





# Preventing Future Harm: Identifying the Drivers of an Unsafe Discharge to Improve Safety on an Inpatient Oncology Service

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## ABSTRACT

*Cancer Morbidity, Mortality, and Improvement Rounds is a series of articles intended to explore the unique safety risks experienced by oncology patients through the lens of quality improvement, systems and human factors engineering, and cognitive psychology. For purposes of clarity, each case focuses on a single theme, although, as is true for all medical incidents, there are almost always multiple, overlapping, contributing factors. The quality improvement paradigm used here, which focuses on root cause analyses and opportunities to improve care delivery systems, was previously outlined in this journal.*

This article describes the care of a young patient with aggressive breast cancer, declining performance status, and multiple hospital admissions who died shortly after being discharged home without essential medications or an adequate plan for follow-up. The patient's death due to her malignancy was unavoidable, but she had inadequate resources before her death, leading to avoidable suffering. This outcome resulted from a series of minor errors attributable to inadequate handoffs, challenges establishing realistic goals of care, and hierarchy within and between medical teams that resulted in major lapses at the time of discharge. We explore these issues and discuss how this case led to the establishment of programs designed to empower health care providers and increase engagement of outpatient oncologists at critical points of patients' disease courses.

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## THE CASE

Case details were altered to maintain patient confidentiality, but the themes were preserved.

*JD, a previously healthy 45-year-old premenopausal woman, presented to the emergency room with a left breast mass. She had not seen a doctor since childhood and delayed seeking care because she was busy managing a small business she owned and caring for her young family. She was a recent immigrant and provided income to family members in her home country. Clinical exam and imaging demonstrated a mass measuring over 1.8 cm in the left breast with dimpling of the skin and axillary adenopathy with no evidence of distant metastases. After multidisciplinary discussion, the patient declined neoadjuvant therapy and elected to proceed straight to a left mastectomy and axillary dissection. Surgical pathology showed 1.5 cm tumor that was hormone receptor negative and negative for HER2 with 6/10 lymph nodes involved without extracapsular extension. Margins were negative.*

*Two weeks after surgery, JD met with radiation and medical oncology to discuss adjuvant treatment for her triple negative breast cancer. She was overwhelmed at this*

*visit but consented to start adjuvant chemotherapy followed by radiation. However, after that visit, she did not return to clinic for 9 months despite repeated attempts to contact her. When eventually contacted, she stated she needed to continue working to support her family here and in her home country. She also shared that she was deeply religious and felt that her outcome was 'in God's hands.'*

During JD's initial interactions with medical providers, she shared with her care team what was most important to her—family, faith, and financial concerns—and how they would shape her goals and decisions. Her social history also revealed several social determinants of health associated with worse outcomes among patients with cancer.<sup>1,2</sup> JD was the sole income earner for a large family, and she felt obligated to continue working to provide for her family, a sign of financial toxicity. Financial toxicity describes that the ways out-of-pocket costs associated with cancer care negatively affect quality of life and care quality, and younger patients are more likely to experience financial toxicity since they are more likely to be uninsured or underinsured, have fewer savings, and work lower-level jobs with less flexibility.<sup>3,4</sup> Additionally, JD was an immigrant and spoke English as a second language. Although her English was considered adequate and she

usually declined interpreters, this case raises concerns about what constitutes culturally competent care and what should be done to facilitate true shared decision making when patients and providers come from different backgrounds.<sup>5,6</sup>

Nine months later, JD was admitted to the hospital with back pain and nausea. Her total bilirubin was 3 times the upper limit of normal and imaging showed biliary obstruction from metastatic cancer, innumerable bone metastases, and peritoneal carcinomatosis. Gastroenterology placed of a biliary stent, and her labs and symptoms improved. One week later, JD began single agent chemotherapy. Her course was complicated by numerous missed appointments, persistent nausea, and fatigue. After six cycles of therapy, imaging showed stable disease; however, JD had lost 20% of her body weight and her ECOG performance status had declined from 0 to 2.

