EMBRACING CHANGE
ADVANCING PERSON-CENTERED CARE

ASTRO ANNUAL MEETING 2021

ASTRO'S 63RD ANNUAL MEETING

October 24-27, 2021 · McCormick Place West · Chicago

Challenging Cases in Patient Safety

EMBRACING CHANGE

ADVANCING PERSON-CENTERED CARE

ASTRO

ANNUAL MEETING 2021

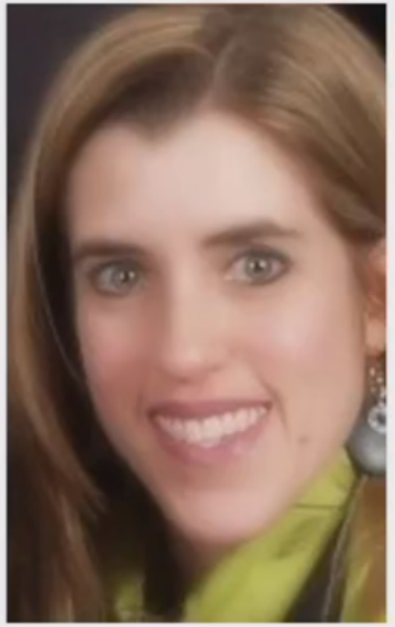
ASTRO's 63rd Annual Meeting

October 24th-27th, 2021 Your Couch, Next to the Dog and Kids

@ SueEvans,MDMPH @ vpoke @BhishamCheraMD





Our Panel

Disclosure

- **Suzanne Evans, MD**
  - Employed by Yale University
  - Member of the RO-ILS RO-HAC.
  - Research funding from Radiological Society North America.
- **Bhisham Chera, MD**
  - Employed by University of North Carolina.
  - Member of the RO-ILS RO-HAC.
  - Co-inventor of IP held by UNC-CH regarding ctHPVDNA Detection methodology – scientific advisory with ownership interest in Naveris, Inc. which has licensed ctHPVDNA technology.
- **Jeff Olsen, MD**
  - Employed by University of Colorado.
  - Member of the RO-ILS RO-HAC.
  - Senior Editor of IJROBP for GI Malignancies
  - Chair of Syntactx Clinical Events Committee for ongoing trial of pancreatic cancer MRgRT
- **Valerie Powell**
  - Employed by University Of Alabama.
  - Family Member employed by ProAssurance.
  - No conflicts of interest to disclose.
- **Bill Salter, PhD**
  - Employed by University of Utah.
  - Member of the RO-ILS RO-HAC.
  - Research funding from RaySearch.
  - Travel Expenses for Mevion Medical Systems.
- **Sheri Weintraub, PhD**
  - Employer: Southcoast Centers for Cancer Care
  - Member of the RO-ILS RO-HAC.
  - Family member with investment interest in Amorsa Therapuetics.

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Become a
CHAMPION OF SAFETY!

RO•ILS | RADIATION ONCOLOGY® INCIDENT LEARNING SYSTEM

Sponsored by ASTRO and AAPM

The mission of RO-ILS is to facilitate safer and higher quality care in radiation oncology by providing a mechanism for shared learning in a secure and non-punitive environment.

RO-ILS Basics

- RO-ILS is an online safety data collection instrument tied with a federally listed patient safety organization (PSO).
- Free. Enrollment includes contracting.
- Web-based, no IT support required.
- Anonymous reporting possible within the practice.
- Access only own practice's data. RO-HAC reviews national data.
- Patient Safety Work Product data protected by federal law.

