



# Hands-On Workshop: Using Incidents to Improve Patient Care

Moderator: Jean Moran, Brett Miller

- Using Root Cause Analysis When Analyzing Incidents
  - Grace Kim

Classification of Incidents

- Jennifer Johnson

Developing a Corrective Action Plan

- Leah Schubert

Hands-On Exercise

#### Hands-On Workshop: Using Incidents to Improve Patient Care

#### Classification of Incidents

Jennifer L Johnson, MS, MBA, FAAPM UT MD Anderson Cancer Center





#### Classifying the Whys

#### Human factors



 $\label{lem:https://encrypted-tbn0.gstatic.com/images?q=tbn:ANd9GcQK91PtJj050dtYgJGlH2CK6zf46-OsOJePSdgS-IQc94pGAMnK$ 

Hierarchy of

causality

Technical

Organizational Management Procedural Issues

Human Behavior involving Staff Patient-related circumstances External factors (beyond facility control)



# Technical Whys

- Proper acceptance & commissioning
- Equipment design
- Equipment maintenance
- Facility environment



# Organizational Management Whys

- Planning program
- Policies & procedures
- Training
- Communication
- Environment
- Leadership



"Don't worry if you don't know the rules – we're making it up as we go along ..."

www.healthcaregovernancereview.org

https://healthcaregovernancereview.files.wordpress.com/2011/07/hgr45\_web.jpg



## Procedural Issues Whys

Fail to detect developing problem

Fail to interpret develop problem

• Fail to select correct rule address problem

Fail to develop effective plan

Fail to execute planned action



https://img.clipartfest.com/a215f8f661a62d494618540062c5393a\_kid-detective-clipart-clipart-



## Human Behavior Whys

- Scope of practice
- Mental slip
- Poor judgment
- Language and comprehension
- Intentional violations
- Negligence



http://www.buzzle.com/images/people/activities/kids/science-behind-temper-tantrums.jpg.



MARCH 18–21 | Hilton New Orleans Riverside | New Orleans, LA Ford, E. C., de Los Santos, L. F., Pawlicki, T., Sutlief, S., & Dunscombe, P. (2012). Consensus recommendations for incident learning database structures in radiation oncology. *Medical physics*, 39(12), 7272-7290.

# Patient-related Circumstances Whys

- Misleading
- Cognitive performance
- Non-compliance
- Language and comprehension
- Patient medical conditions



http://nspt4kids.com/wp-content/uploads/2011/07/baby-not-wanting-to-eat1-300x200.jpg



#### External Factors Whys

- Natural environment
- Hazards

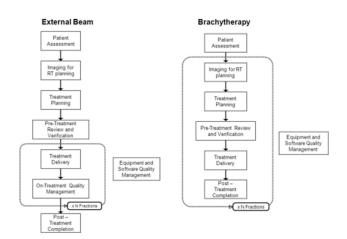


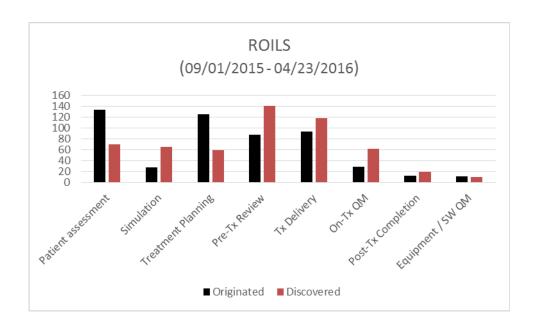
http://unique-information.com/wp-content/uploads/2016/02/natural-disasters-490x275.png



#### Classifying Incidents

#### Origin vs. Discovered







## Classifying Incidents

#### Medical Severity

| Score | Consequences (actual or predicted)   |
|-------|--|
| 10    | Premature death  |
| 8/9   | Life threatening—intervention essential. Possible recurrence due to underdose. |
| 7     | Permanent major disability (or grade 3/4 permanent toxicity)                   |
| 5/6   | Permanent minor disability (or grade 1/2 permanent toxicity)                   |
| 3/4   | Temporary side effects—major<br>treatment/hospitalization                      |
| 2     | Temporary side effects—intervention indicated                                  |
| 1     | Temporary side effects-intervention not indicated                              |
| 0     | No harm  |
|       | Unknown  |

#### Dosimetric Severity

| Score | Dose deviation per course   |
|-------|---|
| 9/10  | >100% absolute dose deviation from the total prescription for any structure     |
| 7/8   | >25%-100% absolute dose deviation from the total prescription for any structure |
| 5/6   | >10%-25% absolute dose deviation from the total prescription for any structure  |
| 3/4   | >5%-10% absolute dose deviation from the total prescription for any structure   |
| 1/2   | <5% absolute dose deviation from the total prescription for any structure       |
|       | Not applicable  |



A common mistake that people make when trying to design something completely foolproof is to underestimate the ingenuity of complete fools.

Douglas Adams



