

Cancer patients' reporting of adverse events



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Background

- Staff at hospitals have reported adverse events since 2004
- Staff in the primary health care sector are included in 2010
- Patient reporting are expected to be included in 2011

- The cancer pathway is complex and the risk of patients being harmed is relatively high
- Patients experience events differently from health staff



Aim of our study

- To test a reporting system for cancer patients
- To analyze the character of adverse events experienced by patients
- To analyze how communication and care have been handled by the staff after events have taken place
- To evaluate how hospitals can use patients reports



Method

- A form was filled in by patients or relatives and returned to the Danish Cancer Society – electronically or on paper
- Information about:
 - Age and gender
 - Type of cancer
 - Description of the adverse event
 - Contact with the staff about the event
 - Suggestions for preventive actions
 - Acceptance of forwarding the report to the hospital
 - Contact address

- Pilot study from December 2008 to March 2009.



Results

- 80 reports containing 102 adverse events
- Adverse events occurred:
 - at hospitals 88%
 - in primary care 12%
- 18 hospitals were represented
- 16 types of cancer were represented
 - breast cancer 25 %
 - colorectal cancer 15 %



When the adverse event happened

- The adverse event happened during
 - diagnostic phase 31%
 - treatment phase 63%
 - control phase 6%



Classification of events

- Wrong or delayed diagnostic procedure 38 %
- Events during clinical procedures 19 %
- Lack of information and communication 17 %
- Medication errors 16 %
- Hospital aquired infection 6 %
- Other events 4 %



Cases

• Delay in diagnosis

Patient operated for breast cancer four years ago. Contacted GP for strong pain in back and hip. Treated with pain killers and physiotherapy without effect. Scanning two month after first contact shows metastases of cancer

• Clinical procedure

Lung cancer identified during checkup. 4 sessions of chemotherapy without effect. Patient was later told that the actual chemo was known to be without effect for that specific type of cancer



Cases

• Hospital aquired infection

Breast cancer patient had inoperated a PICC line for chemotherapy. Several attempts were necessary before successful placing of the PICC. The patient had to walk several times to another departments for X-ray. The patient had staphylococcus infection and collapsed at home.

• Medication

The patient should have chemotherapy in 88% dose due to previous adverse reaction. However two series were given as a 100% dose and the patient had to insist on only having 88%.



Communication about adverse events

- 84% of events were discovered by patients or relatives
- 81% told the staff about the event
- 42% had a dialogue about the event



Hospitals evaluation of patient reports

10 reports evaluated by hospital risk manager

	Relevance	Usability	Learning aspects
7 reports	+	+	+
1 report	+	- More information needed	+
2 reports	-	-	+ For other topics: patient information etc.

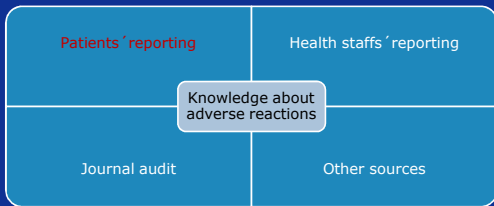


Conclusion

- Patients are capable of detecting adverse events and of describing the context in which they occur
- Patient reports provide new knowledge about how the situation is experienced by the patient
- Knowledge from patients experiences of adverse events can be used in the improvement of patient safety



Different sources of knowledge



Next step: from knowing to doing!

