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Patient safety in cancer care from a systems perspective

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Defined by complexity

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Aim of the study

The aim of this study was to explore gaps in the cancer care continuum and the way practitioners anticipate, detect, and bridge them

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Method

- 12 qualitative interviews, (individual or in group) were performed with health care professionals (n=28), in three county council in mid-Sweden.

- Professionals who participated were managers, administrators, secretaries, medical doctors, general practitioners and nurses in; primary care, inpatient care, palliative care and in advanced home care settings.

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Analysis

- Data were analyzed using latent and manifest content analysis, in order to identify central themes (of individual, technical or organizational character)

- Finally The Functional Resonance Accident Model (FRAM) was used to determine how the variability of individual, technical, and organizational performance in combination may lead to an adverse outcome.

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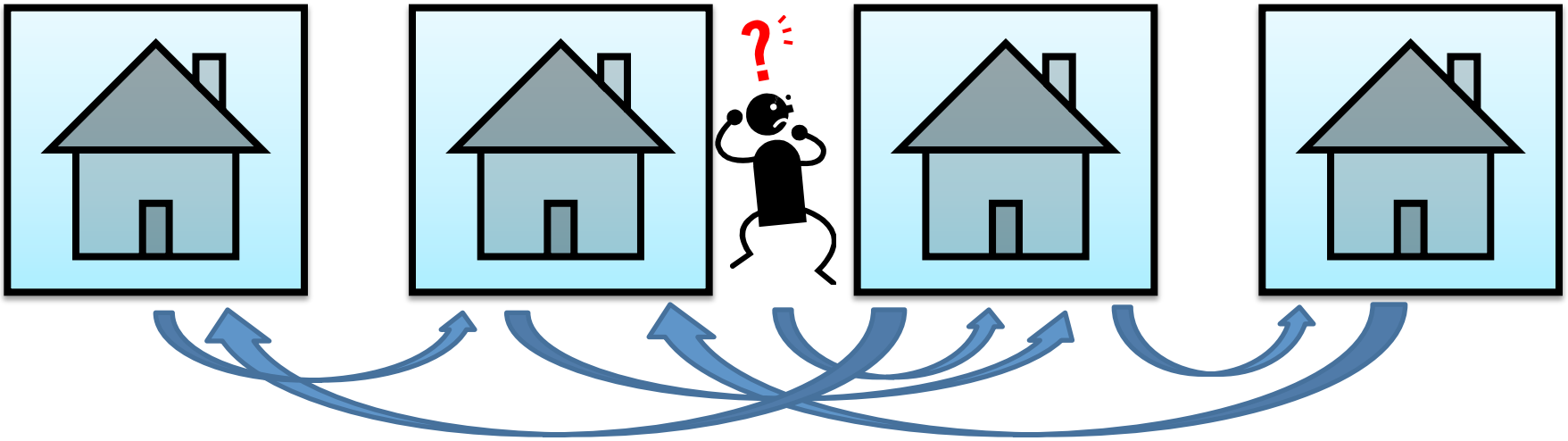
The continuum of care



Coordination

Patient participation

Information

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Information

- What happens next?
  - *“unless you get a call within 3 weeks, call”*
- What is “normal” and what symptoms should I pay attention to?
- What number do I call if I become acutely ill this weekend? “*Put the phone number on the fridge so you can easily find it”.*

