Cancer Care Ontario

Understanding the Landscape of Oncology Medication Incident Reporting in Ontario: A Provincial Initiative

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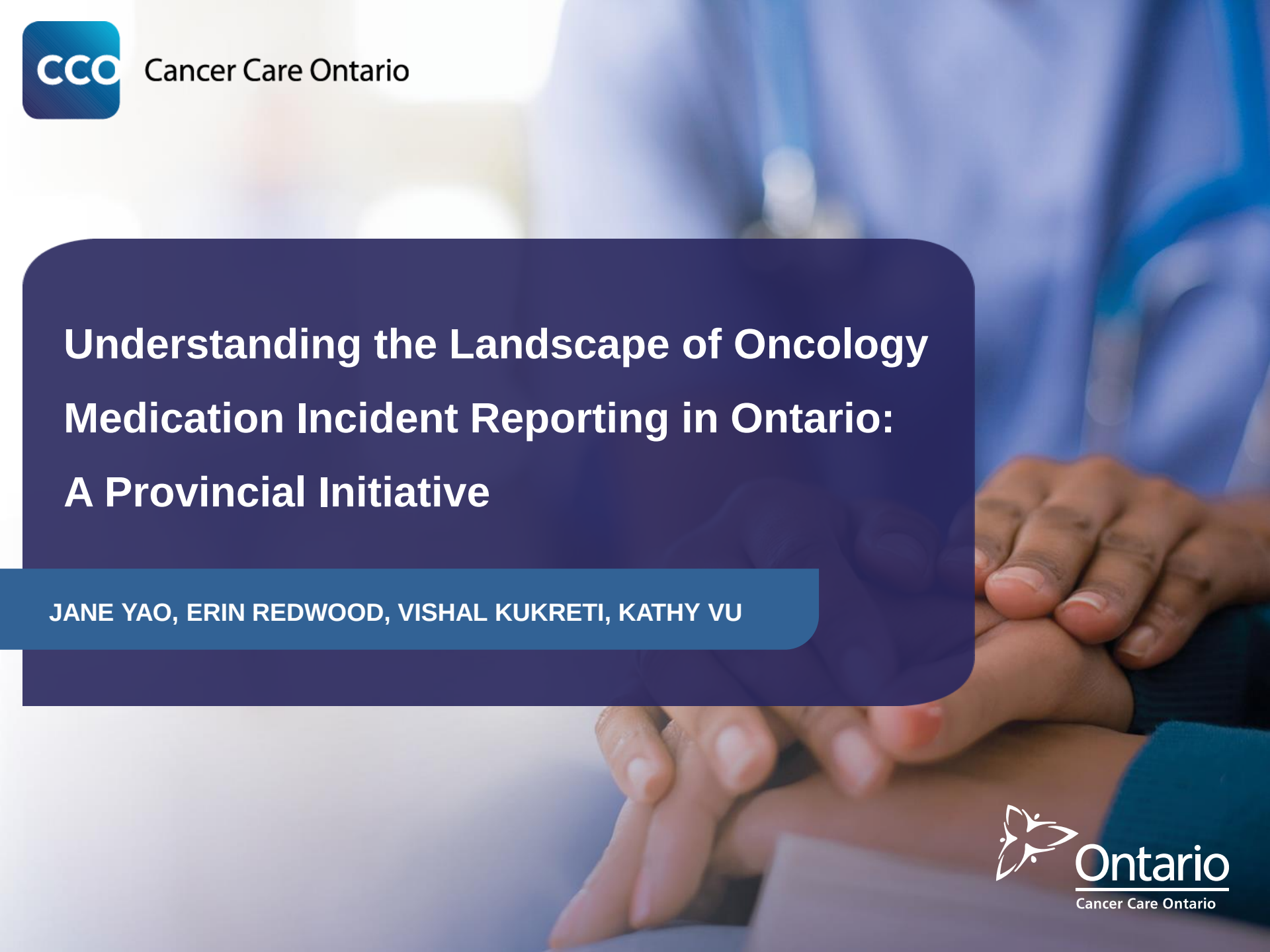

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Today's Objectives

***A Learning Healthcare System*: Improving Safety of Ontario's Cancer System**

- Examine how cancer medication incidents are reported by hospitals in Ontario
- Understand what contributes to low system-level incident reporting from cancer treatment sites
- Explore how to encourage centralized reporting for improving patient safety in the province

Background

Incident Reporting (IR)

Sharing of actual incidents and near misses for reducing the occurrence of the same or similar events in the future

Systemic Treatment (ST)

A class of high-risk medications that can result in significant patient harm when an error occurs

Improved Oversight of ST IR

To trend incident patterns and identify opportunities for making essential changes in order to reduce critical incidents occurring over time

Quality Person-Centred Systemic Treatment in Ontario

2014-2019

SYSTEMIC TREATMENT PROVINCIAL PLAN

By 2019, patients' medication incidents and near-misses will be reported through a recognized system to ensure patient safety within both systemic treatment hospitals and community pharmacies.

