Introduction: Incident Learning to Affect Change

Eric Ford, PhD FAAPM
Professor
University of Washington
Seattle, WA

Disclosures

- None

Historical Perspective

Incident learning in radiation oncology: A review

Eric C. Ford[a)]
Department of Radiation Oncology, University of Washington, Seattle, WA 98195, USA
Suzanne B. Evans
Department of Radiation Oncology, Yale University, New Haven, CT 06510, USA

Med. Phys. 45 (5), May 2018

QI: National Standards

- ✓ "Each department should have a department-wide review committee which monitors quality problems, near-misses and errors."

- ✓ "Employees should be encouraged to report both errors and near-misses."

Safety is No Accident, Zietman et al. 2012

QI: National Standards

A key component of practice accreditation

Recent Developments

- Culture of safety: measurement
- AI methods in safety
- Peer-support
- Education

Safety Program for Residents

EDUCATION

WILEY

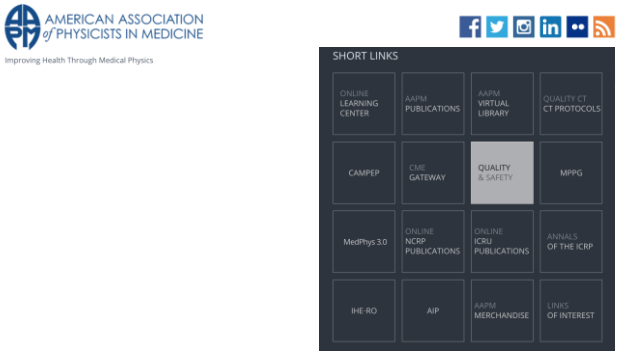
A patient safety education program in a medical physics residency

Eric C. Ford | Matthew Nyflot | Matthew B. Spraker | Gabrielle Kane | Kristi R. G. Hendrickson

J Appl Clin Med Phys 2017; 18:6: 268–274

Recent Developments

- Culture of safety: measurement
- AI methods in safety
- Peer support
- Education
- AAPM website landing page



AAPM Summer School 2020

"Advances in Quality Assurance"

June 2020

Directors: E. Ford, M. Miften

Learning Objectives for This Session

1. Develop effective corrective actions to mitigate potential incidents and near misses.
2. Apply systems thinking to quality initiatives such as error mitigation and compliance with accreditation standards.
3. Appreciate the value of national incident learning.

Speakers

- **Samantha Hedrick, PhD** "Proton Therapy: Lessons Learned"
- **Zoubir Ouhib, MS** "What Happens When Someone's Challenge Becomes Everybody's Challenge"
- **Suzanne Evans, MD** "History Repeats itself: RO-ILS and the Efforts to Change the Future"