During cycle six, JD was admitted for intractable nausea and vomiting. Her symptoms improved with medication optimization. On hospital day 4, she could not tolerate solid foods, but she requested to be discharged to return to work. A social worker spoke with JD several times, but she respectfully declined assistance. The inpatient team attempted to facilitate a goals of care discussion, but JD declined stating that her care was ‘in God’s hands.’ Her outpatient oncology team planned further chemotherapy, and JD was anxious to restart treatment.

Four days after discharge, JD was readmitted with nausea, vomiting, abdominal pain, and high fevers. Blood cultures revealed polymicrobial bacteremia, and imaging showed intrahepatic biliary dilation. Cholangitis was diagnosed. During a 20-day admission, JD received broad-spectrum antibiotics, a new biliary stent and a venting gastric tube. Biopsy showed metastatic triple negative breast cancer. She initiated total parenteral nutrition (TPN) with the hope she could recover enough to receive additional systemic therapy. The palliative care team met with her daily to address her symptoms and help with coping. JD again was resistant to talk about the severity of her illness or her goals of care with the palliative care team—she felt her tumor would eventually respond to treatment, and she was eager to resume chemotherapy.

JD now had three unplanned hospital admissions in <6 months (Fig 1). Patients with metastatic solid tumors with a single unplanned admission have a median overall survival of 6 months.<sup>7</sup> After a second unplanned admission, median overall survival drops considerably.<sup>8</sup> Other features, such as JD’s extensive peritoneal carcinomatosis and declining performance status, also pointed to a poor prognosis.<sup>9</sup> JD’s outpatient oncologist and the palliative care team tried several times to discuss her poor prognosis and her goals of care, but JD consistently stated that she wanted to continue any available treatment and that her faith would guide her decisions.

Two weeks after discharge JD started treatment with a novel antibody drug conjugate. At the C1D1 visit, she

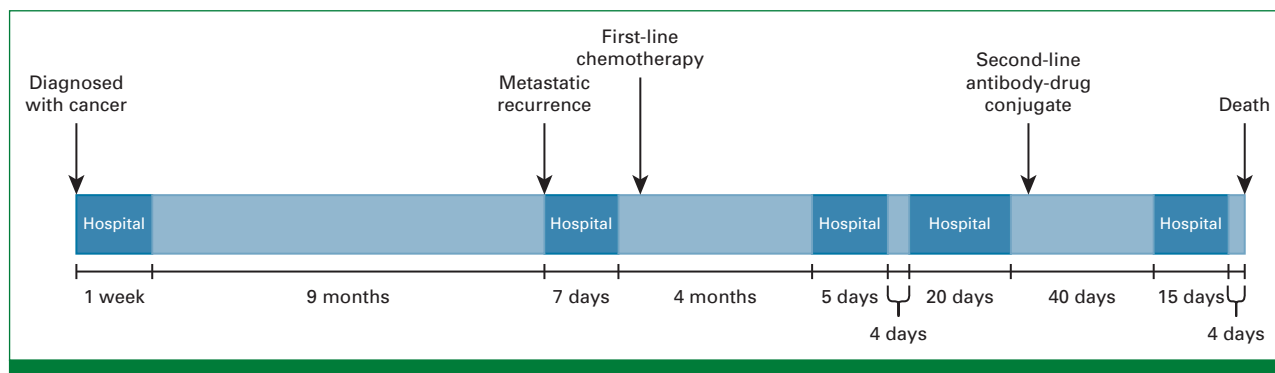
reported leaving her gastric tube open most of the day due to persistent nausea. During cycle 2 of treatment, JD fell at work and was admitted for pain and failure to thrive. Imaging showed tumor progression at multiple sites and new brain metastases. JD’s husband stated she was not taking some of her medications because of high costs and side effects; they made her too sleepy to work.

Several days after admission, a goals of care meeting was held with the outpatient oncologist, the inpatient oncology team, palliative care, social work, a medical interpreter, JD and her husband. At that time, JD’s pain and nausea were moderately controlled with intravenous (IV) narcotics, IV antiemetics and gastric tube venting. TPN was stopped due to anasarca, and she was receiving a continuous IV dextrose infusion. The treatment team discussed the possibility of home hospice, but JD was not ready to transition to hospice. She insisted her goal was to return home to be with her family and return to work, and she implored the medical team to try additional antineoplastic treatments. JD’s outpatient medical oncologist strongly encouraged her to consider hospice. However, when pressed on whether there were any available treatments, he indicated immunotherapy was possible based on her recent biopsy showing a high tumor mutational burden. He estimated the chance of responding was less than 20% and said JD would need to be home with an improved performance status to receive additional therapy.