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Current State Survey

Objective: Understand how hospitals in Ontario are reporting cancer-related medication incidents internally and externally

Methodology: Online survey sent to all 77 ST facilities in winter 2014/15 (18 questions: multiple choice and open-ended responses)

- A. Internal IR structure and processes
- B. IR knowledge and culture
- C. Reporting to the National System of Incident Reporting (NSIR)

Thematic Analysis

Provincial Planning

Reporting to NSIR

- Reporting of critical medication incidents to NSIR is mandated by the Ontario Ministry of Health and Long-Term Care (MOHLTC)
- NSIR allows users to securely and anonymously report, analyze, discuss and share information on patient safety incidents
- Batch uploading to NSIR facilitates the process of submitting incident reports by eliminating the need for double entry at facilities that report through an internal risk management system

Incident type	Definition (Regulation 965, Public Hospital Act)
Critical incidents	Any unintended event that occurs when a patient receives treatment in a hospital setting that (1) results in death, serious disability, or injury/harm to the patient; and (2) does not result primarily from the patient's underlying medical condition or from a known risk inherent in providing treatment.
Non-critical incidents	Incidents related to moderate harm, mild harm, none/no harm, near misses, or reportable circumstances.

Current State Survey Results

- Response rate: 75% (58 of 77 sites)
- All 14 Local Health Integration Networks (LHINs) represented

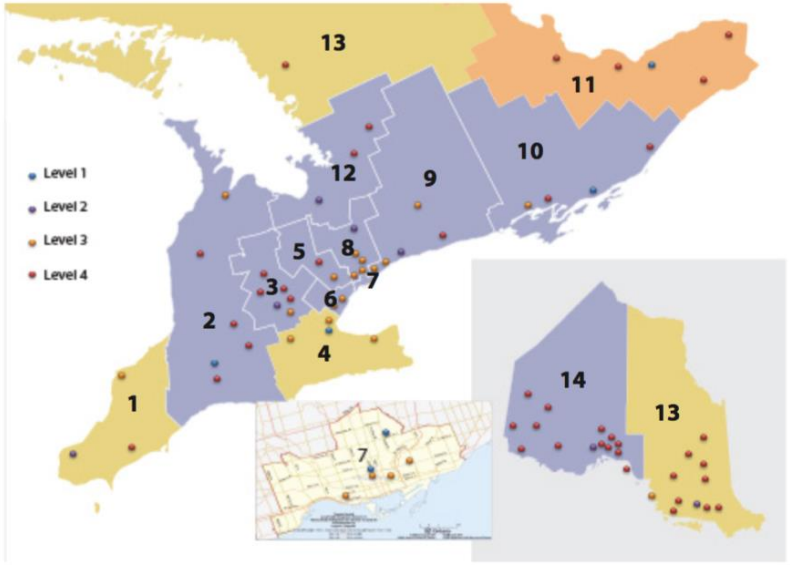


Fig. 1 Ontario's LHINs and ST sites

Level	Facility Description	Survey Completion
1	Integrated Cancer Programs (ICPs)	100% (7/7)
2	ICPs	100% (8/8)
3	Affiliates	100% (19/19)
4	Satellites	56% (24/43)

Table 1 Survey completion by facility level

A. How are cancer medication incidents reported within hospitals?

- **All 58** sites have a hospital-wide risk management system (RMS)
- No cancer clinic-specific RMS
- **76%** use proprietary electronic systems for facility-level reporting

