



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

Developing a Corrective Action Plan

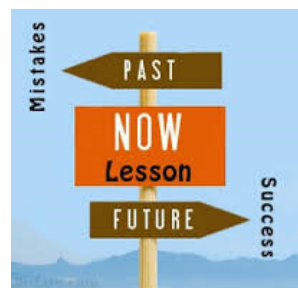
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I have no conflict of interest to disclose



Incident Learning

- Corrective actions, responses, solutions, mitigation strategies, interventions, etc.
- We've all been doing this the entire time, but what can differ
 - Formality
 - Scope of reports
 - Who's involved



Objectives

- Framework and techniques for identifying and implementing actions in response to incidents
- Practical tips for success and challenges faced
- Use in your own clinic

Step 1: Start with all the Information

You have now found the underlying causes and contributing factors to the incident and you've determined that you *should* implement corrective actions

Tip: You need to know the problem in order to solve it

Step 2: Assemble the Team

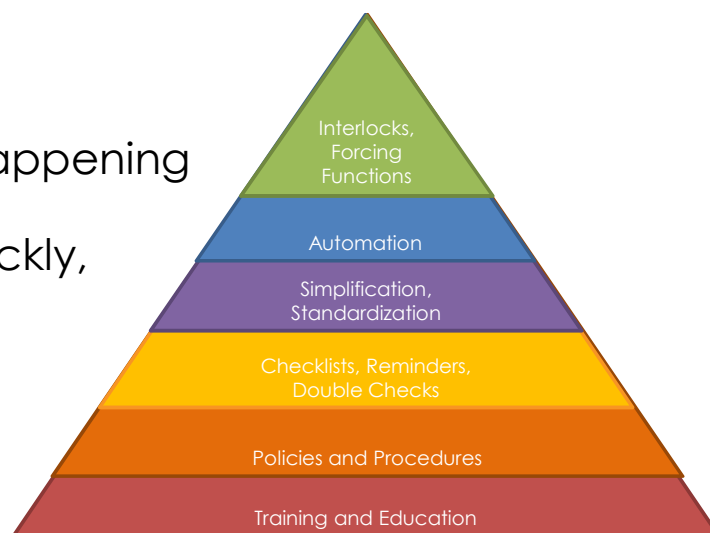
- May/may not include staff involved (RCA)
- Representatives from each staffing group
- Front line staff vs supervisors
 - Understand the actual clinical process
 - Ability to implement corrective actions (or backing)

Tip: Attitude is key

- Just culture
- Improve process vs assign blame
 - Room for improvement
- Creativity in brainstorming actions

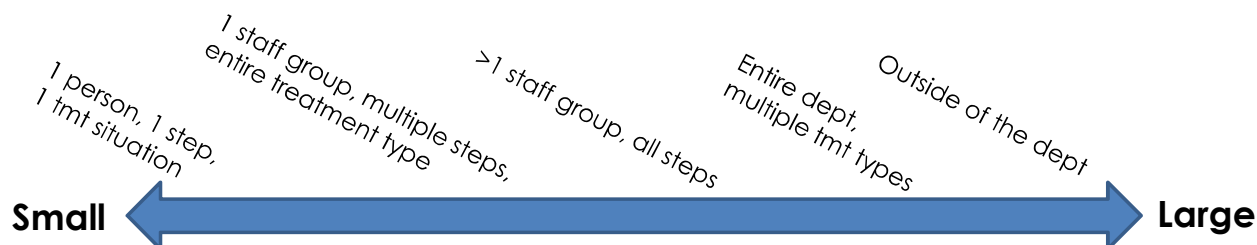
Step 3: Brainstorm Possible Actions - Types

- Prevent incident from happening
- Make incident more quickly, easily detectable
- Mitigate its impact



Step 3: Brainstorm Possible Actions - Scale

- Timeline –5 days, 5 months, 5 years
- Scope - situations, treatment types, staffing groups



Step 3: Brainstorm Possible Actions - Example

- Immediate action (<5 days)
 - patient, couch, training, company
- 5 days
 - education, stay clear zone
- 5 months (large scale)
 - annual training, prospective project on dept-wide collision risks



Step 4: Choose the Optimal Actions

- Effectiveness
 - Does it actually solve the problem
 - How effective
 - Monitor the effectiveness
- Feasibility
 - Implementation timeline
 - Required resources
 - Amount of effort from amount of staff
 - Likelihood of staff compliance
 - Downsides or undesirable consequences

	Proposed Action #1	Proposed Action #2	Proposed Action #3
Proposed Action			
Does it effectively solve the problem?			
How soon can it be implemented?			
How likely would staff comply?			
What resources does it require?			
How can its effectiveness be monitored?			
What are the downsides or undesirable consequences?			

