality conferences to learn from events and incident-reporting systems that aid in more broad program implementation. How can we be aware of potential risk scenarios and avoid making common mistakes within medical oncology?

Welcome to Project Oncology on ReachMD. I'm Dr. Jacob Sands. And joining me today to discuss how we can improve quality and safety for patients in oncology is Dr. Joseph Jacobson, Senior Advisor for Quality and Patient Safety at Dana-Farber Cancer Institute and prior Chief Quality Officer. Dr. Jacobson is an Associate Professor of Medicine at Harvard Medical School.

Dr. Jacobson, thanks for joining me today.

Dr. Jacobson:
Thanks for the invitation, Jacob.

Dr. Sands:
So quality and patient safety is such an important field that kind of touches on everything, yet it's also not really what people often grow up wanting to work in. What drew you into this field?

Dr. Jacobson:
I trained as a medical oncologist now almost 40 years ago. I was trained in the way that we all are, in the science and the practice of medicine, but what struck me early on in my career is that patients were not uncommonly exposed to risks that weren't necessary. There were harm events that were often preventable often due to very simple things like the absence of failsafe systems for administering medications, for the lack of standardization. Those are a couple of examples. But that led me ultimately towards doing additional training, a midlife crisis if you will. I went back and did a master's in epidemiology in the early 1990s where I was exposed for the first time for those who had invested their whole careers in quality and patient safety. Following that, I sort of never looked back. And although I continued to practice oncology throughout my career, I also became progressively more interested in how we make patients safer, how we measure the quality and safety of care that we administer, and most importantly, how we can improve those things.

Dr. Sands:
Now quality and patient safety is something that I think everybody considers as a part of what they're doing in care for patients, but really, there are a lot of systems in place and whole teams within hospitals that are working on optimizing their different systems to minimize risks. Can you talk a bit more about those safety nets so to speak that are being developed?

Dr. Jacobson:
In the best of worlds, neither our clinicians nor our patients are thinking about patient safety during the day because they are convinced

that we have the infrastructure in place to keep them safe and to provide the best care, but in fact, when you start peeling the layers back from any hospital system, you'll find that there are all kinds of programs and processes in place that are designed to both measure anything that may not be going as well as we might like but also to assure that care is as safe as it possibly may be. There are national bodies that require us to measure many things in healthcare. The Joint Commission representing CMS is one of those. So they require that all hospitals, for example, have a voluntary reporting system in place so that when anyone spots a risk or worse, may identify a patient who's actually exposed to harm or experienced it, that kind of information will be collected anonymously, discreetly, but collated and shared so that there can be institutional learning.

There are all kinds of systems in place that require that what we do as a profession—administer chemotherapy—is done in the safest possible way. ASCO years ago created the set of standards for prescribing and administering antineoplastic therapy. There are all kinds of safety systems built into our electronic health record. Not all those are perfect, but they are there to help assure safety. An example, obviously, is the use of computer order entry rather than writing orders out by hand, as I did for most of my career.

Dr. Sands:
Now this is such a huge topic that I feel like we need to focus in on a few areas for further overview. Let's start with some risk scenarios, so what are some certain scenarios like that which would be the higher-risk scenarios?

Dr. Jacobson:
So even though our care is so much safer than it used to be, there are risks that persist. In the last couple of years working with my colleagues at the Dana-Farber and at Beth Israel Deaconess Medical Center and Massachusetts General Hospital, we actually looked at several hundred incident reports from those sites to understand what lingers that maintains some risk for our patients. And, for example, we found in our three hospitals that we studied, two of which used the same information system and one uses a homegrown system, there are some risks that we found across all sites.

There's one that we called carry-forward errors in writing chemotherapy from cycle to cycle. This probably wouldn't have happened with paper orders, but with electronic orders, we have the opportunity to order a cycle of chemotherapy, and when it's time for the patient to receive the next cycle, to copy that forward for cycles two and three and four; it's very easy to overlook a dose reduction that may have been made midcycle. We found challenges in scheduling the frequency of follow-up treatments, for example, for adjunctive therapies. We found challenges in the electronic health record related to scheduling follow-up visits. There are some things that our electronic health record does really well. There are others that don't.

It's interesting that we found challenges with something that we talk about glibly in healthcare now, smart pumps. Our pumps have language programmed into them, but we found that those smart pumps sometimes weren't so smart, and we stumbled upon some significant programming errors that led to misadministrations of drug, including some high-risk drug. We found problems in the environment of care because we separate generally where we provide our exams and where we provide infusion, and that means that there are opportunities for what I would call voltage drops, information not being communicated from the exam area to the infusion area. Those are some examples.

Dr. Sands:
Now aside from these risk scenarios, there's, of course, also the clinician's mindset and potential blind spots. I think I've heard you refer to these as cognitive errors within the system. And so what are some of the blind spots where we need to be most aware of something that we're potentially missing when we're providing care to patients?