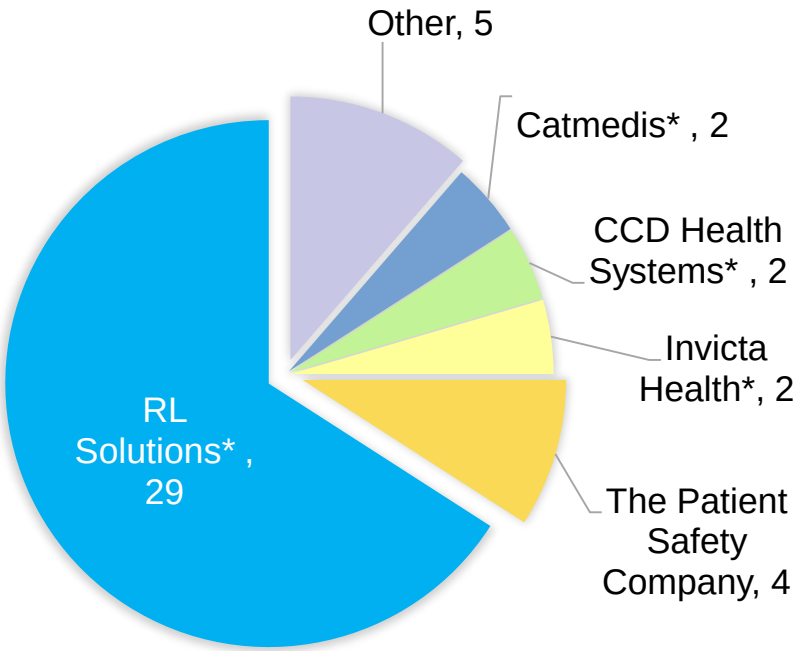


Fig. 2 RMS vendors (*Canadian companies)

