Raising the Safety Bar: The Hematology/Oncology Patient Safety Committee

The Problem
Enhancing healthcare safety is a cornerstone of the Institute of Medicine’s Aims. The Hematology/Oncology Patient Safety Committee (HOPSC) at Beth Israel Deaconess Medical Center (BIDMC) is a multidisciplinary team of healthcare providers that meets monthly to review inpatient and ambulatory adverse events, near misses, and medical errors that impact patient safety.

Aim/Goal
To quantify and qualify the cases that the HOPSC reviewed during 2012-2013. We reviewed the number of events reported to the HOPSC and those that were elevated to the Medical Peer Review Committee (MPRC). Events were subdivided into setting (inpatient and ambulatory), reporting provider type (physician/advanced practice provider and nurse), and type (medication and non-medication related).

The Results/Progress to Date
- 1,061 events were reported to HOPSC over 2 calendar years.
  - 8 events were escalated to MPRC.
- 77.8% events were inpatient and 22.2% were ambulatory.
- 3.8% events were reported by physicians/advanced practice providers (MD/APP) and 96.2% were reported by nurses.
- 24.4% events were medication-related and 75.6% were non-medication-related.

Lessons Learned
- Through review of healthcare provider event reports, the HOPSC has identified several types of adverse events and near misses in the Hematology/Oncology division at BIDMC.
- Events are mostly reported by inpatient nurses and are primarily non-medication-related.

Next Steps/What Should Happen Next
- This report of HOPSC operations may guide oncology practices elsewhere and subspecialty divisions within BIDMC in developing patient safety peer review committees.
- Follow-up of implemented action plans with assessment of both process and outcome measures would further demonstrate the value of the HOPSC.
- Given the skewed reporting pattern, we will investigate reasons why reporting by physicians, especially in the ambulatory setting, is limited.

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