Quality and Safety in Hospitalized Patients with Cancer

A. Charlotta Weaver, MD[a,*], Joanna-Grace Manzano, MD[b]

KEYWORDS

• Hospitalized patients with cancer • Oncology hospital medicine
• Quality improvement • Patient safety • Falls • Venous thromboembolism
• ICU transfers • CLABSI

HOSPITAL MEDICINE CLINICS CHECKLIST

1. Patient safety is defined as freedom from accidental injury. Health quality is defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
2. Patient safety measures have been developed to evaluate and analyze patient safety. Many are developed by federal programs such as the Agency for Health Research and Quality and endorsed by the National Quality Forum. Several metrics are publicly reported and allow for benchmarking and interhospital comparison. Metrics may be tied to Medicare reimbursements.
3. Patient falls among hospitalized patients with cancer are problematic, since hospitalized patients with cancer have higher fall and fall injury rates than patients without cancer.
4. Venous thromboembolism is a common complication in patients with cancer because of a hypercoagulable state. Most hospitalized patients with cancer should receive thromboprophylaxis throughout hospitalization.

CONTINUED

Disclosures: None.
[a] Division of Hospital Medicine, Northwestern University Feinberg School of Medicine, 211 East Ontario Street, Suite 700, Chicago, IL 60611, USA; [b] Section of Hospital Medicine, Department of General Internal Medicine, The University of Texas MD Anderson Cancer Center, 1515 Holcombe Boulevard, Unit 1465, Houston, TX 77030, USA
* Corresponding author.
E-mail address: aweaver@nmh.org

Hosp Med Clin 5 (2016) 368–378
http://dx.doi.org/10.1016/j.ehmc.2016.02.007
2211-5943/16/$ – see front matter

CONTINUED

5. Intensive care unit transfers and admissions at end of life may be indicators of misuse of aggressive care, but cultural beliefs and disparities may play a bigger role. Patient and caregiver preferences should be examined in depth to understand and guide decisions at end of life.
6. Central line–associated bloodstream infections (CLABSIs) are common among patients with cancer. Guidelines for prevention and management are available, but there is value in understanding organizational patterns, adherence to guidelines, and their association with CLABSI rates.

KEY PRINCIPLES

How is patient safety defined?

The Institute of Medicine (IOM) defines patient safety as freedom from accidental injury, which means injury that results from the health care provided, not the disease course. The 1999 IOM report *To Err is Human: Building a Safer Health System* reported an estimated 44,000 to 96,000 deaths from preventable adverse events each year in the United States, at a cost of $38 billion to $50 billion annually (4% of health care costs).[1] Controversial at the time it was released, the problem of adverse events in medicine is now accepted as reality. More recent estimates by Landrigan and colleagues[2] revise deaths from preventable events significantly upward compared with the IOM report.

How is health care quality defined?

IOM defines quality of care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[3] The World Health Organization defines quality of care as "a process for making strategic choices in health systems."[4] *Crossing the Quality Chasm* describes 6 dimensions to measuring quality, and these primary aims have become widely accepted and adapted to improving quality in health care: safe, effective, patient-centered, timely, efficient, and equitable.[3]

How is quality improvement defined?

Batalden and Davidoff[5] described quality improvement (QI) as the "combined and unceasing efforts of everyone—healthcare professionals, patients and their families, researchers, payers, planners and educators—to make the changes that will lead to better patient outcomes (health, better system performance [care] and better professional development)." A shorter description of QI is: a formal approach to the analysis of performance and systematic efforts to improve it. Swartz and colleagues[6] describe the lean process as one of the QI management methodologies in their *Hospital Medicine Clinics* article "Lean Hospitalists."

How is patient safety measured?

Since the IOM published *To Err is Human*, a new safety culture has developed in the health care environment. An increase in original research on patient safety, as well as