

# Introduction

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RETHINKING MEDICAL PHYSICS

## Outset

What are the secrets to successfully implementing safety initiatives and maintaining staff engagement?

# WGPE Brief History

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.



# WGPE

TG100

SPA

MPPG 3a

TG275

TG275  
Education  
Module

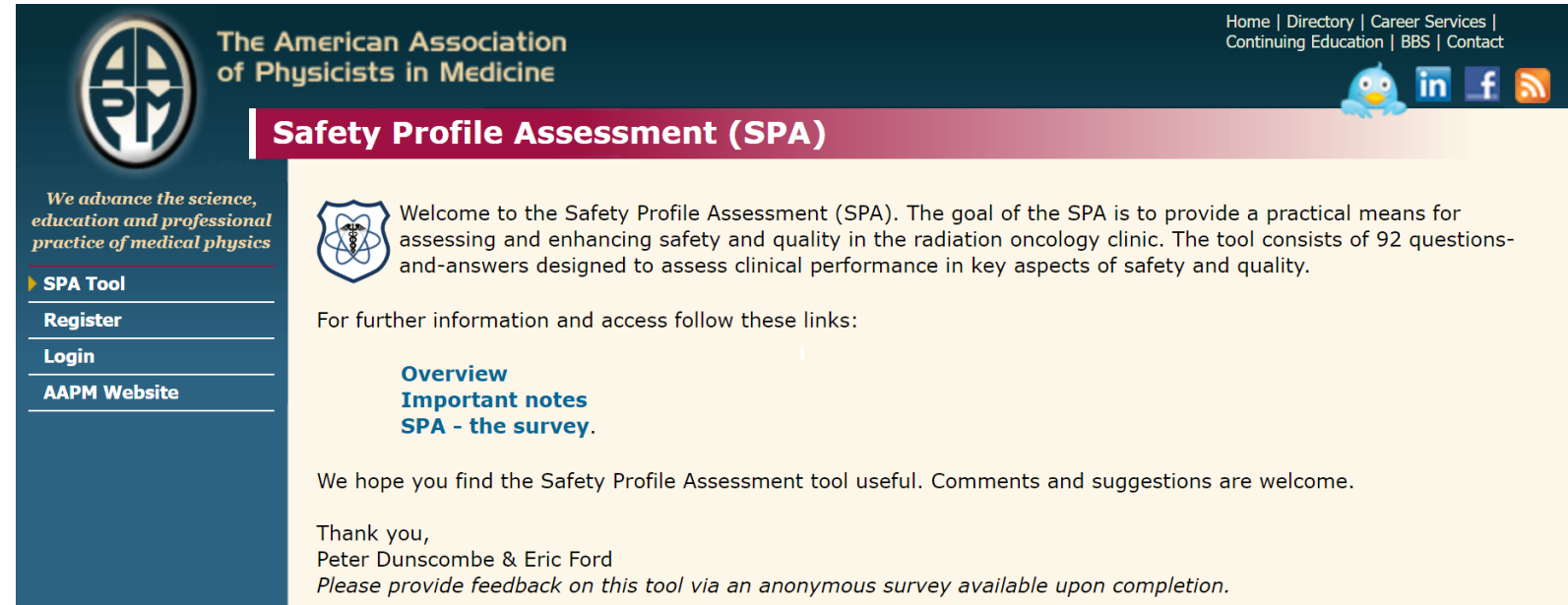
TG314

TG288

Resource  
Page

# WGPE

## SPA



The American Association of Physicists in Medicine

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**Safety Profile Assessment (SPA)**

*We advance the science, education and professional practice of medical physics*

- SPA Tool
- Register
- Login
- AAPM Website

Welcome to the Safety Profile Assessment (SPA). The goal of the SPA is to provide a practical means for assessing and enhancing safety and quality in the radiation oncology clinic. The tool consists of 92 questions-and-answers designed to assess clinical performance in key aspects of safety and quality.

For further information and access follow these links:

- [Overview](#)
- [Important notes](#)
- [SPA - the survey.](#)

We hope you find the Safety Profile Assessment tool useful. Comments and suggestions are welcome.

Thank you,  
Peter Dunscombe & Eric Ford  
*Please provide feedback on this tool via an anonymous survey available upon completion.*

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.

# WGPE

## SPA

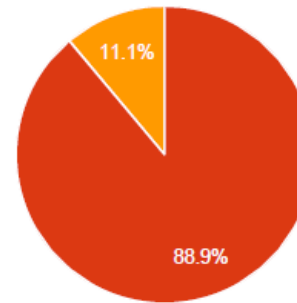
### Safety Profile Assessment

There are 57 assesments in the system.