At the end of the meeting, the plan was to manage JD’s symptoms as best as possible while she remained an inpatient and try to progress to a point that she could be discharged home with supportive care. However, over several days, documentation and conversations evolved so that the stated goal became to discharge JD home with a plan to receive outpatient immunotherapy.

Documentation from the family meeting on hospital day 10 was clear: All members of the care team recommended hospice, either at home or inpatient, but JD was not ready to accept this recommendation. She had previously indicated that she wanted to receive any available treatments, and after the meeting, she focused on the remote possibility of future immunotherapy. During multiple handoffs in care as inpatient teams transitioned over the next week, the language in the notes gradually shifted from describing a goal of getting JD home, ideally on home hospice, to discharging her to receive immunotherapy as an outpatient.

There were two drivers of this shift. First, JD’s insurance did not cover outpatient administration of some IV medications she needed, so discharge plans changed to accommodate her medical needs and her goal of returning home. Second, as providers shifted within each team, information was lost during the handoffs. JD became the only source of continuity throughout the admission, and her desire to continue treatment with immunotherapy went from being a remote possibility to the main narrative.



**FIG 1.** Timeline of major events during JD's disease course. Note that timeline is not to scale.

On hospital day 15, a Saturday, JD requested to go home to be with her family. She was on oral opioids and antiemetics, but she could still not tolerate oral intake or clamping of her gastric tube for more than 30 minutes, and she continued to receive the IV dextrose infusion. The inpatient team could not coordinate a plan with the home-based palliative care team over the weekend, and the patient's insurance would not cover visiting nursing services. She was supposed to be discharged with a three-day supply of oral opioids, but the medications were neither given to her prior to discharge nor sent to a local pharmacy due to issues with prior authorization. For nutrition, the dextrose infusion was stopped, and JD was encouraged to drink small sips of high glucose liquids. The discharge note stated the plan was for JD to follow up with her outpatient oncologist the following week to start immunotherapy.

Later that day, JD's husband called the oncologist's office because JD was in pain, and they did not have any pain medications. The covering provider sent a 3-day prescription for an incorrect dose of opioids—only 20% of the dose she was taking during her admission—to the local pharmacy.

Two days after discharge, the home-based palliative care team made their first home visit and found JD dehydrated, delirious, in pain, and showing signs of opioid withdrawal. They initiated an urgent goals of care conversation with JD's family and her outpatient team. JD was too delirious to participate in the conversation, and her husband agreed to transition her to home hospice. JD died at home two days later.

## DISCUSSION

This case describes a young woman with advanced breast cancer who supported a large family and consistently expressed a goal to do everything possible to continue caring for them (ie, to continue treatment) even as she experienced a precipitous clinical decline. Her care team left open the door for further treatment when there was little hope of meaningful clinical improvement, and flawed care