A. How are incidents managed and communicated?

Process for Reviewing Incidents and Disseminating Review Outcomes

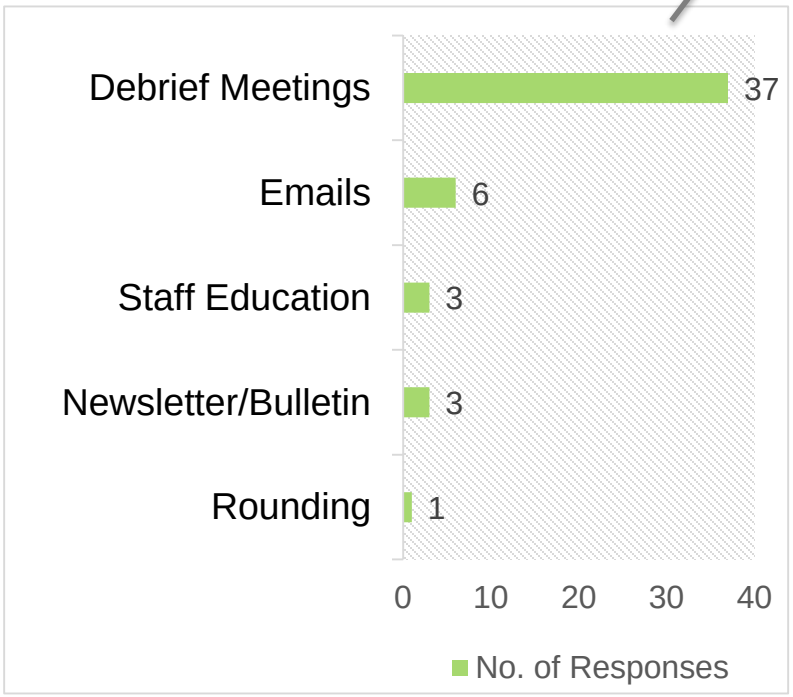


Fig. 3 Unit-level communication

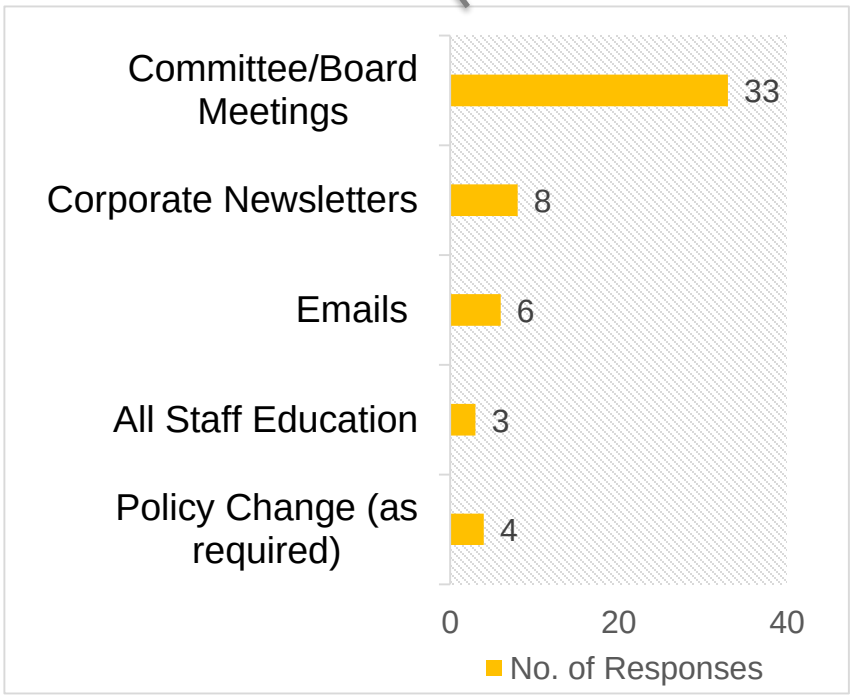
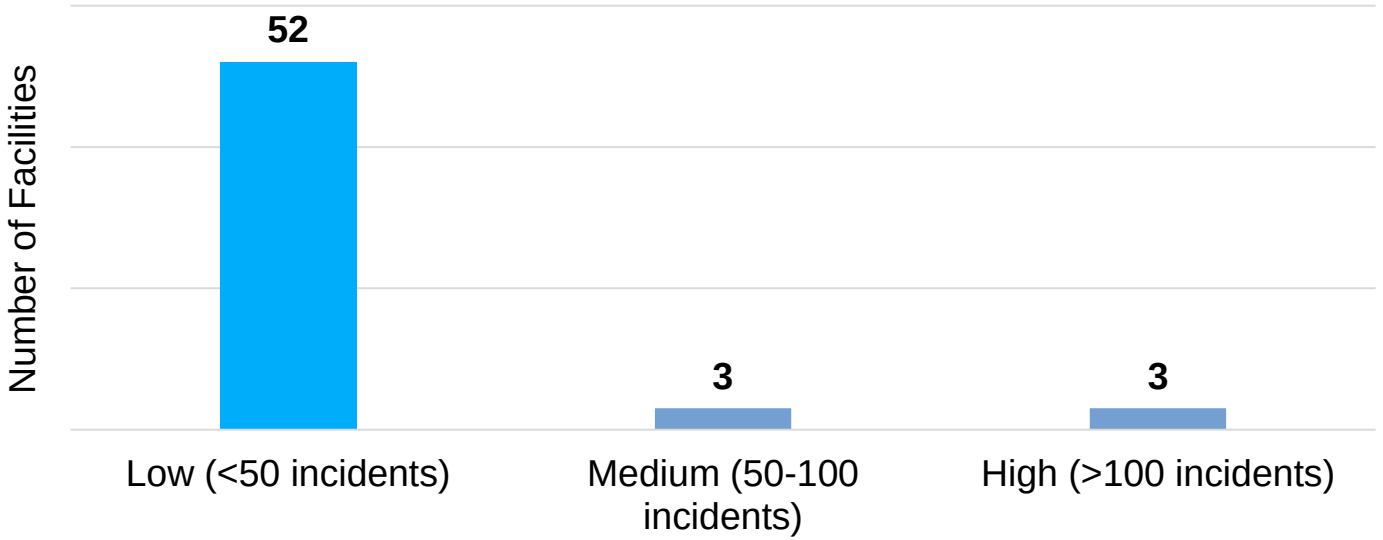


