

# Unique Considerations in Establishing a Safety Program in a Community Setting

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# Disclosure

- Financial support from the Banner Health Risk Management Fund Program

# Learning Objectives

- Learn about risk management experience in a community practice setting.
- Learn specific recommendations for performing risk management in the context of Kotter's Change Model, using TG-100 as an example.
- Learn some unforeseen benefits of performing the various steps.

# Scope of the Presentation

## WHAT THIS IS

A discussion of the subtleties and nuances we found working through FMEA for the first time as a small community practice.

## CONFESSION

I've had no specific training in change management, and didn't really know what to do beyond following my intuition... maybe that's why this is hard.

# The Problem for Small Clinics

Clinical process is equally complicated across various practice sizes.

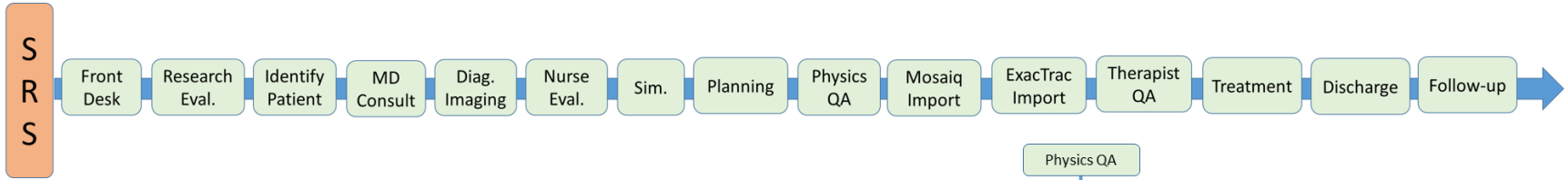
Therefore,

Small clinics may have difficulty performing prospective risk management given the time and effort required to complete it.

# McKee Medical Center (MMC), Loveland, CO

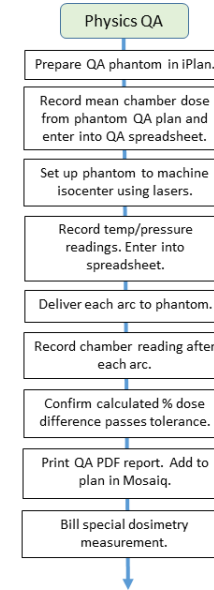
- Single linac clinic: TrueBeam STx
- 20-30 patients/day
- SRS, SBRT, motion management
- Individuals from each discipline form the core of the clinical team.
- We exist as part of unified regional network, but our FMEA was concentrated at this site.

