

Creating a Culture of Quality Improvement in Cancer Care

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Quality assurance (QA) in healthcare dates back to the early years of the previous century, with the first efforts being to record and track patient course and outcome to assess safety and efficacy of treatments.^[1] Even in the 19th century, there were instances in which improvement efforts such as handwashing were the first attempt at QA. After World War II, QA gradually became part of management and quality improvement (QI) became a key step to performance improvement in many fields.^[2] By 1970, the Institute of Medicine (IoM) was established in the United States, and it gradually developed the goals of QA and QI in medicine when seminal papers disclosed the very high number of hospital deaths attributed to medical errors.^[3]

According to the IoM, quality in healthcare is defined as care that is safe, effective, patient centered, timely, efficient, and equitable.^[4] Such efforts gradually started in oncology and by the middle of the previous decade the American Society of Clinical Oncology (ASCO) established a tool for QI and QA that is oncology-specific. Similar efforts started elsewhere in the world about the same time. Cancer care is complicated, and errors can occur and have a detrimental effect on patient safety, quality of life, and patient experience. The patient with cancer is in an already highly burdened and compromised state; further trials and tribulations are particularly dangerous and should be avoided at all costs.

Quality improvement in cancer care presumes measurement of the care delivered against well-established standards, which must be based on strong evidence. Thus, developing measures and standards relies heavily on the existence of guidelines for which care to deliver and how to deliver it.

As mentioned previously, the most advanced, oncology-specific QI effort—the Quality in Oncology Practice Initiative (QOPI)—was established by ASCO in 2005 and has evolved gradually over the years in collaboration with the Oncology Nursing Society (ONS).^[5] The tool includes a number of modules encompassing several aspects of cancer care. There are disease-related modules

that relate to the diagnosis and management of various types of cancer. In addition, quality parameters are used to assess more general aspects of oncology, as for example the appropriate use of antiemetics and end-of-life care.

The *Global Journal on Quality and Safety in Healthcare* is particularly focused on international efforts geared toward improving medical care worldwide. The culture of QI and QA in healthcare is developed over time and involves the entire medical team. Some aspects of healthcare are universal and should apply worldwide, whereas others need to be adjusted for resource-limited settings. It is important to publish all such efforts in international, peer-reviewed journals to help promote this culture globally.

In settings with limited resources, improvement efforts should start in areas that do not need physical or financial resources, such as better documentation and organization of the patient chart and certain areas of training. Furthermore, the culture of adherence to standards needs to be developed.

Another critical aspect of care in terms of patient safety is chemotherapy administration: the right drug, to the right patient, at the right time, in the right dose and rate.^[6] This process has been perfected by the ONS and is central to all oncology quality-of-care assessments. Not only is it critical to administer the drug appropriately but also to prepare it safely, to minimize staff exposure to toxic substances, and store it in the correct conditions. Venous access must be safe and the staff must be aware of protocols for extravasation and anaphylactic reactions, as well as for drug spillage.

The new era of oncology already involves many oral agents, and patient education is key to ensuring adherence and safe self-administration. Patient education involves assessing the ability of the patient and family to understand and follow the instructions safely. More recently, an entirely new set of instructions is warranted in the setting of immunotherapy, helping the

patient recognize potentially serious autoimmune side effects.

Resource limitations are not the only aspect that may require adaptation when quality measures are used internationally. Measures related to patient communication, fertility preservation, advance directives, end-of-life care, caregiver involvement, consent, and so on are deeply affected by how the society is organized and the prevailing attitude toward such matters. Although western culture places great importance on an individual's right to autonomy and self-determination, in other societies the family unit is the nucleus, and its balance determines how each member chooses to face illness, frequently yielding all decision making to relatives. Advance directives are not even legal in some countries, and different religions have different attitudes toward end-of-life care. In these ethical matters, quality measures and standards may need to be adjusted in a culturally sensitive manner to ensure applicability in all settings.

As cancer care is becoming more complicated and sophisticated, it is of critical importance that a level of safety is maintained and quality of care is constantly

assessed and improved. This is a culture worth cultivating already at the outset of training for the sake of all patients worldwide.

References

1. Burstin H, Leatherman S, Goldmann D. The evolution of healthcare quality measurement in the United States. *J Intern Med.* 2016;279:154–159.
2. Tsutsui WM. W. Edwards Deming and the origins of quality control in Japan. *J Jpn Stud.* 1996;22:295–325.
3. de Jonge V, Sint Nicolaas J, van Leerdam M, Kuipers EJ. Overview of the quality assurance movement in health care. *Best Pract Res Clin Gastroenterol.* 2011;25:337–347.
4. Slonim, AD, Pollack MM. Integrating the Institute of Medicine's six quality aims into pediatric critical care: relevance and applications. *Pediatr Crit Care Med.* 2005;6:264–269.
5. Neuss MN, Desch ED, McNiff KK, Eisenberg PD. A process for measuring the quality of cancer care: the quality oncology practice initiative. *J Clin Oncol.* 2005;25:6233–6239.
6. Grissinger M. The five rights: a destination without a map. *P T.* 2010;35:542.