Fig. 4 Corporate-level communication

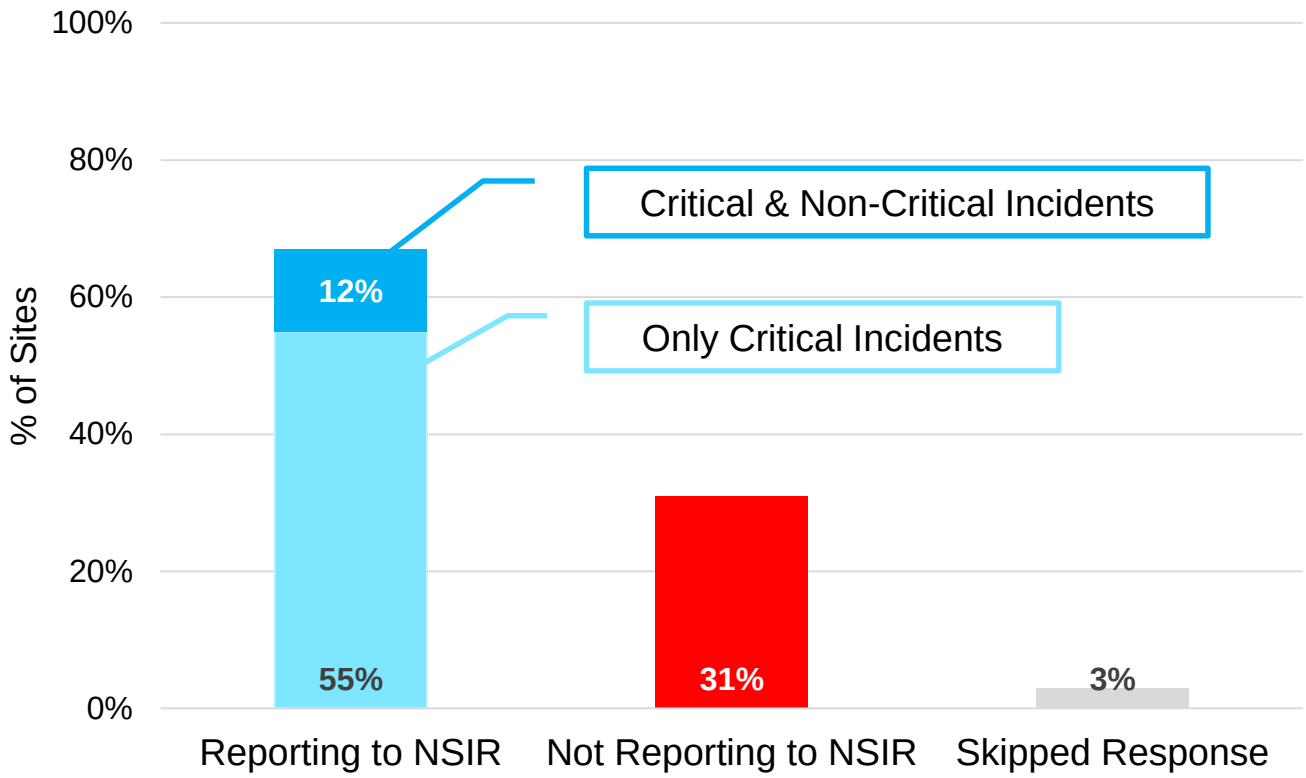
B. What types of oncology medication incidents are reported at hospitals?

- Over **90%** indicated critical and non-critical ST-related incidents are internally reported when they occur
- **4** critical and **1196** non-critical cancer specific incidents were reported in FY13/14
- Of the sites that reported non-critical incidents, **90%** reported low volumes of incidents:



C. Are these incidents reported to NSIR?

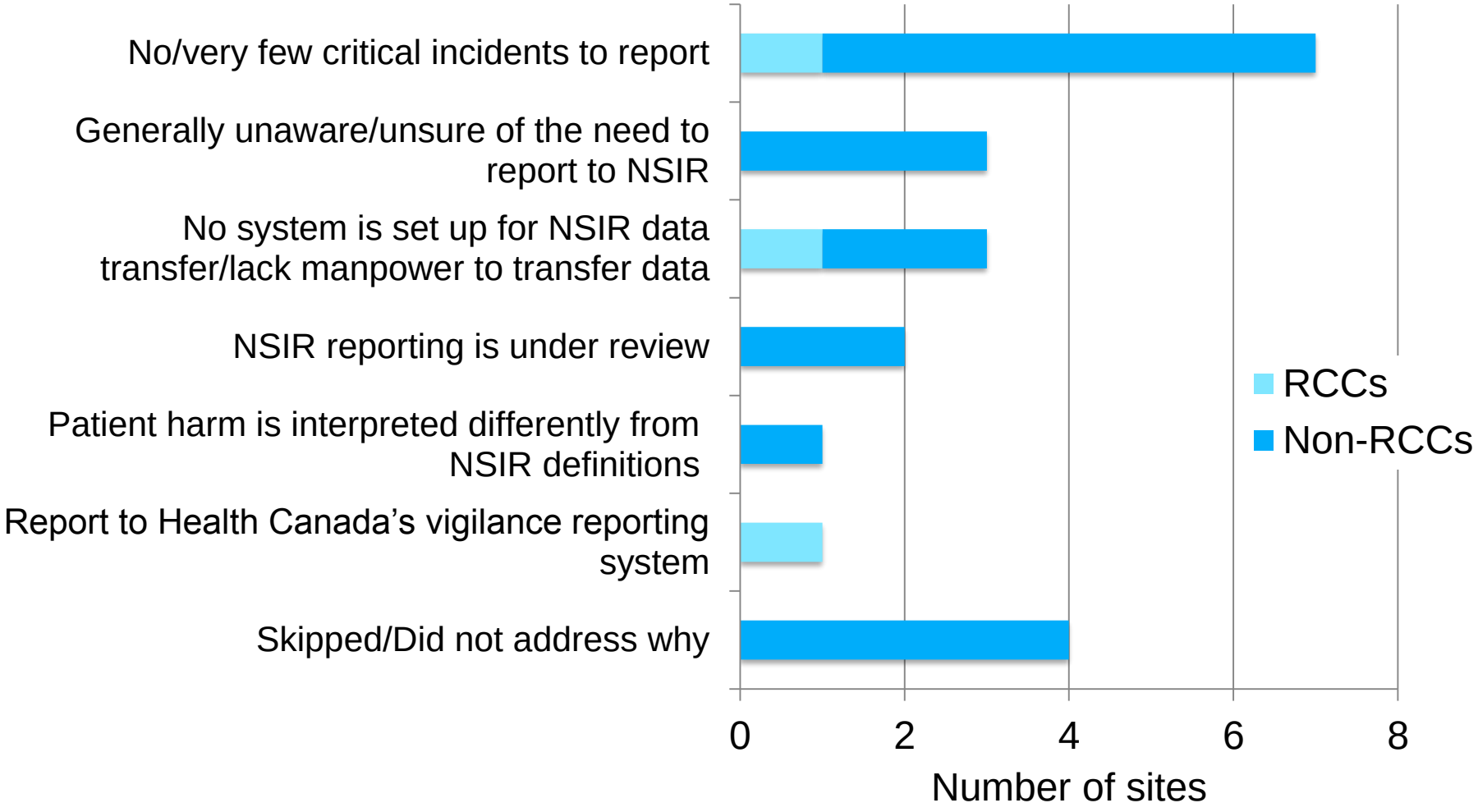
- **67%** report to NSIR when critical incidents occur (i.e. including intent to report):



