Safety is Job One

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For several years the Ford Motor Company's consumer ads used the slogan "Quality is Job One" to raise public awareness of the importance the company placed on producing quality products. We in the cancer community should make the same commitment around patient safety.

A prime tenet of the medical community is "first, do no harm." How can we do anything less? Our patients are facing a life-threatening disease; we are providing treatments that have high risk in terms of complications and toxicity. At a minimum, we must meet the standard of the nursing mantra of the five rights for providing medications:

1. The right patient
2. The right time
3. The right route of administration
4. The right drug
5. The right dose.

I was reminded recently through my hospital's safety monitoring system that "to err is human" is a reality.

In our outpatient infusion suite, providers always identify patients with two unique identifiers before proceeding with any procedure or treatment. We usually do so by verifying the patient's full name and date of birth. As documented in a recent safety report, however, a caregiver who was setting a patient up for chemotherapy greeted the patient by a single first name, proceeded to set the patient up in a treatment chair, and began the assessment. It was only after further discussion that the caregiver discovered that there were two patients in the unit with the same first name that day and, in fact, the caregiver was dealing with an entirely different individual. One can certainly imagine the complications had the therapy proceeded that day with a chemotherapy infusion intended for someone else.

Our system classifies this type of event as a "near miss" and requires the individuals involved to document a plan of corrective action. In this case, review and reinforcement with the caregiver about why the standard protocol on identification must be followed 100 percent of the time with every patient.

In this case, redundancy saved the day. When preparing to perform a lab draw, the caregiver did reconfirm both name and birth date, and at that time corrected the misidentification of the patient. The event, however, was reported in accordance with our safety monitoring protocol and provided a "teachable moment" for the full staff to review as a reminder of the necessity for following the patient identification protocol 100 percent of the time.

I urge each of us to ask ourselves how we are doing within our programs and practices. Are we monitoring for events that put patients at risk? Are we encouraging the reporting of all incidents by creating a climate that is non-punitive in nature? Are we regularly reviewing reported incidents with all the professionals and staff involved in providing the care? Are we changing and updating procedures when we find that they have loopholes or opportunities for miscommunication or misidentification?

Safety must be on our radar screens, and certainly one would have difficulty arguing that it is anything less than "Job One."

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