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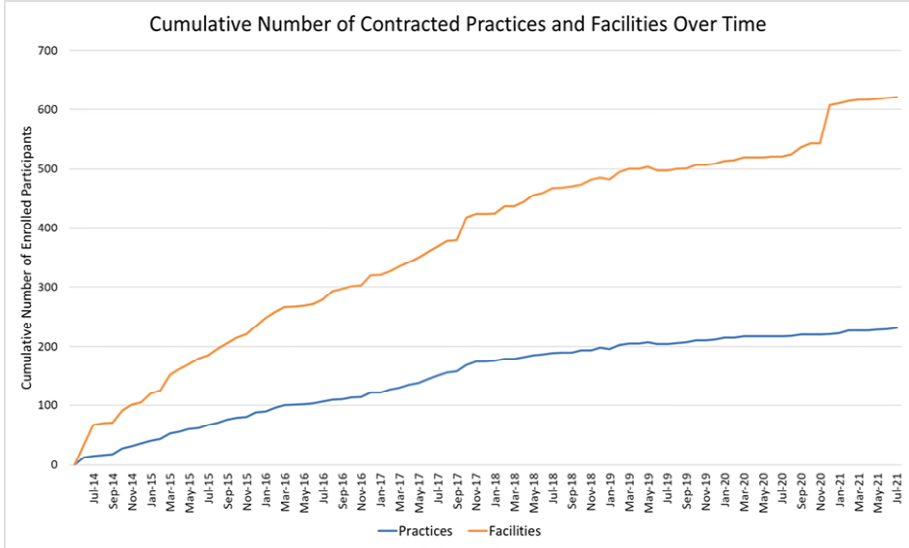
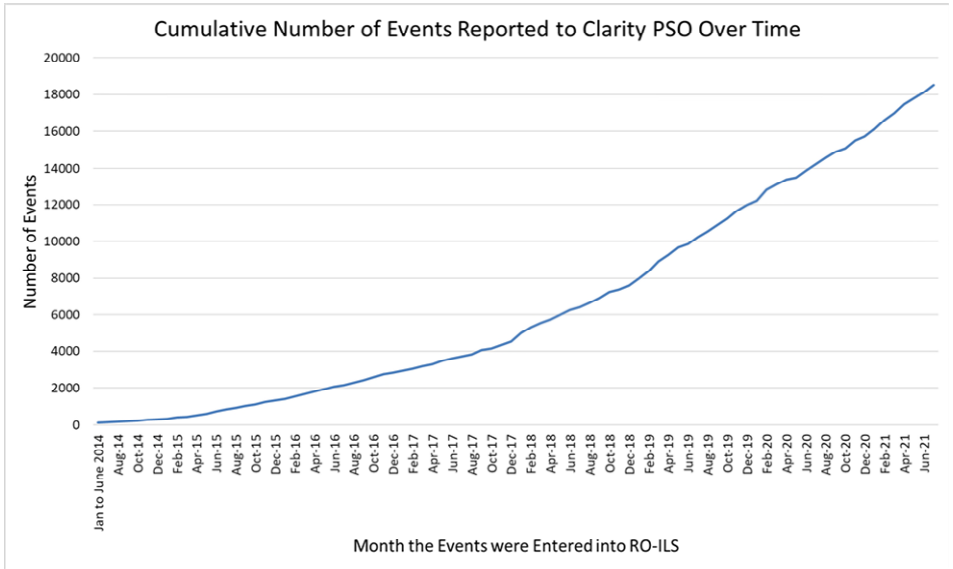
RO-ILS Program Update

- Established program 7 years.
- Enrollment
  - **624** facilities
  - **~25%** of U.S. facilities.
  - Facilities in **47** states and Puerto Rico.
- **More than 19,250** events have been reported to the PSO.





Learning Objectives

- 1. Implement systems-based approaches to common near miss events in radiation oncology.
- 2. Determine the likely sources of system weaknesses associated with radiation therapy incidents.
- 3. Discuss the ways of which patients can be engaged in patient safety.

Theme: Communication

- Interdepartmental – Radiation Oncology + Med Onc, Surg Onc, etc.
- Intradepartmental – Within the radiation oncology team.