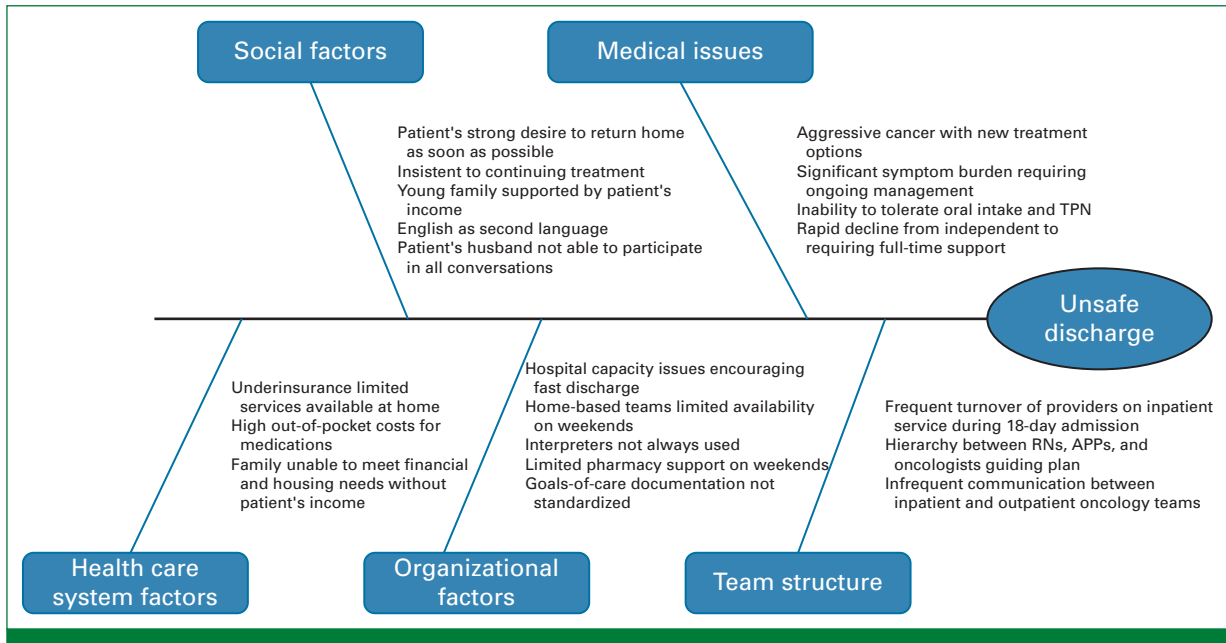
transitions and handoffs led to an unsafe discharge. As a result, JD spent her final days in pain without adequate support from her health care team. Numerous issues contributed to JD's outcome; here, we will focus on unclear goals of care, flawed handoffs, and hierarchies within medical teams.

### Goals of Care

Oncologists avoid goals-of-care conversations for many reasons—concern they may negatively affect patients, lack of training, prognostic uncertainty, concerns about cultural appropriateness, fear of letting patients down, and the emotional burden of delivering “death sentences”.<sup>10,11</sup> This latter concern is especially resonant. While taking steps to guard their own well-being, oncologists should recognize how their emotions can affect clinical reasoning and judgment.<sup>12</sup> Whether because of bias or other factors, oncologists tend to overestimate overall survival for patients with advanced cancer,<sup>13,14</sup> and prognostication is becoming more challenging as small percentages of patients have durable responses to novel therapies.<sup>15</sup>

Clinician's emotional responses to difficult conversations can also lead to collusion—interconnected responses to a shared emotional trigger between individuals with a strong bond—with patients.<sup>16</sup> When patients such as JD resist end-of-life conversations and focus on unrealistic goals, oncologists may unconsciously collude with them by avoiding direct communication about poor prognoses or offering unrealistic treatment options.<sup>17</sup> JD's outpatient oncologist strongly encouraged hospice as JD's best option and informed JD that future immunotherapy was unlikely to provide benefit, and inpatient providers repeatedly documented JD's clinical decline. However, every member of the care team moved forward with the plan to discharge a dying patient for treatment that she was unlikely to receive.