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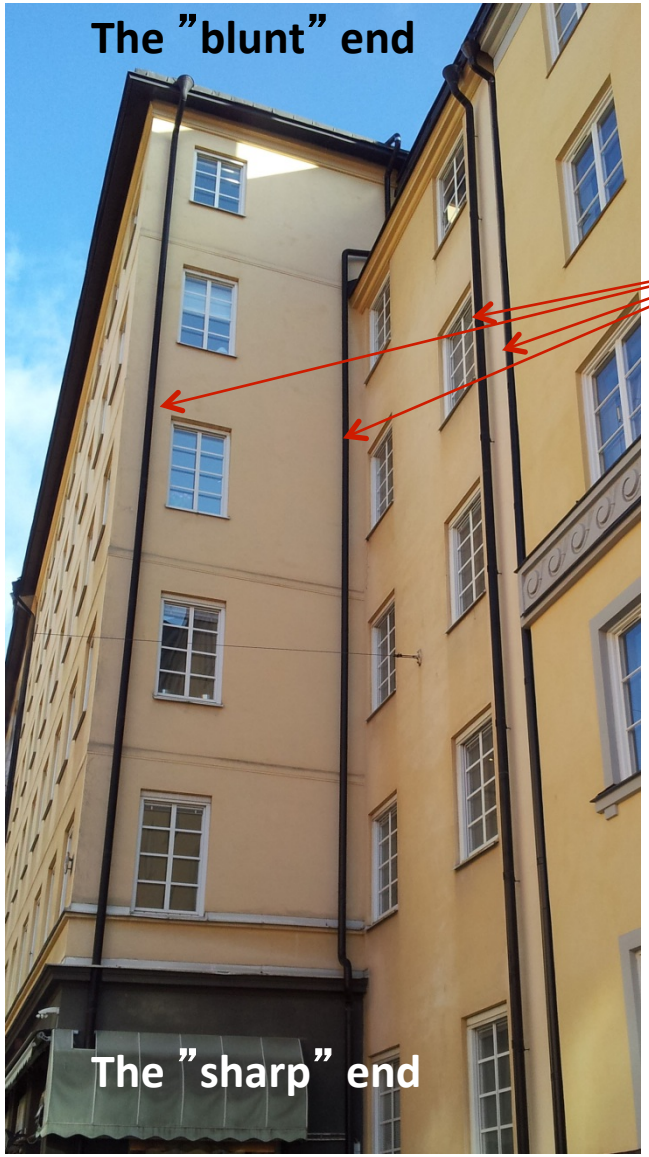
The ”vertical” organization of care



Care organized in ”downpipes”

Communication takes place from top to bottom

Few or no “gutters” that facilitate communication between different specialties and different caregivers

Feedback
Learning organization

Team-meetings
Treatment conferences

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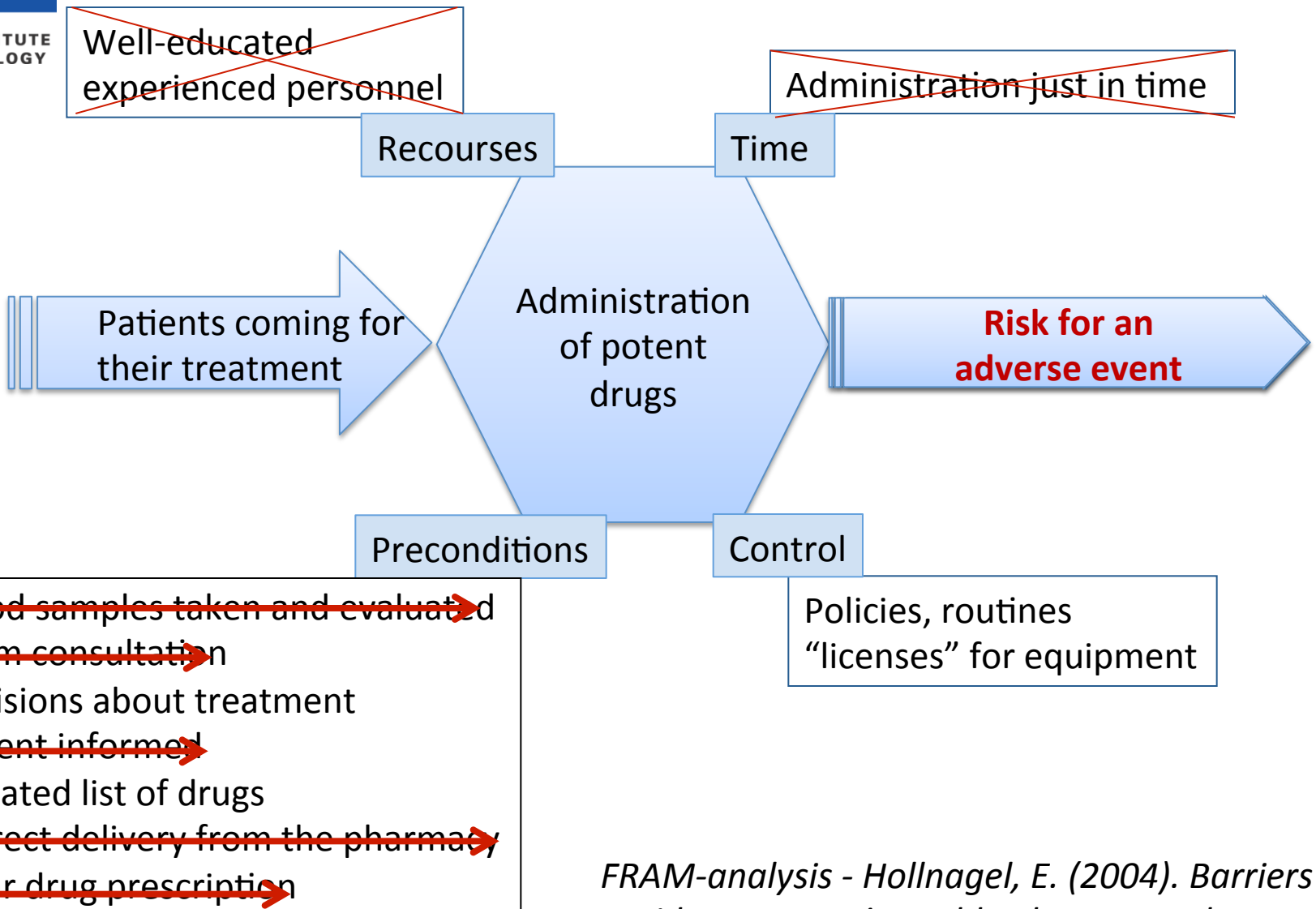
Where does my responsibility start and stop?