- **Communication with the PATIENT is central!**

POSTER VIEWING | VOLUME 99, ISSUE 2, SUPPLEMENT , E547, OCTOBER 01, 2017

Let's Talk: Communication Errors in Radiation Oncology

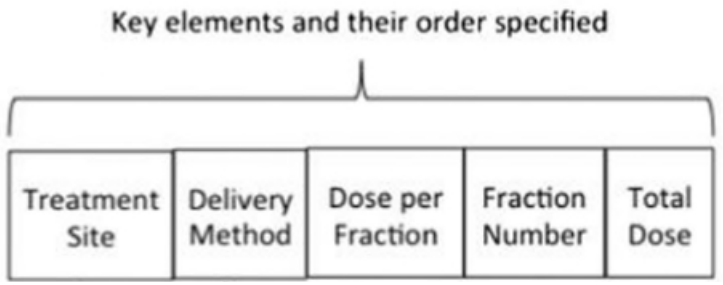
A. Blakaj • L. Wootton • J. Zeng • M. Nyflot • E.C. Ford • M.B. Spraker

DOI: https://doi.org/10.1016/j.ijrobp.2017.06.1914 •

- A total of 4,617 safety-related events were captured over the 5-year period with 1002 (22%) directly involving communication. Of these, 400 events were selected at random for analysis; 20% of these were potentially severe events.
- Written communication errors comprise 62% of communication events, whereas verbal errors were 32%.
- Absence of communication and a miscommunication were important factors in 50% and 21% of events respectively.
- Most communication events (54%) originated during patient assessment or treatment planning phases

RO-ILS: Communication

- RO-ILS education includes Themed Reports, Case Studies, Safety Notices.
- RO-ILS identified miscommunication of the radiation therapy prescription as a problem.
- As a result, improved communication in radiation therapy is a cornerstone of ASTRO's white paper on standardizing dose prescriptions



- American Society for Radiation Oncology (ASTRO). "2017 RO-ILS Year in Review." https://www.astro.org/uploadedFiles/_MAIN_SITE/Patient_Care/Patient_Safety/RO-ILS/2017YIR.pdf.
- S. B. Evans, B.A. Fraass, P. Lerner, K. S. Collins, T. Nurushev, M. J. O'Neill, J. Zheng, and L. B. Marks. (2016). "Standardizing dose prescriptions: an ASTRO white paper." *Pract Radiat Oncol* 6:e369–81.

4 Variations on our Theme

- Interdepartmental Communication
- Communication with the Patient
- Intradepartmental Communication
- When Communication goes wrong (Disruptive individuals)

Interdepartmental Communication
Case 1: Confusion between IVC filter and shunt.

Elderly patient scheduled after CT simulation for MRI Brain

All appropriate pre-screening was performed.

Patient has an IVC filter. However, patient told MRI screeners that she had a shunt, not understanding the distinction. MRI staff ultimately did not do the scan. They didn't call the treating physician to clear up this shunt matter (orders clarified ivc filter).

RT planning was delayed by 2 weeks for re-scheduling of the patient's MRI.

Interdepartmental Communication
Case 2: Oncotype Results Pending

- Patient with breast cancer had a ct-sim and was planned and started.
- In the interim, med onc ordered oncotype and did not communicate this. Therefore RT was not held for oncotype results
- Patient received two fractions when the oncotype came back high risk and chemotherapy was indicated despite RT having started.

Interdepartmental Communication
Case 3: Not so Concurrent Chemo-RT

- Patient with stomach cancer did not begin oral chemotherapy with the start of radiation
- This was caught by the treatment therapists when they asked patient if they have started oral chemotherapy on the walk to the treatment room.
- The MO had been informed of the RT start date by RO, but the prescription for oral chemo was not entered by the MO and oral chemo not sent to PT
- Current procedure is for sim therapist to explain importance of receiving pills prior to treatment, and this was performed in this case. The patient's family member assured the therapist that they understood the process.
- The sim therapist also added an alert to make treatment therapists are aware that patient must begin chemo pills day of treatment.
- This led to a delay in care for about one week as the pills still needed to be ordered.

Interdepartmental Communication Discussion

- Case 1: Confusion between IVC Filter and Shunt
- Case 2: Oncotype Results Pending
- Case 3: Not so Concurrent Chemo-RT

Take Home Points: Inter-Departmental Communication

- Often the most challenging to fix because we do not own all the processes
- 200% accountability: “I’m 100 percent accountable for my own best practices and I’m also 100 percent accountable for your best practices.”
- Relationships
- Detailed RT Rx so concurrent can be verified by therapy, importance of V sim only day to catch this
- Standard Methods of Communication

Patient Communication
Case 4: Patient Identity – Set up for Treatment

- Therapists called the name of the next patient, and a patient with larynx cancer stood up when the name was called.
- The patient was asked for their birthday, but therapy did not verify it on the screen
- The patient was brought into the room, and the therapists began setting up treatment for prostate cancer.
- At this point the patient clarified that he had laryngeal cancer.
- The patient was asked his name and it did not match the screen. The appropriate patient was brought for treatment.

