Introduction

Grace Gwe-Ya Kim, PhD, DABR
Associate Director, Quality Assurance and Safety
Radiation Medicine & Applied Sciences

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What are the secrets to successfully implementing safety initiatives and maintaining staff engagement?
Charges (12 May 2005)

• Provide a historical database of errors reported in the Radiotherapy Community

• To assess the utility methodologies and tools used in error reduction for application in medical physics.

• Make recommendations to the Radiotherapy Community in terms of: staffing, processes, tools needed to carry out particular procedures in order to avoid errors and provide guidance in the practice of error reduction techniques.
Charges (Dec 2013)

• Develop and disseminate tools to improve safety and quality in all the clinical areas of medical physics using approaches that extend beyond traditional measurement-based QA

• Foster collaborative safety initiatives and projects with other professional societies within therapeutic and diagnostic radiation medicine

• Facilitate interactive sharing of knowledge and experience in the areas of patient safety and quality.
Charges (Dec 2013)

- Disseminate information to the AAPM membership and the radiological community in general on issues involving safety and quality in all the clinical areas of medical physics

- Oversee and coordinate societal and intersocietal initiatives on the areas of patient safety and quality improvement, such as the implementation of the recommendations from Task Group 100

- Participate and provide guidance on distributed incident learning systems at the national and international level.
The SPA consists of the following:

- 92 questions carefully selected from various authoritative reports and recommendations to assess performance in key, safety-critical areas.
- Summary of your clinic's performance via visual pie charts.
- Bar graphs allowing you to benchmark your performance against other participants.
- Downloadable Quality/Safety Improvement Log to guide safety improvement initiatives.
- Annotated bibliography for further guidance on best practices and standards.
Safety Profile Assessment

There are 57 assessments in the system. The pie charts and bar graphs for each section below are based on your current answers only.

1. INSTITUTIONAL CULTURE

- Most of the time / Agree: 11.1%
- Sometimes / Neutral: 88.9%

1. INSTITUTIONAL CULTURE

Bar graph showing responses:
- Always / Strong...
- Most of the time...
- Sometimes / Neutral...
- Rarely / Disagree...
- Never / Strongly...
- Do not know...

17. Clinical staff are informed of corrective actions arising from the review of reports of errors and near misses. You answered Sometimes / Neutral for a score of 3

Question 017

(shorter lines are better)

You in 2012: [Blue Bar]
Avg: [Red Bar]
AAPM COMMITTEE TREE

Task Group No. 275 - Strategies for Effective Physics Plan and Chart Review in Radiation Therapy (TG275)

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Committee Website | Directory: Committee | Membership

Email  You may send email to this group now using gmail or outlook.
- or -
You may save the address 2019.TG275@apam.org
to your local address book. This alias updates hourly from the AAPM Directory.

Charge
1. To review existing data and recommendations that support the use of physics plan and chart review; and to review the current recommendations on the qualifications for performing these.
2. To provide survey information on current practices in the community with respect to physics plan and chart review.
3. To provide risk-based recommendations for the effective use of the following physics review: initial plan and chart check, weekly chart check and end-of-treatment chart check.
4. To provide recommendations to software vendors for systems design and operations that best facilitate physics plan and chart review.

Eric Ford
Task Group Chair

Web-based Survey

Risk Assessment

Provide recommendations
QUALITY & SAFETY RESOURCES
Quality & Safety Resources: This site highlights quality and safety tools developed by AAPM committees for use by our members.

- PSYCHOLOGY OF HUMAN ERROR
- INCIDENT REPORTS AND DESCRIPTIONS
- GUIDELINES
- SAFETY CULTURE – GENERAL
- SAFETY CULTURE – CHECKLIST
- SAFETY CULTURE – TEAMWORK
- SAFETY CULTURE – PEER REVIEW
- SAFETY CULTURE – TRAINING
- SAFETY CULTURE – INCIDENT LEARNING
- RISK ASSESSMENT TOOLS – PROCESS MAPPING
- RISK ASSESSMENT TOOLS – FAILURE MODE AND EFFECTS ANALYSIS
- RISK ASSESSMENT TOOLS – FAULT TREE ANALYSIS
- RISK ASSESSMENT TOOLS – ROOT CAUSE ANALYSIS
- RELATED QUOTES
WGROILS

• ROILS User Guideline
• AAPM WG RO-ILS Recommended Curriculum on Quality Improvement and Incident Learning
• Task Group 327: Crowd-sourced solutions to the problem of wrong shift instructions
Your contributions! – TG327

We need your support!

Refer to the Newsletter article in Nov/Dec 2018 for more details.
Outline of this session

• Methods for Overcoming Barriers and Techniques for Rolling out Interdisciplinary Change
  Leah Schubert

• Successful Establishing a Safety Program in an Academic Environment
  Todd Pawlicki

• Unique Considerations in Establishing a Safety Program in a Community Setting
  Bradley Schuller
Learning Objectives

• Understand how to design solutions to improve patient safety
• Discuss problem and issues in measuring and reporting safety.
• Become aware of the range of tolls, solutions and strategies to improve patient safety.