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HENDES MAJESTÆT DRONNINGEN

Title

Patient safety in Danish cancer care

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R+D projects

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Background

Error happens when people work together to perform complex tasks in complex organizations. This is also the case in the treatment of cancer. Some errors harm the patient, and some of this harm can be prevented. Knowledge of the types of adverse events that occur in cancer treatment can be used to enhance patient safety. Due to their potential fatal disease and the often multifaceted treatment they receive, cancer patients may have an increased risk of iatrogenic harm. There is no reference method that can be used to estimate the true occurrence of adverse events.

Purpose

The aims of the project are to

- identify risks and safety hazards for Danish cancer patients
- test the use of Global Trigger Tool to identify adverse events (harm) to cancer patients
- apply a disease-specific approach to the analysis of adverse events in the national Danish Patient Safety Database
- test a patient reporting system

Method

A combination of three different methods has been used to identify adverse events (AE):

1. Retrospective record review using Global Trigger Tool (GTT)



2. Analysis of data from the national Danish Patient Safety Database (DPSD)
3. Patient reporting of patient safety events

AEs were categorized by type and consequences to the patient in all three studies. Major event types were further subcategorized and analyzed.

Results

1. The overall rate of AEs identified with GTT was 68/1,000 patient days. The majority of harm was related to events categorized as Clinical process, Hospital acquired infections and Medication. Harm was rated as Temporary harm that required intervention, Temporary harm that required initial or prolonged hospitalization or Permanent patient harm.
2. The majority of DPSD-cancer events were related to Medication, Clinical process, Documentation and Clinical administration. Most events led to no or minor harm to the patient, but in some cases patients suffered permanent harm.
3. Most of the patient-reported events were related to Clinical process, Medication and Communication/information. Consequences to the patients were physical, psychological or social in nature.

The usability of each method in relation to monitoring patient safety in cancer care has been discussed.

Conclusions

The findings of the project have created an understanding of some of the safety problems in Danish cancer care. The perspective of identifying risks and hazards were to create a knowledgebase for prevention and safety improvement. Recommendations on selected safety issues have been made. The recommended actions have not yet been implemented.

Triangulation of methods is helpful in drawing a nuanced picture of patient safety in cancer care. Each method identifies different risks and hazards, some of which are unique to cancer care whereas others are not disease specific.

Our work primarily covers in-hospital treatment of cancer patients. Further work needs to be done in order to gain knowledge of patient safety in the whole patient pathway, including ambulatory and primary care as well as in transitions.