Step 5: Implement Your Action Plan (Small)

- Who will implement
- When will it be done
- How to communicate to staff
- Feedback for effectiveness

Tip: Regular meetings of ILS committee help to drive progress

Step 5: Implement Your Action Plan (Large)

- Establish a sense of urgency (buy in)
- Who will implement (involved staff, champions)
- Develop the goal and strategy
- Communicate to staff
- Remove obstacles
- Publicize short term wins
- Consolidate into culture

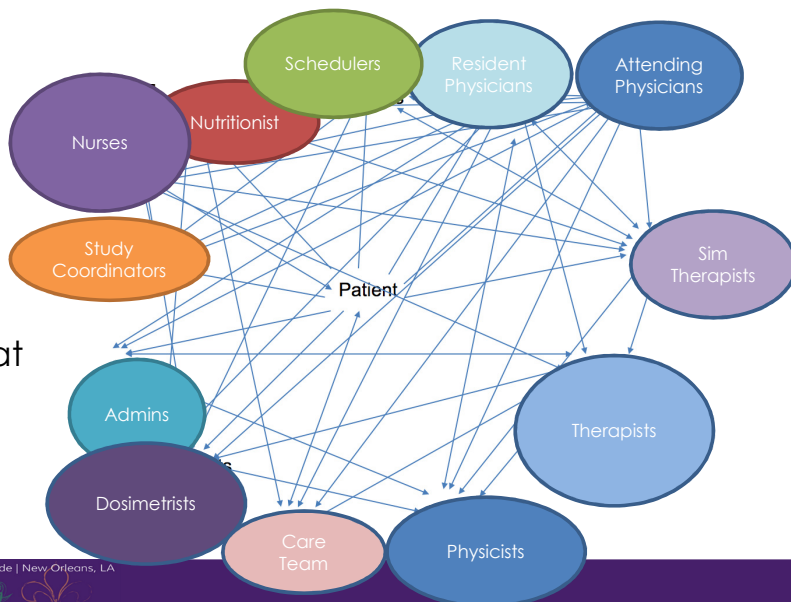
Example: HDR Project

- Physician and physicist
- Involved 'problem' staff
- Meetings, chart audit, survey
- Patient chart; continue for new tmt programs

CYLINDER		Fraction Date				
HDR Safety Checklist		1	2	3	4	5
Task Verified by Physicist with Responsible Staff						
Before Staff Leave Room						
Attending, physicist, and nurse present in room						
Time Out: Patient identity verified using two identifiers by attending and dosimetrist/physicist						
Anatomical treatment site verified by attending and dosimetrist/physicist						
Correct applicator verified by attending and dosimetrist/physicist • diameter (cm) = <input type="text"/> # segments = <input type="text"/> # source = <input type="text"/>						
Applicator placed by attending (or resident under attending's personal supervision)						
Transfer guide tube connected and measured by dosimetrist/physicist • cylinder length = <input type="text"/> cm • diameter = <input type="text"/> cm						
Connection(s) verified by attending and physicist • cylinder = <input type="text"/> channel						
Pre-treatment survey performed by physicist						
At Console: Before Treatment Starts						
Room empty except patient						
Prescription & current fraction verified by dosimetrist/physicist						
Plan documents, pretreatment report signed by attending and physicist						
Authorized Medical Physicist and Authorized User signoff:						
Turn Key and Start Treatment						

Communication and Feedback

- Involve affected staff
 - Knowledge of the process, buy in
- Iterative process
 - pilot, feedback, full scale, refine and repeat
- PR campaign
 - making efforts



Do We Really Have Time for All This?

- Resource intensive
- Continuous process, within available resources
- Not all actions take as much effort
- Can start to impact the culture
- Positive changes can motivate other staff
- Shift the thinking towards a standard part of everyone's jobs

Tip: Actions in Our Institution

- 2-3 large scale projects per year
- Numerous smaller process changes
- Education critical (>50 reports per year)

Summary

- Start with the information
- Gather your team
- Brainstorm possible actions
- Choose the optimal actions
- Implement your action plan

- Now it's your turn...



Choosing the Optimal Actions Worksheet

Problem Being Addressed:	
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What resources does it require?			
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