Reduce Risks to Patients in Your Practice

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Patient safety has been the buzzword for numerous initiatives in the past decade, but much of the focus has been on hospital care, where the risk for medication errors, falls, iatrogenic infections, wrong-site surgery, and other incidents of patient harm is high. But in fact, ambulatory care settings are where patients—those with cancer perhaps more than others—receive the majority of their health care. This article highlights high-risk areas of oncology practice and offers strategies for enhancing patient safety.

Creating a culture of patient safety is not done by going through a checklist, although assessing your office systems in light of risk is important (see "Practice Assessment" in the Additional Resources box). In a culture of patient safety, people understand that underlying system flaws, not individuals, are the source of most errors. Developing well-designed systems for safe patient care requires a team approach in which assigning blame has no part. Accordingly, trust and mutual respect are essential components of a patient safety culture.

Establishing a patient safety culture takes time and leaders who promote efforts to reduce risk. Physicians have a key leadership role and can champion patient safety by fostering a team culture and initiating risk-reduction strategies.

Oral Medications

"An emerging risk for our patients is the gradual shift from administering parenteral chemotherapy to prescribing oral agents," states Joseph O. Jacobson, MD, chief quality officer at Dana-Farber Cancer Institute and past chair of the ASCO Quality of Care Committee. "Medical oncologists have gotten very good at administering parenteral chemotherapy safely—most practices have a series of safety checks that make the risk of error very low. But most practices don't yet have in place the kind of safety mechanisms needed to guarantee safe administration of oral medications."

Guidelines for measures to address safety concerns related to oral cancer medications are not yet in place, although ASCO and the Oncology Nursing Society convened a multistakeholder meeting late in 2011 to begin that process. Until such guidelines are available, consider potential risks to patients to whom you prescribe oral agents and take steps to avoid them.

Patient compliance with filling the prescription is one area of concern. Help ensure that copayment levels or ability to pay do not stand in the way of filling an order. Have your financial counselor assess your patients' insurance coverage for oral agents and help patients access patient assistance programs if needed. Develop a communication system with one or more pharmacies to have them notify your practice when a patient's prescription is filled, and give your patient directions and a map to the designated pharmacy.

Unsupervised administration of oral chemotherapy in the home is an additional area in which risk of error is increased. For example, a toxic drug may require a certain number of days off before restarting. Unintended extended use can result in severe cumulative toxicity or even death. Meticulous patient follow-up can help mitigate this risk. Create a schedule for the patient to call your office to confirm dosages taken and report symptoms. Establish a tracking system so that if the check-in call is not received on schedule, your practice calls the patient. Compliance can also be monitored by asking the patient to bring in their medications to count the remaining supply.

Using a computerized provider order entry (CPOE) system can potentially avert medication errors, but existing systems will require modification to manage oral agents. CPOE avoids illegible prescriptions and incomplete information, and can often be programmed to interact with an electronic medical record to flag treatment contraindications.

Patient Handoffs

Transition of the responsibility of patient care between caregivers is another point of increased risk. The receiving physician may not be aware of pending test results, the treatment plan may not be clearly communicated, the patient may not be adequately informed and involved, or the ownership of specific responsibilities may not be clear. Oncology practice involves many such transfers, such as the transition of care between primary care physician and oncologist, and between a medical oncologist, interventional radiologist, surgeon, or hospitalist.

"Safe handoffs are critically important to the safe delivery of health care services," says Miranda Felde, MHA, assistant vice president of the Department of Patient Safety at The Doctors Company, a national medical liability insurer. Felde advises having face-to-face communication or, at minimum, a phone call between providers when transferring responsibility of patient care, because talking directly with another provider affords the opportunity for questions and clarification. Avoid interruptions while exchanging information. Help ensure that all information is transmitted by using a standardized checklist that addresses the patient's current condition, treatment and services needed, and any recent or anticipated changes.

If you are transferring responsibility for office appointments while you are away, hold a team meeting, including the covering physician, nurses, and other caregivers, to briefly discuss each patient who will be seen. A team approach to care is optimal for patient safety.

Hospitalized Patients

Risk of errors increases when your patient is hospitalized, for numerous reasons: Communication channels are complex; patient acuity is higher; the hospital laboratory and pharmacy dispensing systems are different from those in your office; and the drug formularies may be different. In addition, the skills and experience of nurses caring for your patient will differ from those of the nurses in your office. Even though nurses may have completed training to administer antineoplastic medication, they may not be familiar with terminology you typically use.

These are some strategies to reduce the risk of harm to hospitalized patients:

- Encourage questions from nurses; a rushed manner can inhibit their asking for clarification.
- Do not use oral orders; if it is necessary, follow read-back procedures in which the nurse writes down the order and then reads it back to you.
- Write legibly at all times; spell out drug names and familiarize yourself with do-not-use abbreviations such as U, qod, zeros after a decimal point, and cc.
- When you walk into your patient's room, double-check the labels on the intravenous bags.
- Read the nurses' notes and the medication administration records regularly.
- If you find that the hospital's standardized medication order forms are incomplete, difficult to use, or need revision, communicate your suggestions to the pharmacy; whether such forms are on paper or part of a CPOE system, your input can be valuable in ensuring accuracy of medication orders.

Transfer of patient care responsibility to a hospitalist or the oncologist covering for you is another area of increased risk of error. One study of 2,644 patients discharged from hospitalist services found that 41% had test results return after discharge. Of these results, 9.4% were potentially actionable.[1] Although this study was not limited to oncology patients, it demonstrates the communication challenges inherent in the care of hospitalized patients. As suggested in the Patient Handoffs section above, talk directly to a hospitalist or partner overseeing in-hospital care of your patient, both when care is transferred to the other physician and when the patient is discharged. Do not communicate through the nurse, the medical record, or other written notes.