"It's like handing over the stick, not knowing that there is someone who receives"



FRAM-analysis - Hollnagel, E. (2004). Barriers and accident prevention. Aldershot, UK: Ashgate.

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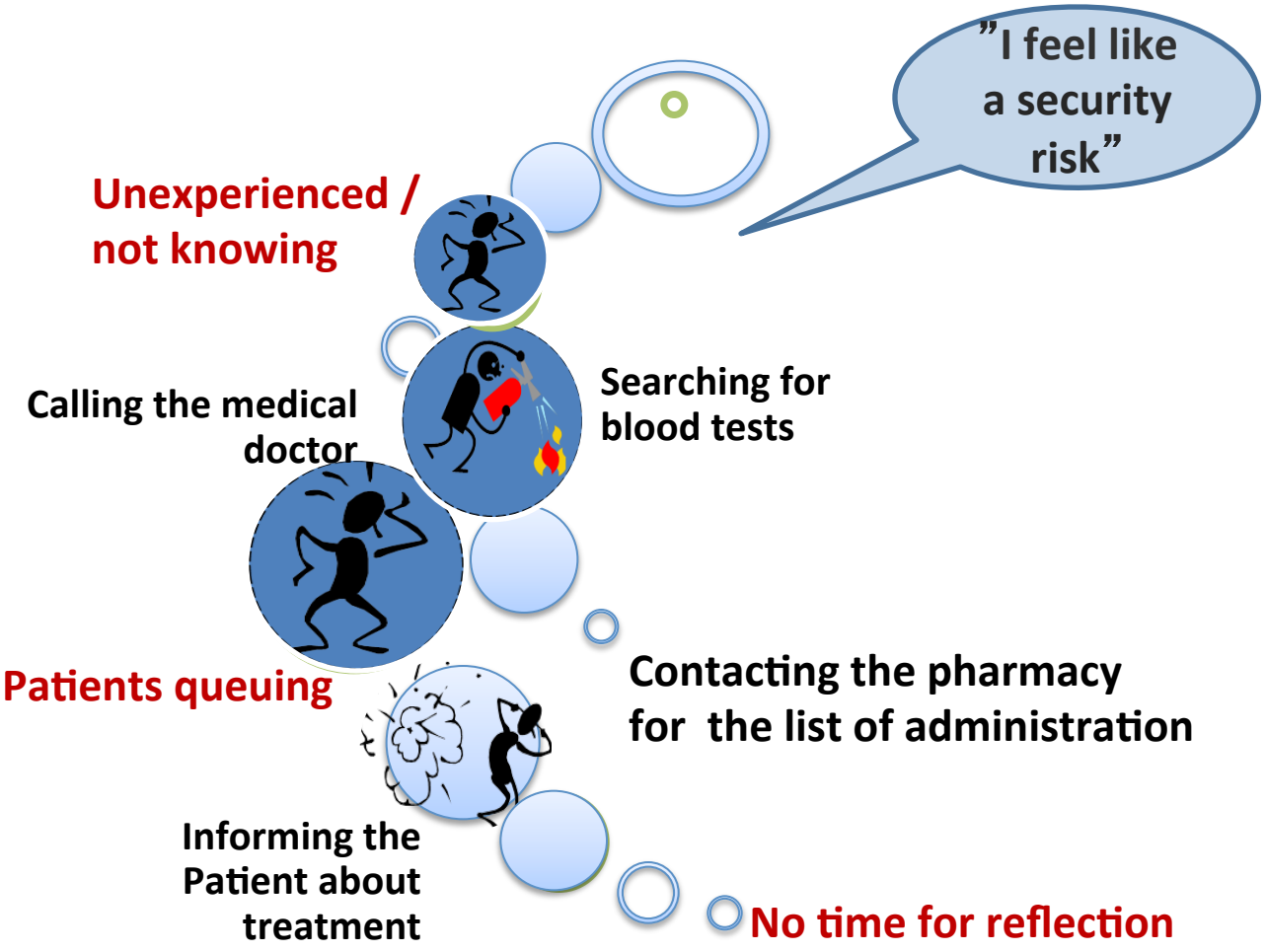
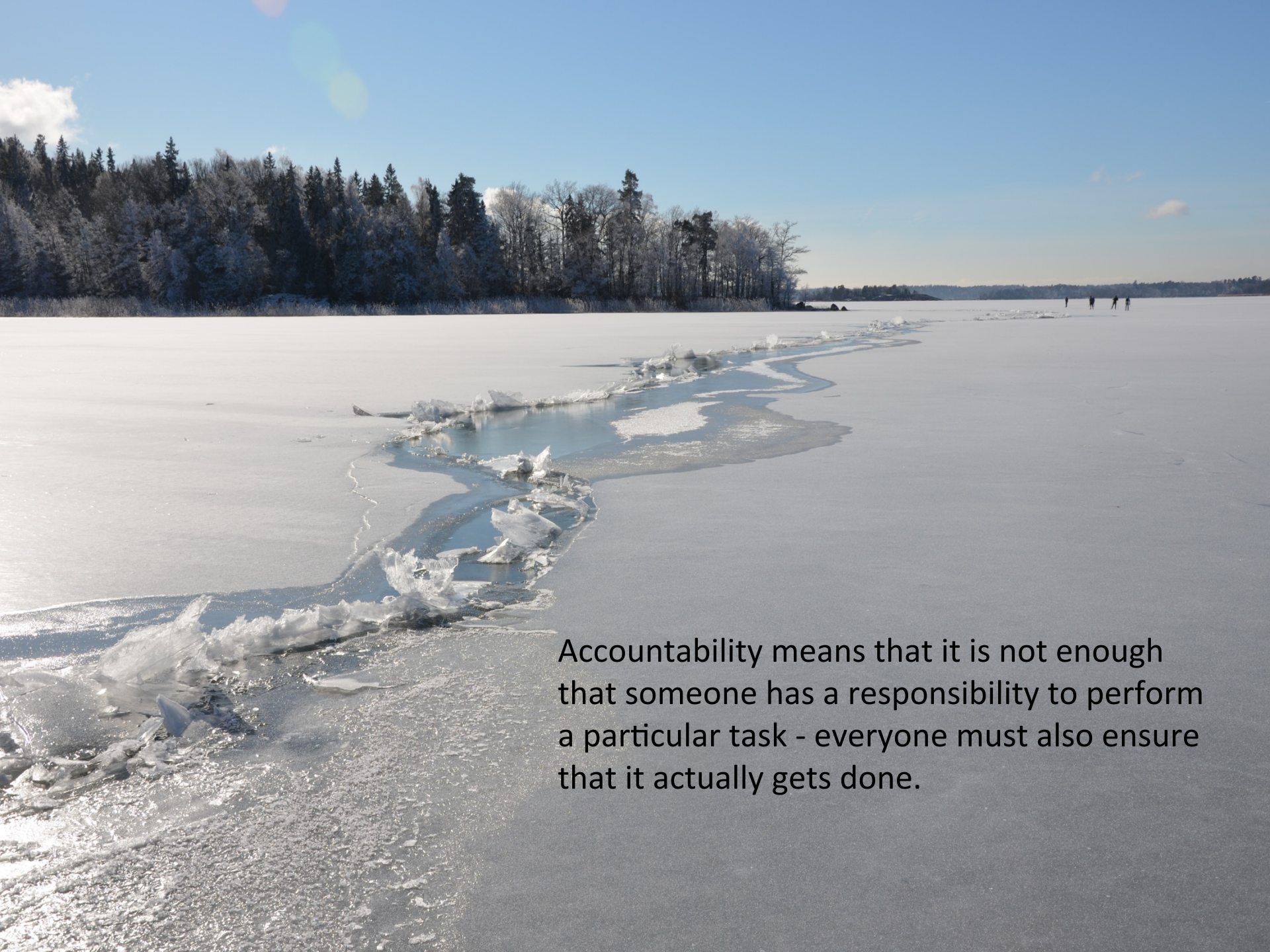
Hazards at ”the sharp end”