- **No** site in Ontario is currently using batch uploading to NSIR for cancer medication incidents

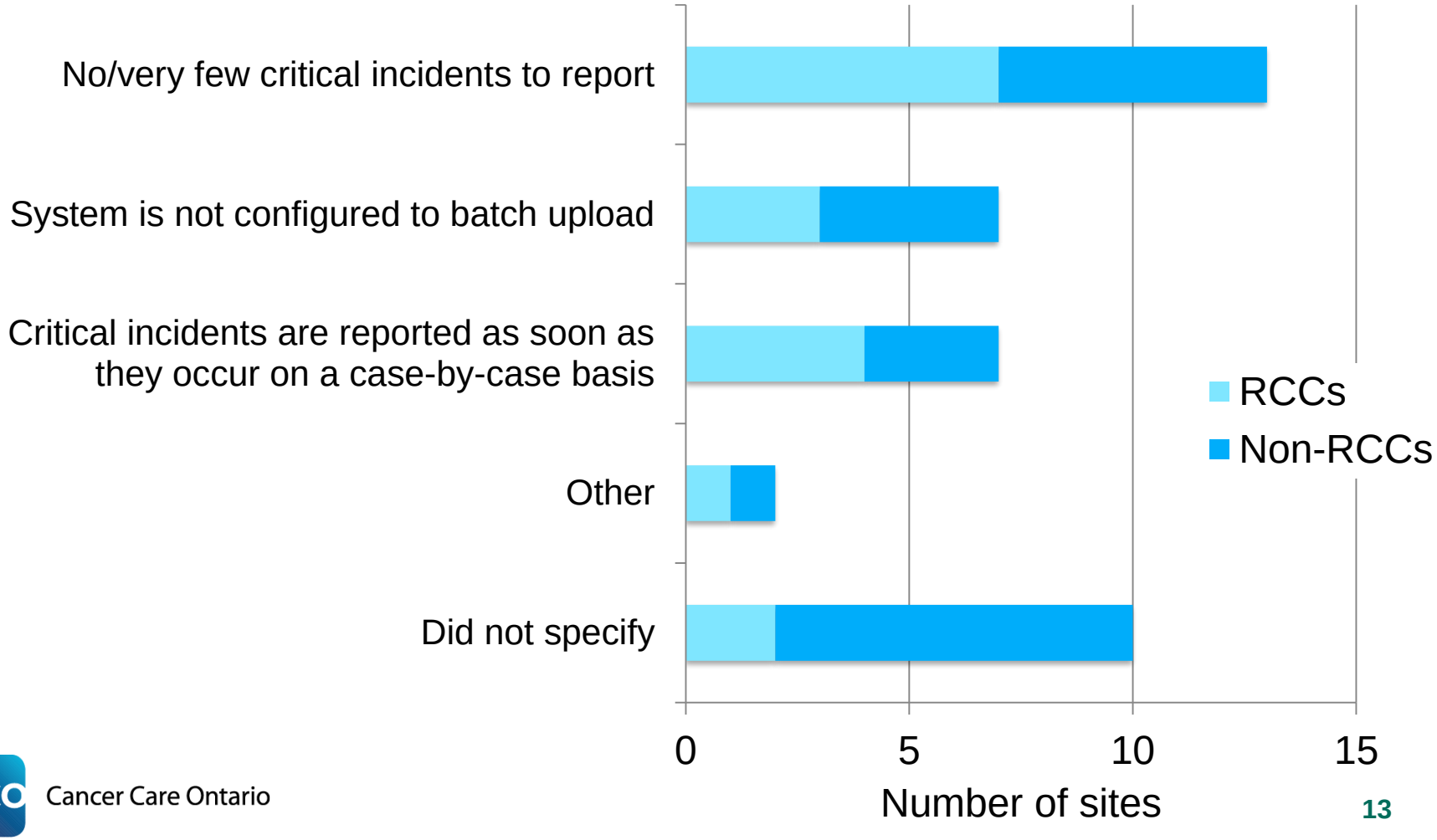
C. NSIR reporting

Reasons for not reporting to NSIR at levels 1 – 4 sites (n = 17)

