

Introduction: Incident Learning to Affect Change

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Disclosures

- None

Historical Perspective



Incident learning in radiation oncology: A review

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1. INTRODUCTION	
1.A	Error and outcomes
1.B	Recommendations for incident learning and career practice
1.C	Definitions and terms
1.D	Summary of incident learning studies in radiation oncology
1.E	National and international relations: ILS
2. INSTITUTIONAL INCIDENT LEARNING SYSTEMS	
2.A	Structure of a departmental incident learning system
2.B	Identifying events for inclusion in the ILS
2.C	Performing a root-cause analysis
2.D	Developing and implementing action plans or process improvements
2.E	Attitudes and barriers to and ILS participation
2.F	Integration of incident
3. PRACTICAL ADVICE FOR DEVELOPING AND MAINTAINING AN ILS PROGRAM	
4. A SYSTEMS VIEW OF ERROR	
4.A	Safety culture and just culture
4.B	Training and communication
4.C	Cognitive bias
4.D	Addressing cognitive bias
5. RESPONDING TO INCIDENTS OF HARM	
5.A	Medical error disclosure
5.B	The patient experience
5.C	The impact of incidents on the professional
6. CONCLUSIONS	
*Complex, expanded version of the introduction available in online supplementary materials.	

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

Practice Management
APEx - Accreditation Program for Excellence

APEx is APEx's new practice accreditation program. It is built on recognized regulatory bodies by standards in assuring the radiation oncology team the safety and care in patient and procedures. APEx was created to ensure excellence in radiation therapy practice. The program evaluates standards of performance derived from evidence-based practice and consensus practice for radiation oncology. The program provides internal peer review of actual practice. Further, the internal evaluative and processes are a range of the accreditation.

Standard 7: Culture of Safety
The radiation oncology practice (ROP) fosters a culture of safety in which all team members participate in assuring safety; the practice capitalizes on opportunities to improve safety, and no reprisals are taken for staff that report safety concerns.

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



SHORT LINKS

ONLINE LEARNING CENTER	AAPM PUBLICATIONS	AAPM VIRTUAL LIBRARY	QUALITY CT CT PROTOCOLS
CAMPEP	CME GATEWAY	QUALITY & SAFETY	MPPG
MedPhys.3.0	ONLINE NCRP PUBLICATIONS	ONLINE ICRU PUBLICATIONS	ARTICLE OF THE ICRP
HE RO	AIP	AAPM MERCHANDISE	LINKS OF INTEREST



- Improving Health Through Medical Physics
- My AAPM
- AAPM
- Public & Media
- International
- Medical Physicist
- Members
- Students
- Meetings
- Education
- Quality & Safety
- TG100 Implementation Guide
- Radiation Oncology - Incident Learning System (RO-ILS)

QUALITY & SAFETY RESOURCES

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

- **Safety is No Accident: A Framework for Quality Radiation Oncology and Care**
- **Practical suggestions for dipping your toe in the TG-100 waters**
The Working Group on implementation of TG-100 has developed this 'tip sheet' based on feedback from the community regarding early experiences with implementation of the risk analysis methodology described in the TG-100 report.
- **Tutorials on Integrating Formal Risk Management (TG-100) into your practice**
These short videos have been created by the Work Group on the Implementation of TG-100 to help AAPM members lead and participate in implementing formal risk management concepts into their clinics. Members are encouraged to use the videos with their teams.
- **Radiation Oncology - Incident Learning System (RO-ILS)**
ASTRO and AAPM sponsor the national RO-ILS system. All members of the public are welcome to access guides, quarterly, and annual reports. These reports can be helpful in identifying opportunities for improvement in

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"