# MMC FMEA

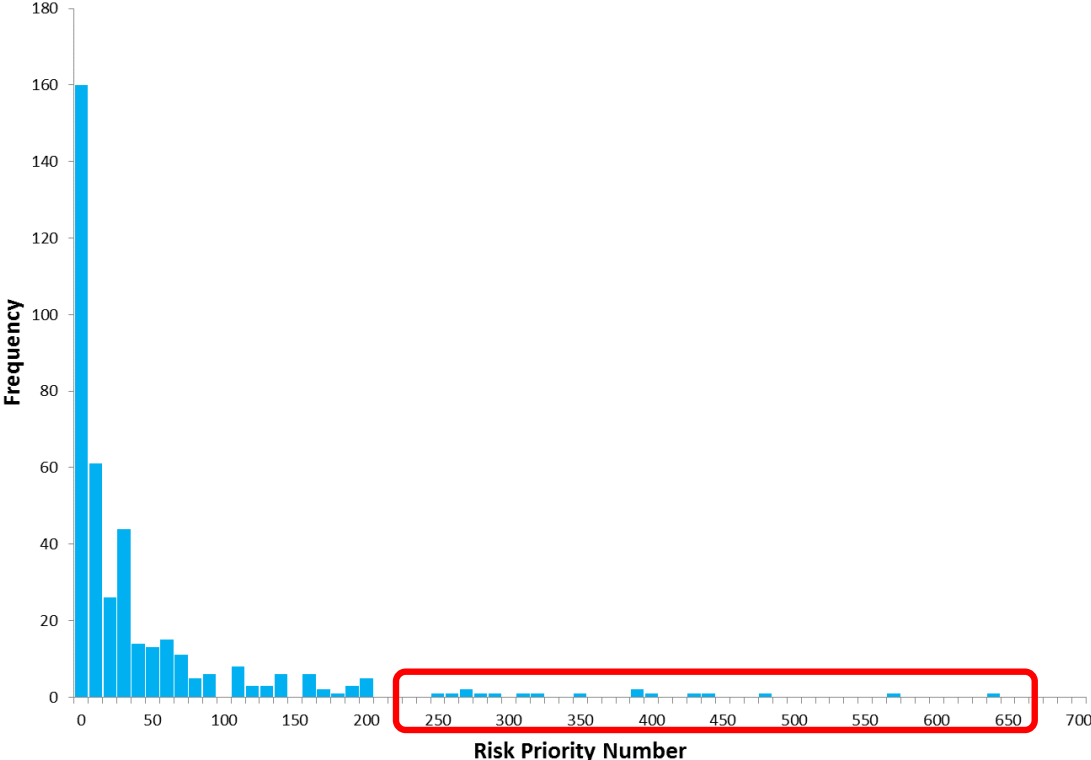


## Process Map

- 15 major process steps identified.
- 183 sub-process (minor) steps identified.



# MMC FMEA





# MMC FMEA

Task	Session Time Required	Estimated Person-Hours
Project leader training at AAPM Summer School	5 days	40 hours
Initial department education (preparation and delivery)	6 hours	48 hours
Team recruitment	4 hours	8 hours
Team education	2 hours	16 hours
Process mapping (including electronic formatting)	33 hours	66 hours
FMEA evaluation and data collection	40 hours	120 hours
<b>Total (not including AAPM Summer School)</b>	<b>85 hours</b>	<b>258 hours</b>

# Placing This Project in the Context of Kotter's Change Model

# Buy-In: Sense of Urgency & Creating Vision

- Sometimes, there is an assumption that buy-in is automatic.
- We anticipated that prioritizing this project would be a substantial hurdle.
- We dedicated a lot of time to our initial pitch to the department.

Initial department education (preparation and delivery)	6 hours
Team recruitment	4 hours
Team education	2 hours

# Buy-In: Communicate the Vision

- Make quality and safety concepts tangible to the entire program.

## Part 1

### **Moving Towards a Culture of Safety in Radiation Oncology**

**Medical Error, Root Cause Analysis, and Safety  
Culture**

## Part 2

### MOVING TOWARDS A CULTURE OF SAFETY IN RADIATION ONCOLOGY

Process improvement methods and Failure Modes and Effects Analysis (FMEA)

- Consensus that prospective risk management should be a priority.

## Buy-In: Build a Guiding Team

- Individuals were approached.
- Time was used to assess interest and willingness to participate.