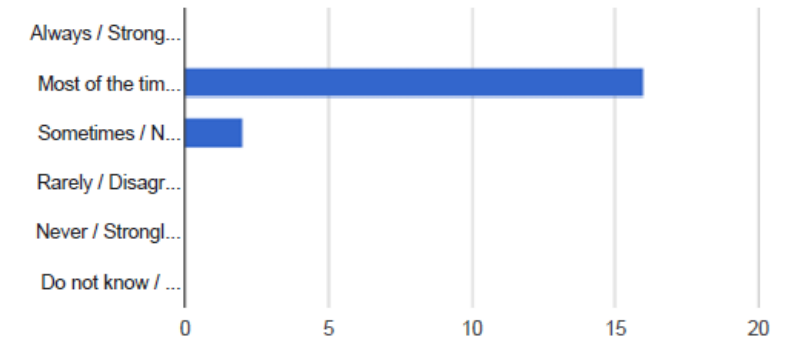
The pie charts and bar graphs for each section below are based on your current answers only.

#### 1. INSTITUTIONAL CULTURE

- Most of the time / Agree
- Sometimes / Neutral



#### 1. INSTITUTIONAL CULTURE



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



# WGPE

## TG275

### AAPM COMMITTEE TREE

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

- [bookmark this page](#) (bookmarks show under "My AAPM" in the menu to left)

[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@aapm.org](mailto:2019.TG275@aapm.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.

Chair



[Eric Ford](#)

Task Group Chair

Web-based  
Survey

Risk  
Assessment

Provide  
recommendations

# WGPE

## Resource Page



Improving Health  
Through Medical Physics

My AAPM

AAPM

AMERICAN ASSOCIATION  
*of* PHYSICISTS IN MEDICINE

### QUALITY & SAFETY RESOURCES

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

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[Continuing Education](#) | [BBS](#) | [Contact](#)



- ▶ 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.

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
















Welcome, user Kim\_31178  
There are **4 other users** online (3 registered, 1 guest). There are **2 alerts** (2 bad posts).

**Common error pathways**  
Moderators: [Weintraub\\_10552](#), [Kim\\_31178](#), [Manger\\_53857](#), [Schofield\\_28808](#), [Ezzell\\_1624](#), [Tonigan\\_51503](#)

[New Thread](#) [New Poll](#)

Message format  
Flat ▼ [Go](#)

Jump to page: [AAPM](#) → Common error pathways

Thread Subject	Author	Viewers	Replies	Last Post
Announcements				
  <b>How to use this forum to provide solutions to "Wrong shift information"</b>	<a href="#">woodward</a>	17	0	 Last Post : 9/21/2017 11:01 AM > Posted by <a href="#">woodward</a> 
 <b>Pathway 5: Shift instructions manually calculated or transcribed incorrectly</b>	<a href="#">Ezzell_1624</a>	16	3	 Last Post : 11/28/2018 3:43 PM > Posted by <a href="#">Ezzell_1624</a> 
 <b>Pathway 7: Patient orientation label incorrect in planning CT</b>	<a href="#">Ezzell_1624</a>	17	2	 Last Post : 11/13/2018 5:30 PM > Posted by <a href="#">Ezzell_1624</a> 
 <b>Pathway 3: IGRT reference images created from wrong dataset</b>	<a href="#">Ezzell_1624</a>	7	2	 Last Post : 11/13/2018 5:19 PM > Posted by <a href="#">Ezzell_1624</a> 
 <b>Pathway 2: IGRT reference images created with wrong isocenter</b>	<a href="#">Ezzell_1624</a>	9	2	 Last Post : 11/13/2018 5:18 PM > Posted by <a href="#">Ezzell_1624</a> 
 <b>Pathway 1: Patient marked incorrectly in sim</b>	<a href="#">Ezzell_1624</a>	25	2	 Last Post : 11/13/2018 5:10 PM > Posted by <a href="#">Ezzell_1624</a> 
 <b>Pathway 6: Origin/Reference point marked incorrectly in planning</b>	<a href="#">Ezzell_1624</a>	16	2	 Last Post : 11/9/2018 4:24 PM > Posted by <a href="#">Ezzell_1624</a> 
 <b>Pathway 4: Shift instructions are not created</b>	<a href="#">Ezzell_1624</a>	7	1	 Last Post : 11/9/2018 4:19 PM > Posted by <a href="#">Ezzell_1624</a> 
  <b>ABR Self Directed Educational Project Template</b>	<a href="#">Ezzell_1624</a>	2	0	 Last Post : 11/7/2018 7:20 PM > Posted by <a href="#">Ezzell_1624</a> 

# 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.