Accountability means that it is not enough that someone has a responsibility to perform a particular task - everyone must also ensure that it actually gets done.

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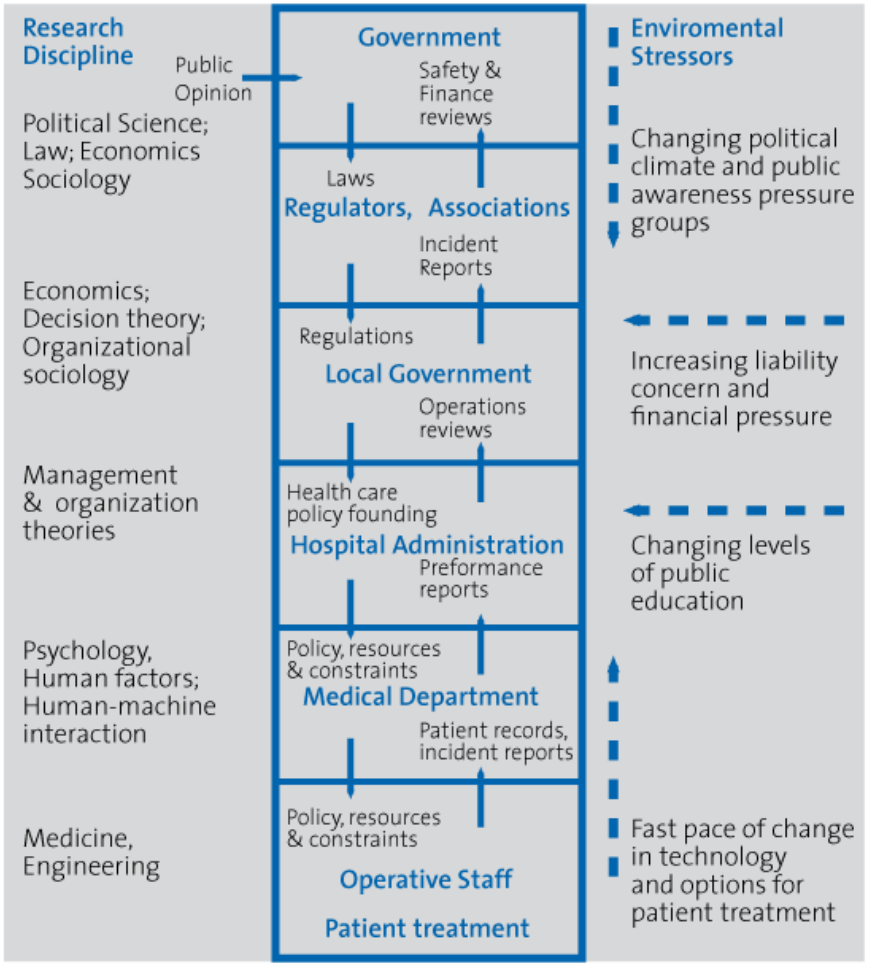
From a systems perspective



Källa: Rasmussen 1999


Thank you for listening?