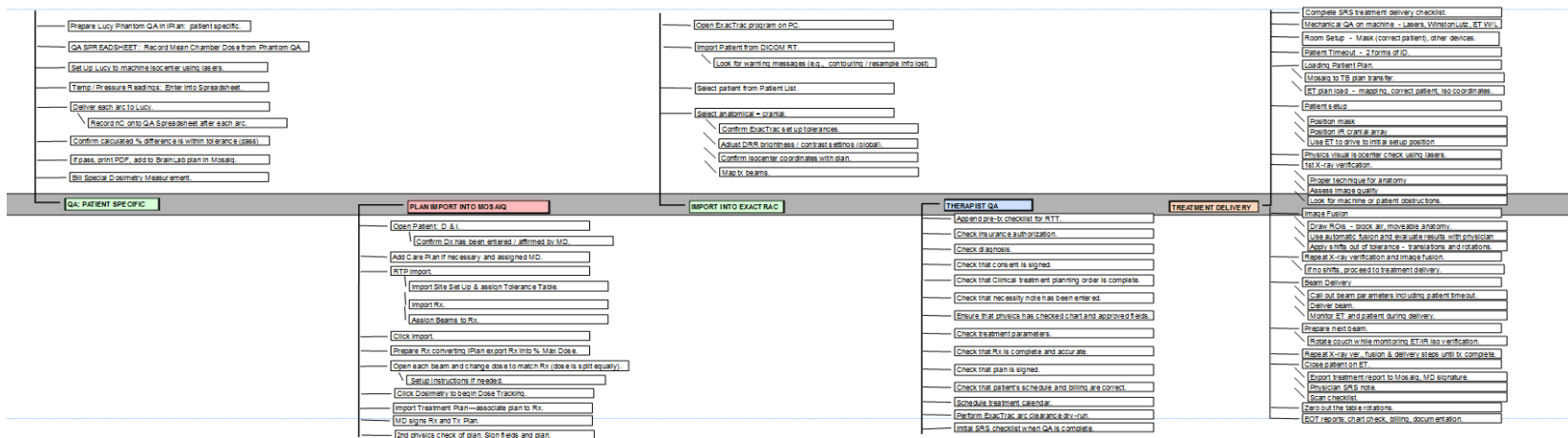
9-person team accounted for a large percentage of the clinical staff.

# Buy-In: Empower Action and Remove Obstacles

- Once FMEA team was assembled, 2 hours were spent teaching the mechanics of FMEA.
- This energizes the team and re-establishes the motivation for the project.

# Process Mapping: Empower Action & Remove Obstacles

- SRS chosen as the scope of the project. (TG-100, Sec.8).
- Major process steps determined as a group.
- Sub-process steps determined by small groups with the most domain expertise.



# Process Mapping: Empower Action & Remove Obstacles

- TG-100 Appendix B: Recommends to “choose the right level of detail”.
  - For the first process map, err on the side of including more detail.
  - This minimizes the risk of missing important failure modes due to lack of sufficient detail in the process map.
- \*\* We aimed to provide enough detail such that another radiation oncology team could execute our SRS procedures.



# FMEA: Empower Action & Remove Obstacles

- Facilitator guidance is key here.
- \*\* Meetings are difficult to schedule since the team comprises a large percentage of the available clinical staff.
- \*\* Schedule open meetings for people to attend when their schedules permit.
- Facilitator attends every meeting.
- FMEA topic dictated by the expertise of the attendees.

# FMEA: Scoring Consistency

- Facilitator provides an important anchor point to help maintain consistent scoring.
- This ensures that no major process step is over- or under-emphasized due to inconsistent scoring bias.
- Note on scoring bias: FMEA meeting structure described above could introduce bias, but at least the facilitator provides some consistency.

## Importance of the Facilitator: Use Credibility to Drive More Change

- The facilitator is the driving force behind the FMEA project.
- Training is key:
  - TG-100
  - TG-100 workshops
  - 2013 AAPM Summer School Material

# Post-FMEA Practice Changes: Embed in the Culture

- Simple mitigation steps were implemented to reduce risk.
- Focused on redundancy (TG-100, Sec.8).
- For our 10 highest scoring failure modes:
  - 5 checklist additions
  - 5 simple procedural changes.

# Unforeseen Benefits

- Process mapping.
- Multi-D meetings.
- Spending time together in a different context.

# Cultivating a Safety Mindset: Checklist Development

- Lessons learned from FMEA project distilled into simpler safety-oriented projects.
- Reference ROILS data: establish a sense of urgency.
- Highlight the importance of each discipline's role while referencing known incident causes.
- Provide tools.
- Value each person's input to drive consensus: embed in the culture.

# Summary

- It pays to spend time on department buy-in.
  - Education.
  - Approach individuals.
- Heavy weighting on “Empowering action & removing obstacles”
- Simple practice changes have a large impact on risk reduction.
- Take advantage of the new safety mindset.

# Acknowledgements

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