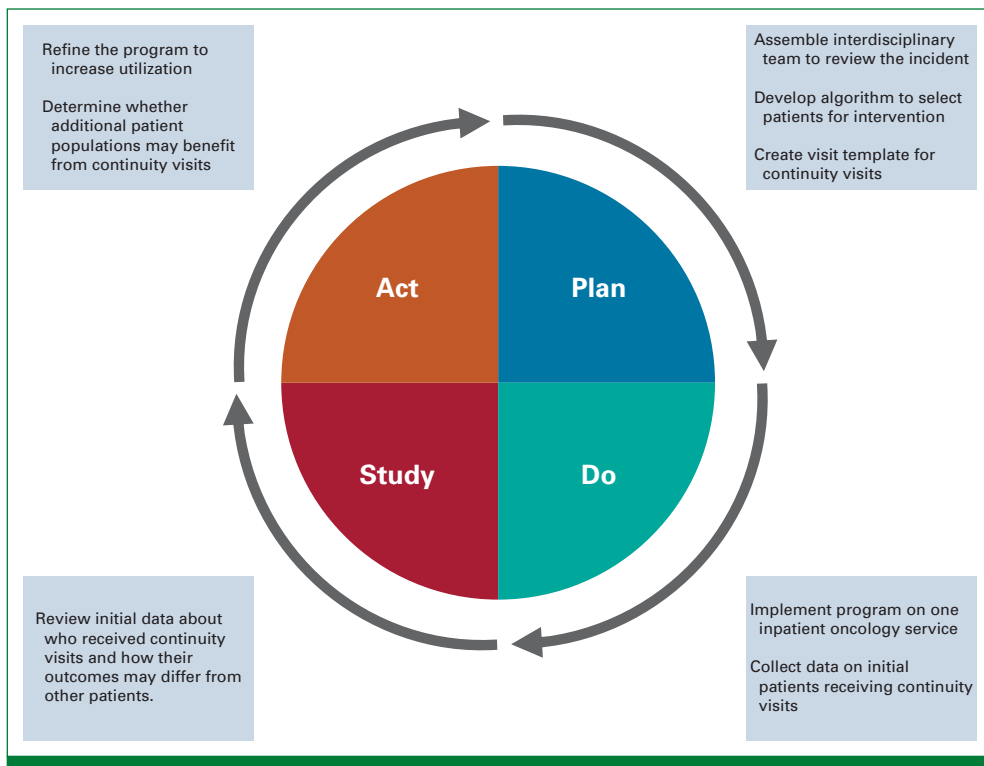
These issues are consequential. Avoiding honest conversations about a poor prognosis can prevent a patient from focusing on things that are most important near the end of life—a sense of completion, preparing for death, funeral arrangements, and coming to peace with God.<sup>18</sup> If clinicians



**FIG 2.** Fishbone diagram illustrating numerous issues that contributed to errors during JD's disease course. APP, advance practice provider; RN, registered nurse; TPN, total parenteral nutrition.

had consistently told JD that, on average, patients initiated on immunotherapy during hospital admissions have a median overall survival of <2 months,<sup>19</sup> that may have helped

focus her efforts on spending time with her family and spiritual community rather than pursuing a remote possibility of further treatment.



**FIG 3.** PSDA cycle with details about how this quality improvement tool could be used to implement an intervention in address one of the systemic issues highlighted by this case. Figured on the basis of PSDA Directions from the Agency for Healthcare Research and Quality's Health Literacy Toolkit.<sup>33</sup> PSDA, Plan-Do-Study-Act.

Fortunately, there are evidence-based approaches to improve goals of care discussions. Validated tools can improve prognostication, and team-based approaches to goals-of-care conversations can reduce the emotional burden on oncologists and decrease the chance of patient-provider collusion.<sup>10,13</sup> Additionally, interdisciplinary team meetings held in advance of family meetings can improve alignment on shared messaging and important information to share.

## Care Transitions

Care transitions are important quality challenges and have been discussed in previous cases of this series.<sup>20</sup> Incomplete communication during handoffs increases medical errors, and the importance afforded handoffs has outsized effects on an organization's safety culture.<sup>21,22</sup> Considering the effects of major and minor handoff errors, in a study at Great Ormond Street Hospital for Children, de Leval<sup>23</sup> found that the accumulation of minor errors—errors that in isolation would not be life threatening—during care transitions was as strongly associated with poor outcomes as major errors.

In JD's case, both the accumulation of minor errors during her final admission and major errors at the time of her discharge contributed to her outcome. Minor errors during handoffs led to the documented goal for her care during her final admission to shift from getting JD home, likely with hospice, to discharging JD for a trial of immunotherapy. It is not certain that the shift in the goal of care contributed to the errors at the time of her discharge, but consistent recommendations of hospice would have increased the chances of discharge with appropriate resources for end-of-life care.

Ultimately, JD's eagerness for an early discharge over a long weekend led to a cascade of errors—sending her home without an adequate nutrition plan, without pain medications and without a handoff to the outpatient team—that directly contributed to her poor symptom management before her death. During follow-up conversations, multiple members of JD's care team expressed concerns about the discharge plan, but they did not feel they owned responsibility for her care, and no one expressed concerns at the time or paused the plans to ensure JD was discharged safely.

