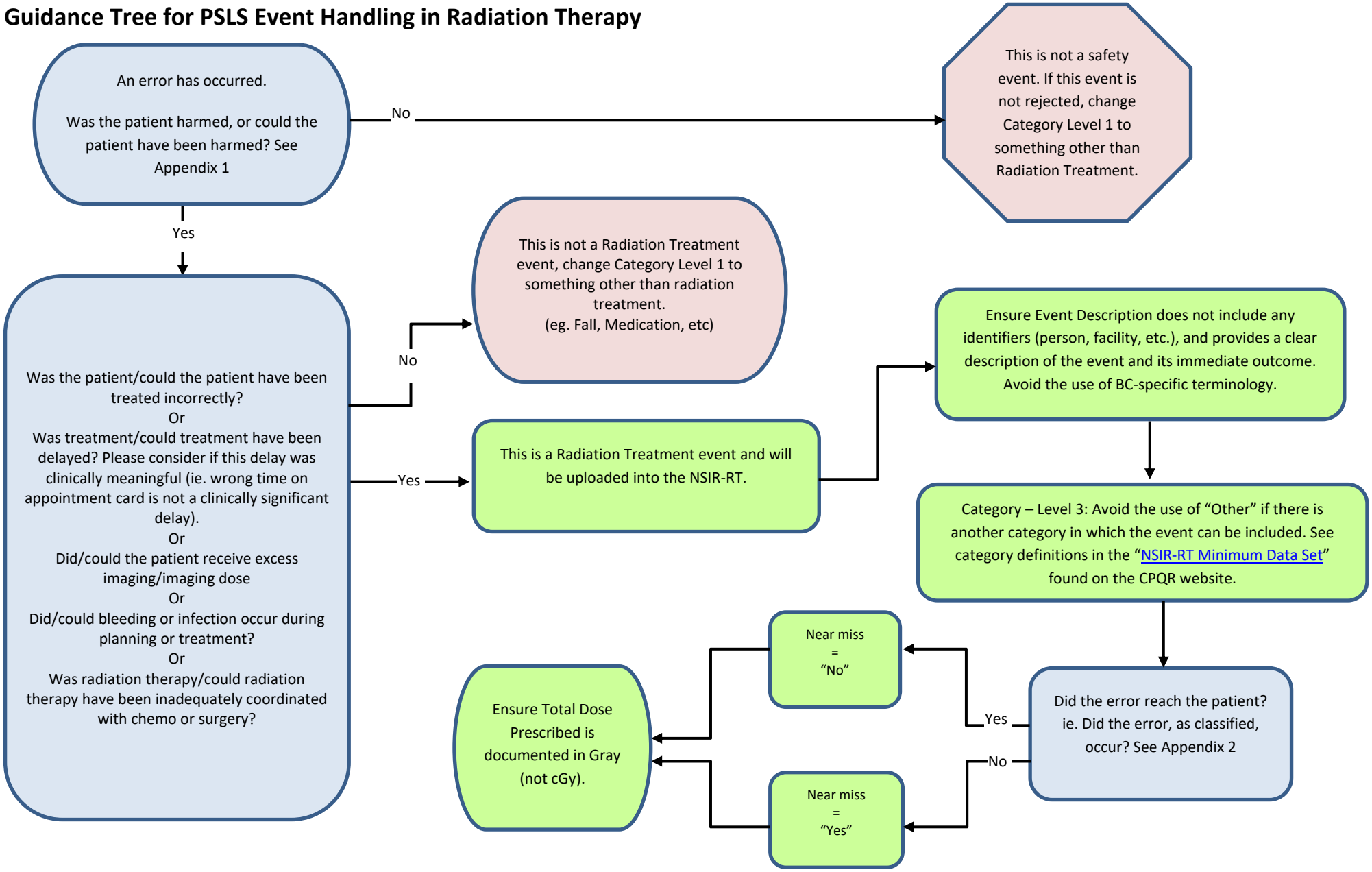
Guidance Tree for PSLS Event Handling in Radiation Therapy



This guidance tree is used for the handling of radiotherapy incidents within the BC Patient Safety and Learning System (BCPSLS). It is shared with permission from BC Cancer. For more information, contact Alison Giddings at agiddings@bccancer.bc.ca. Additional information about radiotherapy incident investigation is available via the CPQR incident investigation course.

Appendix 1: Errors not resulting in patient harm

Not all errors in healthcare could result in harm to the patient. The PSLS system is sometimes used by radiation therapy departments to track these types of errors, or technical variances. Only true safety events, or those events that could result in patient harm, will be included in the upload to the National System for Incident Reporting (NSIR-RT). Events that could not result in patient harm can either be rejected by the handler (these events remain in the PSLS for tracking and trending), or removed from Category 1 "Radiation Therapy" and included in another Category 1 such as "Documentation" or "Clinical Process/Procedure".

Examples:

1. The patient is being treated for cancer in their right breast. Treatment is planned for the right breast, but fields are labeled as "Left" in ARIA.

   While this is an error, it is not a safety event. There is no conceivable scenario in which this patient would receive treatment to their left breast. This could be categorized under "Documentation".

2. Only one source used for second laterality check.

   While this constitutes an error in following the laterality policy, the laterality of the patient's diagnosis or treatment plan was never in question. At no time was there a chance that they would be treated incorrectly. This could be categorized under "Clinical Process/Procedure" or "Documentation".

Appendix 2: Near miss

Events that do not reach the patient are considered a "Near Miss". If an event reaches the treatment unit and is caught just prior to treating a patient, it is likely still a "Near Miss", unless there is a clinically significant delay in treating the patient, or the patient is impacted psychologically. It is helpful to consider the Category – Level 3 in which the event is placed.

Examples:

1. The patient was scanned with one arm up and one arm down. The set up sheet indicated both arms up. This was discovered on first patient set up as one of the treating therapists had scanned the patient.

   Category – Level 3 for this event is "Wrong patient position, setup point or shift." It would be considered a near miss as this patient was not treated in the wrong position.

2. After setting up a patient for treatment to the right breast, radiation therapists applied isocentre moves as indicated in the set up sheet. The move was documented as 6.0 cm left, but was, in fact, 6.0 cm right.

   Category – Level 3 for this event is "Wrong patient position, setup point or shift." It would be considered a near miss as the correct move was applied before imaging and treating the patient.