TreatSafely

Minimizing Error

Maximizing Quality

CHECKLISTS

The Exercise

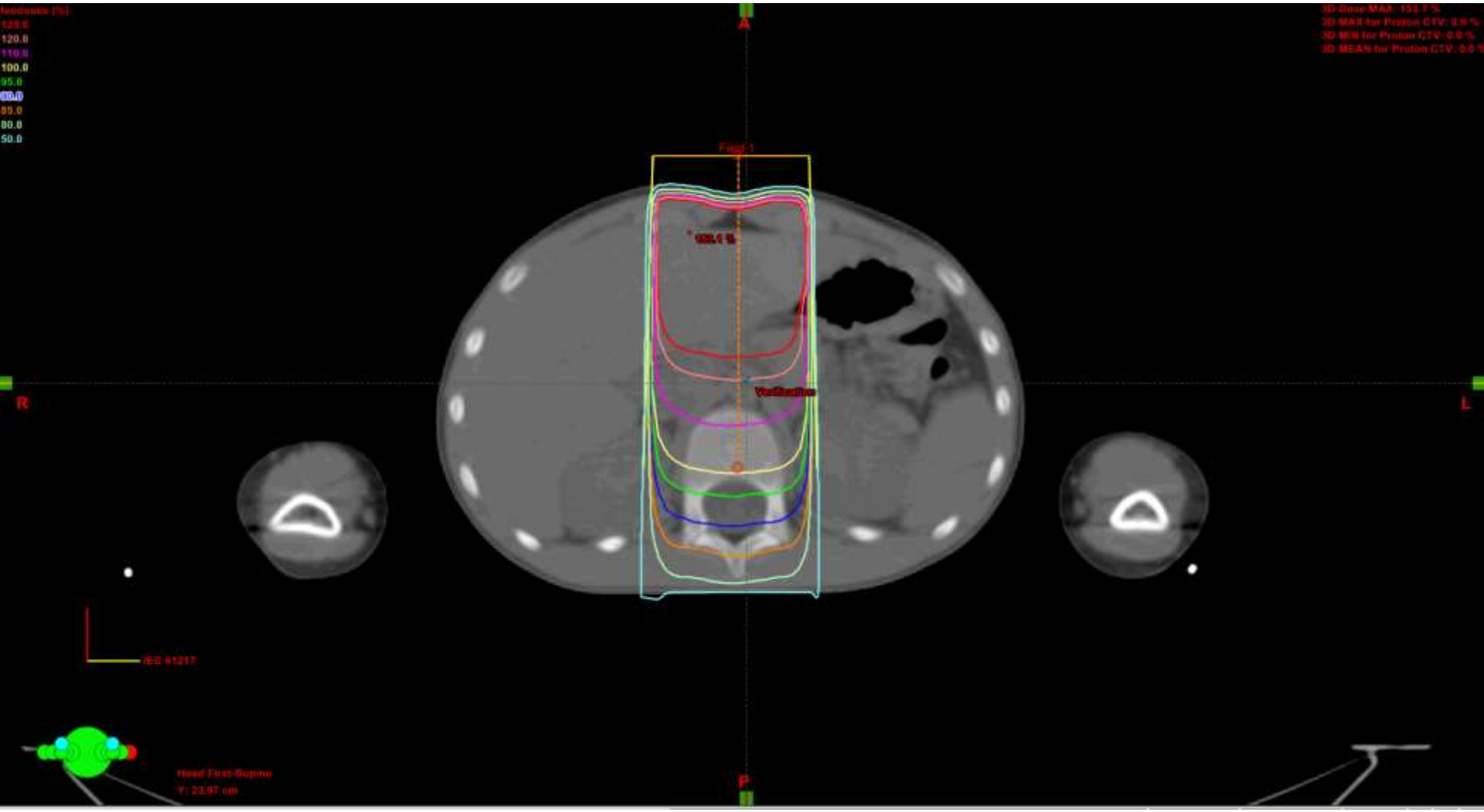
Objectives

1. Review a clinical incident
2. Determine possible causes (mini-RCA)
3. Discuss if this is a systematic or random problem
4. Identify steps in process maps where the "error" could have been prevented
5. Determine if additional steps are needed
6. Develop Checklist item(s) that would address this error

The case

- Prescription
  - **Intent**: Palliative
  - **Site**: Spine (T11 through L1)
  - **Energy**: 6MV
  - **Dose**: 3000 cGy @ 300cGy/fraction
  - **Setup**: Isocentric treatment
  - **Prescription point**: Isocenter
- No other details given
- After 5 fractions, a concern (incident) was raised during a weekly physics check

What is wrong with this picture?



Problem statement

- Anterior ~150% hot spot
- The case went through:
  - Treatment planning
  - Plan reviews
    - MD?
    - Physics?
    - Therapy?
- Is this an error? ☐ Yes ☐ No

Analysis

- Is this a random or a systematic problem?

☐ Systematic ☐ Random

- Where in the workflow did the process fail?
- Why did the process fail?
- Are there adequate preventive steps in the existing process?
- Do we need checklist item(s)?

☐ Yes ☐ No

Checklist items

- How many checklists (i.e. Do we need redundancy?)

  ☐ 1 ☐ 2 ☐ 3

- Where in the carepath do we insert checklist item(s)?
  - _____
  - _____
  - _____

Checklist items

- What is the checklist item(s) wording?
  - _____
  - _____
  - _____
- What measures will be used to evaluate effectiveness?
  - _____
  - _____
  - _____

Conclusions

- Most events are not black and white
- Systematic vs. random classification and approach are important considerations
- Ability to quantify usefulness and impact is one of the key elements of sustained culture and continuous improvement cycle

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