Dr. Jacobson:
Well, there is a whole science related to things that are called cognitive biases. We are imperfect machines, right? And when we head into patient care, we often come in with a variety of biases. There could be last-case bias in which we walk into the room being profoundly influenced by the last patient we saw. Maybe their outcome was great, or maybe it was problematic, and when we confront the next patient with a similar illness, we may be biased towards that. There are anchoring biases where we head into an exam room to see a patient who we know very well, we know their diagnosis, but if they present to us with something that may be subtly different, we're likely to anchor on the diagnosis we already have at hand and that can lead sometimes to catastrophic consequences. There are availability bias—you know, what's the information that we have at hand when we walk into the room. Those can influence us as we are

working in often distracted environments, we are behind schedule, and we have to reach a therapeutic decision in a hurry, and that's a vulnerability. It's sort of the nature of the beast, if you will, of having humans involved in patient care—which, of course, we would never want to remove.

Dr. Sands:
For those just tuning in, you're listening to Project Oncology on ReachMD. I'm Dr. Jacob Sands, and I'm speaking with Dr. Joseph Jacobson about quality and patient safety in oncology.

Now we've discussed quite a bit about the clinician and what the clinician focuses on and part of the participation of clinicians within that is filling out incidence reports to help with system awareness around areas that are particular pain points. Can you talk a bit about incidence reports and any broader information that we have about those and how they have led to system development?

Dr. Jacobson:
We've not been very good as a profession entering incident reports. Across most hospital systems, less than 10 percent of incidents or incident reports are placed by physicians and at our own institution that number is under 2 percent. In our institution, most are placed by nurses and pharmacists, so I guess the most important thing I would say is if you as a provider stumble upon a situation where you think patient safety is at risk, even if an event hasn't happened, you have access to an electronic incident reporting system. I can almost guarantee you that this exists in your hospital system. You usually find it on your intranet and in about the course of two or three minutes, you can click into the system and explain the scenario, and once you've done that, your work is done. And then the quality and patient staff collects those incident reports, reviews them for severity, collates them so that they fall into a series of categories, and ultimately looks to see where improvements can be made to reduce future risk for patients. So incident reporting is a potential way to identify existing risks and reduce them for future patients.

Dr. Sands:
So you've talked about the incident reporting system and how that alerts the Quality and Patient Safety team to other issues that are happening and collating those based on numbers. And so what are the next steps after that patient reporting?

Dr. Jacobson:
So there are other tools that hospital systems and cancer centers have available to them. We can go to patient records. There are now a growing number of tools that are available to review the electronic health record electronically. Those are called trigger tools. A recent report in The New England Journal from a series of Harvard hospitals used manual review of trigger tools to see, for example, how safe patients are when they are admitted to the hospital across about 10 Harvard-associated hospitals, and what they found is about a quarter of patients will experience an adverse event while they're in the hospital, and at least a quarter of those are potentially preventable, some due to cognitive errors but more often due to failures in the system.

We can do audits of hospital records. We can review mortalities. All hospitals are mandated to look at mortalities to see whether or not they were expected or not. We can source patient complaints and patient grievances. We can look at malpractice claims. There are registries that societies like the American Thoracic Society keep for looking at outcomes, so there are many ways to do this.

Dr. Sands:
What are some places that our listeners can go to for more information about this or any other resources you can direct them to?

Dr. Jacobson:
At Dana-Farber we've started doing Morbidity, Mortality, and Improvement rounds where we pick cases that make us a little bit uncomfortable and talk about them openly but most importantly talk about what we can do to make the next patient safer. Those MM&I rounds we've now brought to publication. The JCO Oncology Practice has agreed to publish a series of MM&I reports. The first two of those from our institution, Dana-Farber Cancer Institute, have been published. The third is in press, and fourth and fifth articles are now in preparation. And once we get this process up and running, we will invite outside institutions to submit their own MM&I's. But for now, I guess the most important thing is to talk about the fact that our patients are exposed to risk every day, and in my opinion, our most

important responsibility is to try to reduce those risks as close to zero as we can get, recognizing that we'll never get to zero risk.

Dr. Sands:
Thank you for sharing those key takeaways. I look forward to following that JCO oncology Practice MM&I series. I think you had said that that's quarterly. As we come to the end of the program though, I want to thank my guest, Dr. Joseph Jacobson, for sharing his insights on quality and patient safety in oncology. Dr. Jacobson, thanks for speaking with me today.

Dr. Jacobson:
My pleasure. Thanks for the invitation.

Dr. Sands:
I am Dr. Jacob Sands. To access this and other episodes in our series, visit ReachMD.com/ProjectOncology, where you can Be Part of the Knowledge. Thanks for listening.