First, Do No Harm

It is paradoxical that those of us in helping professions sometimes cause harm. Many remember the profound impact that the 1994 chemotherapy errors at Dana-Farber Cancer Institute had on institutional practices (Conway & Weingart, 2005). Some of us have had our own experiences with errors or near misses. In 1999, the Institute of Medicine (IOM) raised awareness of medical errors, including 44,000–98,000 hospital-related deaths, in *To Err Is Human.* IOM defined medical errors as the "failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim." The focus has broadened from preventing errors to promoting patient safety, defined as "the prevention of harm to patients, where harm can occur through errors of commission and omission."

Since 1999, much has been done to address safety and quality in health care.

Patient-centered care: Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.

Teamwork and collaboration: Function effectively within nursing and interprofessional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality patient care.

Evidence-based practice: Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.

Quality improvement: Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of healthcare systems.

Safety: Minimize risk of harm to patients and providers through system effectiveness and individual performance.

Informatics: Use information and technology to communicate, manage knowledge, mitigate error, and support decision-making.

Figure 1. Quality and Safety Competencies

Note. Based on information from Cronenwett et al., 2007.

In 2003, IOM published several reports, including a road map for the development and adoption of key healthcare data standards in *Patient Safety: Achieving a New Standard for Care.* Quality and Safety Education for Nurses developed the knowledge, skills, and attitudes for six competencies in nursing (Cronenwett et al., 2007) (see Figure 1). All of the competencies are core to oncology nursing practice, education, management, and research. So when we think about safety, we need to focus on issues that extend beyond chemotherapy administration.

In 2008, the Joint Commission established national patient safety goals based on available evidence and recommendations from an interdisciplinary team of healthcare providers. The goals are reviewed regularly and changed to reflect new evidence. Of course, individuals and organizations need to assume responsibility to implement the goals and create a culture of safety. Have you reviewed and/or implemented them for your practice? If not, consider doing so. Patients have to worry about cancer, but they shouldn't have to worry about the care they are receiving.

The Oncology Nursing Society (ONS) develops products and services to help nurses deliver safe, high-quality cancer care, including the Chemotherapy and Biotherapy Course (www.ons.org/ceCentral/treatment/chemo/index.shtml), Radiation Therapy Course (www.ons.org/nursingEd/radiation.shtml), and Putting Evidence Into Practice® resources (www.ons.org/outcomes/pep.shtml). We know that ONS members are concerned about this topic by their number of calls, the topics and manuscripts submitted for meetings and to the journals, and the requests for more products and services. In addition, the Agency for Healthcare Research and Quality has devoted a Web site to patient safety tools and resources (www.ahrq.gov/qual/pstools.htm).

In every issue, the *Clinical Journal of Oncology Nursing* publishes a safety column. Associate Editor Lisa Hartkopf Smith, RN, MS, AOCN®, CNS, (pubCJON@ons.org) deftly identifies and addresses topics of concern for readers. In 2009, *ONS Connect* also is featuring a safety column developed by Contributing Editor Seth Eisenberg, RN,

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OCN® (pubONSConnect@ons.org). Both columns will provide opportunities to address your concerns, so let us know what they are. If you are worried about your patients' safety, others are, too. And our patients need to know that we are always advocating for them.

References

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