Debrief About Near Misses and Errors

Establish a process in your practice for the analysis of errors and near-misses. Felde comments, "You learn from the near-misses as much as you learn from an event that was catastrophic."

A good approach is to convene a group consisting of everyone involved in all aspects of the near-miss or error. Do this as soon after the event as possible, at the end of the same day if possible. It is *essential* to make clear to all involved that the goal is improvement and prevention, not finger pointing or assigning blame. Identify what was done right as well as what problems occurred. Debriefings that result in patient safety improvements, without a punitive component or atmosphere of blame, will help promote an atmosphere in which individuals feel safe in admitting error.

Does Your Patient Understand You?

Health literacy is not merely the same as literacy—the ability to read. Health literacy is the term for patients' ability to understand and process medical instructions and make decisions about their health. A 2003 study found that 59% of patients older than 65 years have only basic or below-basic health literacy.[2] Even well-educated patients can have difficulty interpreting medical jargon, and patients at all levels of education may feel embarrassed to ask for clarification about informed consent documents or complexities of care they don't understand. They may leave your office with unanswered questions about what their diagnosis is, what their treatment will entail, and their options for care. Worse, if they have received an infusion or other treatment, they may not understand what symptoms should be considered normal and what symptoms warrant calling you.

Giving patients clear instructions in language they can understand is critical to reducing the risk of problems. Limited facility in English and differences in culture present increased barriers to effective patient communication.

These approaches can help reduce communication gaps and misunderstandings:

- Use common words and phrases; you likely know not to use "apoptosis" or "hyperpyrexia," but what about "commencement," "toxicity," "unchecked," or even "chronic?" These, too, are medical jargon.
- Explain difficult concepts and new words, such as prognostic factors, staging work-up, and adjuvant therapy.
- Be consistent in use of terms: Don't say "tumor" one time and "mass" the next time, unless you explain that they mean the same thing.
- Use more pictures, less words.
- Avoid nonspecific words like "adequate," "normal range," or "excessive." For example, do not say "Call me if you have excessive vomiting"; be specific, both in written discharge instructions and in talking, about the frequency or level of symptoms such as vomiting, fever, or pain that should result in calling you.
- Use simple sentences and convey only one idea in a sentence: Say "exercise can help you fight fatigue," not "exercise can help you fight fatigue, which can lead to depression."
- Address differences in culture, ethnicity, or language between your patients and yourself or your staff; consider cultural competency training, use of translators, or accent reduction training.
- Ask your patient to explain his or her understanding of treatment and discharge instruction.

Patient materials should be written at the sixth- to eighth-grade level and should use repetition and define terms, advises Diane Blum, MSW, editor-in-chief of Cancer.Net, ASCO's patient information Web site, and chief executive officer of the Lymphoma Research Foundation. "The key is to give patients

information in direct terms, using active verbs and clear language." ASCO's patient information Web site Cancer.Net offers fact sheets and booklets for patients that you and your patients can download at no charge, and they can be ordered in quantity.

Analyze and Improve Systems

Standardized protocols reduce the risk of error. Identify processes in your practice, such as ordering medications, referral processes, or handling laboratory results, for which standard procedures might be developed to reduce risk of errors, particularly those of omission. Everyone involved in the process should contribute to the development of standard procedures. For example, a protocol for taking patient messages needs input from the person answering the phone, the person taking the message (if different), and the person receiving the message.

Using telephone calls as an example, establish a protocol including elements such as the following:

- Training for staff.
- A list of questions to ask the caller.
- Instructions for which calls should be referred immediately to a physician.
- Documentation of all calls from a patient or family member, including date, time, patient name, name of caller and his or her relationship to the patient, reason for call, advice given, and person to whom the call was referred.
- Times by which urgent and nonurgent calls should be returned.
- A follow-up call to check on the patient's status, if relevant to the reason for the call.

After implementing the protocol for a trial period, poll those involved to identify needed revisions. All procedures should be reviewed regularly and updated as needed.

Summary

Medication safety is paramount in medical oncology, and oncologists should make sure their practices comply with the ASCO/ONS Chemotherapy Administration Safety Standards adopted in 2009. For oral medications, establish systems to ensure patient compliance and safe home administration.

Develop safe communication habits for coordinating care with other providers and for patient handoffs. Be aware of risks of error for hospitalized patients and adopt practices to reduce them.

In office practice, creating a culture of patient safety that promotes a team approach to care and in which everyone feels safe admitting an error or near-miss is an essential basis for reducing risks. Establish routine checklists and protocols for communication among caregivers, and for office systems. Evaluate your cultural competency and avoid medical jargon with patients. Supplement your oral explanations and instructions with materials written according to guidelines for health literacy.

Additional Resources

- Chemotherapy Administration Safety Standards, developed jointly by ASCO and the Oncology Nursing Society: www.asco.org/safety
- Practice Assessments:
  - –The Doctors Company: *Interactive Guide for Office Practices:* www.thedoctors.com/KnowledgeCenter/PatientSafety/CON_ID_004057
  - –Medical Group Management Association: *Patient Safety Tools for Physician Practices:* www.mgma.com/pppsa
- Patient safety resources compiled by the Agency for Healthcare Research and Quality: Improving Patient Safety in Medical Offices: www.ahrq.gov/qual/mosurvey10/moimpgen.htm
- Materials for patients: www.cancer.net

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