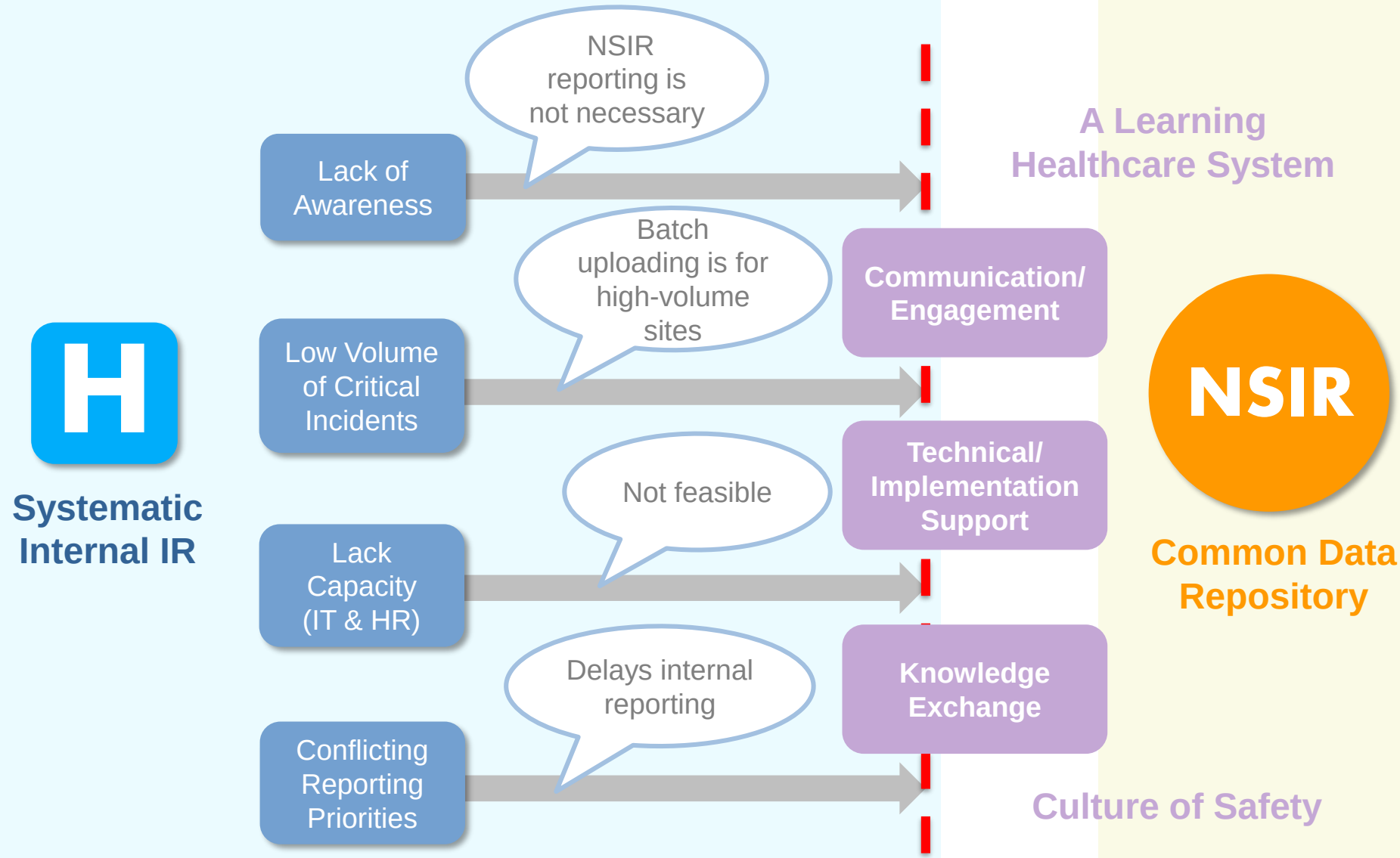


C. Use of the batch upload function

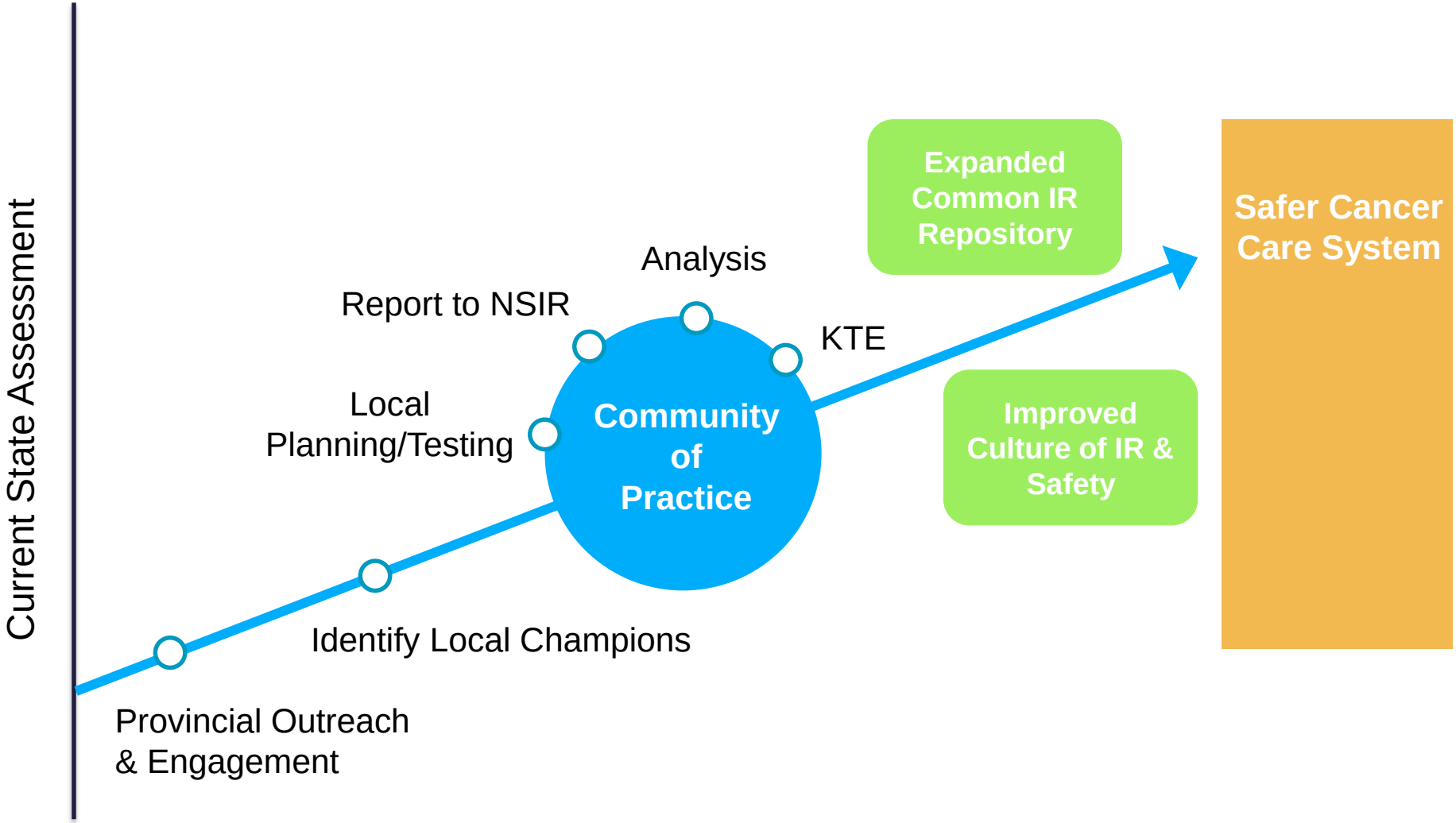
Reasons for not batch uploading at levels 1 – 3 sites (n = 34)



What Do We Know?



Provincial Planning: Next Steps



Thank you!

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