## Hierarchy

Hierarchy, both between and within teams, is firmly entrenched in oncology care and clearly contributed to the gaps in JD's care.<sup>24</sup> The Institute of Medicine's seminal report *To Err is Human* described how authority gradients can impair communication and care quality.<sup>25</sup> Hierarchy decreases physicians' and nurses' willingness to discuss safety concerns,<sup>26,27</sup> and it prevents interprofessional communication and delegation that can empower members of care teams to navigate important care transitions, such as the transition to hospice.<sup>28</sup> The inpatient nurse practitioners were concerned about JD's discharge plan, but they felt powerless to alter the plan which reflected

both the patient's strong desire to pursue additional treatment and the outpatient oncologist's willingness to offer immunotherapy.

Outpatient oncology teams are often viewed as the primary team throughout a patient's course of care, even when patients are under the day-to-day management of an inpatient team while in the hospital. There are good reasons for this hierarchy: Outpatient oncology teams have close relationships with patients and have cared for them through multiple treatments, and these experiences provide important data to guide decisions. Additionally, at academic medical centers, inpatient providers may defer to outpatient colleagues who possess highly subspecialized oncology knowledge. However, when treatment courses are interrupted by multiple admissions, the outpatient team at the top of the hierarchy may have less frequent contact with patients and miss important details about their clinical status.

Because of JD's frequent admissions and missed clinic visits, her outpatient oncology team had just one documented encounter with her in the 30 days before her final admission and only three documented encounters in the preceding 4 months. As she neared the end of her third hospital admission, the inpatient teams may have known JD better than his outpatient team. However, her outpatient oncology team continued to drive the plan for care, and after the outpatient oncologist presented the option for immunotherapy, inpatient clinicians did not feel they could take it away.

In conclusion, this case was discussed at Morbidity, Mortality and Improvement conference at the institution where it occurred. During the conference, the team reviewed JD's course, identified the key factors that contributed to her outcome (Fig 2), and discussed ways to prevent future harm in similar cases. It was discussed that although JD's rapid decline after an unsafe discharge was particularly dramatic, poor communication and entrenched hierarchy commonly lead to safety concerns on the inpatient service. Potential solutions included programs to empower frontline staff who have safety concerns, developing mechanisms to increase participation of outpatient oncologists during inpatient admissions, implementing evidence-based handoff tools, and structuring team meetings to improve multidisciplinary communication.<sup>29,30</sup> After this discussion, two new programs were implemented.

One intervention aimed to promote just culture on inpatient teams by empowering all staff to raise safety concerns and speak up in the setting of hierarchy.<sup>31</sup> Stop the line terminology was introduced to create a framework for holding impromptu meetings using standardized structures and communication tools that can be called if two members of a patient's care team have safety concerns before discharge.<sup>32</sup> The program was widely promoted within the inpatient oncology teams, and there are informational sheets detailing it in all provider workrooms. The second intervention

aimed to increase the involvement of outpatient oncologists through continuity visits with patients who have had multiple recent hospital admissions or a prolonged hospital stay without a clear discharge plan. The continuity visit program was implemented with the Plan-Do-Study-Act framework (Fig 3) and is currently being evaluated.

These programs may be able to mitigate the effects of hierarchy and improve communication within teams, but JD's case highlighted broader challenges and ethical issues. Financial toxicity was an issue in every step of JD's care, but

she declined multiple attempts by social workers to provide assistance. The challenges facing underinsured patients with no alternative source of income are well documented, and addressing the root causes of financial toxicity will require broader shifts in how governments and health systems support patients with cancer. Additionally, this case highlights the delicate balance between respecting patient autonomy and avoiding futile care when patients adamantly request care that is more likely to lead to harm than benefit. Multidisciplinary discussions are essential to navigating these ethical challenges and reducing potential harm.

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### Preventing Future Harm: Identifying the Drivers of an Unsafe Discharge to Improve Safety on an Inpatient Oncology Service

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