DEI and Incident Learning

Overview

Issues related to diversity, equity, and inclusion (DEI) can impact all facets of health care, including patient safety. The RO-ILS Portal can be used as a tool to track DEI-related events impacting, or with the potential to impact, patient safety in radiation therapy so action can be taken to create a safer, more inclusive work environment for staff and similarly, a safer, more inclusive health care experience for patients.

Background

A culture of safety requires open communication, team cohesiveness and regular collaboration to support safe and effective patient care. Each person has a unique set of identities such as race, gender, ethnicity, culture and other characteristics that contribute to their sense of self, experiences and perspectives. It is an unfortunate reality that not all people appreciate and respect all such identities. Biases and discrimination in health care can result in deviation in policy and processes which has the potential to negatively affect patient safety.

Whether subconscious or explicit, biases can harm staff and patients and negatively impact a facility's culture and patient care. This includes conduct that targets individuals or groups because of their:

- race
- color
- age
- sex
- gender identity
- religion
- national origin
- limited English proficiency
- sexual orientation
- disability
- housing status
- pregnancy or pregnancy-related conditions

There are many ways in which identities can impact patient safety. For example, understanding and appreciating a patient's gender identity and using their preferred pronouns empower patients and creates a welcoming environment so they feel comfortable voicing both health care and potential safety concerns. Developing proper processes helps ensure that safety procedures are not missed for certain patients; for example, determining whether a transgender man should need a pregnancy test prior to treatment.

One study identified a correlation between a patient's English language proficiency and safety errors resulting in harm; for individuals with limited English proficiency, almost 50% of events resulted in harm compared to about 30% of patients who speak English.[1] Another study found fewer adverse events were voluntarily reported related to pediatric patients with limited English proficiency than the events estimated by a trigger tool.[2] By identifying a potential issue early, resources and support can be properly

allocated to reduce patient safety risks, such as translator services to help combat language barriers and communication challenges. Appreciating the discrepancies and working to mitigate them is helpful in fostering more equitable health care.[3]

By reporting, such as to RO-ILS, patient-related bias-based events or behavior that were potentially relevant to patient safety, interventions can be designed, implemented and monitored for effectiveness over time. Depending on facility policy, RO-ILS can accept anonymous submissions, which can provide staff a safe space to comfortably voice safety concerns or share DEI-related interactions with the potential to affect patient safety, so that their experiences can be addressed in their local environment. Submitting to RO-ILS will also help raise awareness in other settings allowing for different interventions to be shared with the broader radiation oncology community.

Submission to RO-ILS is not a substitute for other reporting mechanisms. Facilities should have processes in place to address inappropriate staff or patient behavior (e.g., sexual harassment, racial discrimination, inadequate translation services, among others) in accordance with applicable laws and standards. Properly trained individuals, such as human resources and legal staff, should be involved according to the facility's policies.

Leveraging RO-ILS for DEI Efforts

It is important to analyze the ways that individuals' identities and biases, both staff and patient, potentially factor into medical errors so that methods to improve patient safety can be identified. In order to facilitate data analysis, information relevant to patient safety can be documented in RO-ILS.

Potentially relevant RO-ILS data elements may include:

- Patient's age (#203)
- Patient's gender (#204)
- Contributing factor (#231)
  Potential Answer Options:
  - "Patient-focused circumstances" = if a patient's demographics, identity, or ableness is relevant for the event
  - "Hostile work environment"
  - "Inadequate safety culture"

Facilities may also choose to include a keyword (e.g., "DEI") in a free-text data field to further support data aggregation and analysis as incorporated per facility policy.

RO-ILS DEI Examples

The following scenarios serve as examples of DEI-associated safety events and how they could be entered into RO-ILS.

Scenario 1: Patient arrives for their first day of treatment for breast cancer and indicates that for religious reasons, they can only be treated by female therapists. However, two female therapists are not available. Therefore, only one female therapist sets up and treats the patient even though the facility's policy is for two therapists to manage treatment delivery. An error is made during setup and the patient is treated incorrectly.

RO-ILS Structured Data Element	Recommended Answer Option
Event Classification (#104)	Therapeutic Radiation Incident: Radiation dose not delivered as intended, with or without harm
Treatment Technique (#106)	3-D
Problem Type (#233)	Patient position, setup point, treatment isocenter or shift change incorrect
Workflow Error Where Discovered (#207)	Treatment Delivery Including Imaging
Workflow Error Where Occurred (#208)	Treatment Delivery Including Imaging
Contributing Factors (#231) [OPTIONAL]	• Patient-focused circumstances • Inadequate human resources • Policy not followed

In this scenario, a patient's religion was a relevant factor in examining the error. It is important to engage in open communication with any patient whose sincerely held religious beliefs might challenge normal procedures and protocols, at a minimum, to see if there is an acceptable compromise to meet the patient's holistic needs and facility policies/processes.

Appreciating the DEI component(s) in the error can be helpful in identifying trends and exploring what process changes might be appropriate. For example, the facility may want to consider improving patient communication to identify patient-specific needs earlier. They may want to explain the importance of the policy of requiring two therapists for each treatment to patients so they understand the safety risk the single therapist and patient would be placed into in this scenario.

Scenario 2: Patient refuses to receive treatment with a staff member based on the staff member's race or ethnicity.

RO-ILS Structured Data Element	Recommended Answer Option
Event Classification (#104)	Unsafe Condition: Any condition that increases the probability of a safety event
Treatment Technique (#106)	IMRT/VMAT
Problem Type (#233)	Other
Workflow Error Where Discovered (#207)	Pre-planning Imaging and Simulation
Workflow Error Where Occurred (#208)	Pre-planning Imaging and Simulation
Contributing Factors (#231) [OPTIONAL]	• Patient-focused circumstances

In this scenario, there was no specific error related to the patient's care, but the patient's bias may have led to unplanned workarounds that increased the likelihood of an error. Keeping track and informing leadership of these events may allow resources and policies to be used to support staff in this instance and identify ways to manage similar situations.

Next Steps

The AnalysisWizard in the RO-ILS Portal can be leveraged to create reports so these events can be analyzed, and corrective actions can be developed consistent with the policies and procedures of the facility. Staff should not only address specific "isolated" events but consider events in the aggregate and work to highlight and address underlying issues to improve workplace and health care environment circumstances impacting patient safety. The information may also be helpful in seeking resources from the facility management to provide training and facilitation to support an inclusive, equitable and positive safety culture in their environment.

Broadening the perspective to consider such potential factors in patient safety reporting presents an opportunity to more effectively identify and address incidents where DEI issues are impacting patient safety. This process starts with collecting and analyzing events, along with garnering leadership support for such exercises.

Need Additional Assistance?

- For general support about the RO-ILS program, contact roils@astro.org.
- For specific assistance related to reporting an event or other confidential information, contact Clarity PSO at radoncsupport@claritygrp.com or 773-864-8287.
- This information is provided for your convenience only and is not legal advice.

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[1] Language proficiency and adverse events in US hospitals: a pilot study - PubMed (nih.gov)
[2] https://pubmed.ncbi.nlm.nih.gov/35797590/
[3] Embedding Equity into Every Step of Adverse Event Analysis (ihi.org)