Patient Communication
Case 5: Replanning Snafoo

- A replan was in the works for a patient on treatment, but this was not communicated to therapy or the patient
- The patient was on the table for 7th treatment. When therapy tried to open the plan, there was no treatment approved.
- There was a significant delay getting the right plan for the patient to the linac.
- Patient was in dressing room crying because they were scared, and thought something was seriously wrong with her treatment or a change in their cancer.

Patient Communication
Case 6: Difference in Length of Treatment

- A patient with breast cancer had their first treatment. Afterwards, therapy gave patient a calendar with all of their appointments for treatment listed.
- The patient stated that the doctor told them they was only to have 3 weeks of radiation treatments, not 6.
- It was discovered that the physician had discussed hypofractionation with the patient but had devised a treatment plan for 5040 cgy in 28 fractions plus boost
- The consult and CT documents at the time of initial treatment planning had no mention of hypofractionation.

Patient Communication Discussion

- Case 4: Patient Identity – Set up for Treatment
- Case 5: Replanning Snafoo
- Case 6: Difference in Length of Treatment

Take Home Points: Patient Communication

- Consider scripting/developing a language
- Patients often assume something wrong with their disease rather than the treatment team's error
- Consider reconciling patient schedule at simulation to be sure everyone on same page
- Standard practices about prescriptions and who writes them and when
- Importance of MINDFUL time outs (mind wanders 47% of the time, kam et al 2021 https://www.pnas.org/content/118/4/e2011796118#sec-6)

Intradepartmental Communication
Case 7: Patient Identity – IV Contrast

A patient was waiting in clinic for CT simulation. Nursing was paged to room 2 to place an IV with the additional info of patient name and MRN for the IV.

The patient who needed an IV was actually in room 3.

Upon entering room 2, nursing verified the patient's name (correct for the room, not the procedure) and the plan for an IV. Patient stated "Oh, I didn't think I need and IV". Nursing said it was for contrast, and the patient said "Not a problem at all."

When the patient from room 2 got to the sim, the mistakenly placed IV was discovered.

Intradepartmental Communication
Case 8: Pacemaker Information Unknown

A patient was on the treatment table getting films for a verification simulation. The therapists noted he had a pacemaker in the treatment field.

The patient was sent home and the plan was modified to exclude the pacemaker from the fields.

Intradepartmental Communication Discussion

- Case 7: Patient Identity – IV Contrast
- Case 8: Pacemaker Information Unknown

Take home points: Intradepartmental Communication

- Over-reliance on verbal orders
- Stopping the line
- Standard processes for the 3 P's (pregnancy, pacemaker, prior RT) with multiple sources of input (therapy, admins, nurses, md)
- Listening to the patient when something does not meet expectations
- Trust but always verify

Intradepartmental Communication in “special circumstances”

Intradepartmental Communication: Disruptive
Case 9: Implanted Defibrillator Policy Not Followed

- There was a patient receiving SBRT with implanted defibrillator. Per policy, they required magnet on the device during treatment as well as continuous pulse oximetry monitoring.
- The patient did not receive monitoring per policy by nursing.
- The therapist treating the patient stated that they were “aware of monitoring policy; but did not want to step on anyone’s toes”
- Uninvolved nursing staff present stated they were concerned but were “afraid to say something”.

Intradepartmental Communication: Disruptive Case 10: Hostile Patient

- There was a patient receiving SRS who was pleasant when treatment started, but as time went on, the patient began to be quite agitated and hostile, such that this interfered with the ability of the team to treat the patient.

When Communication goes wrong: Disruptive Behavior Discussion

Disruptive Individuals

- Case 9: Implanted Defibrillator Policy Not Followed
- Case 10: Patient Threatened Staff

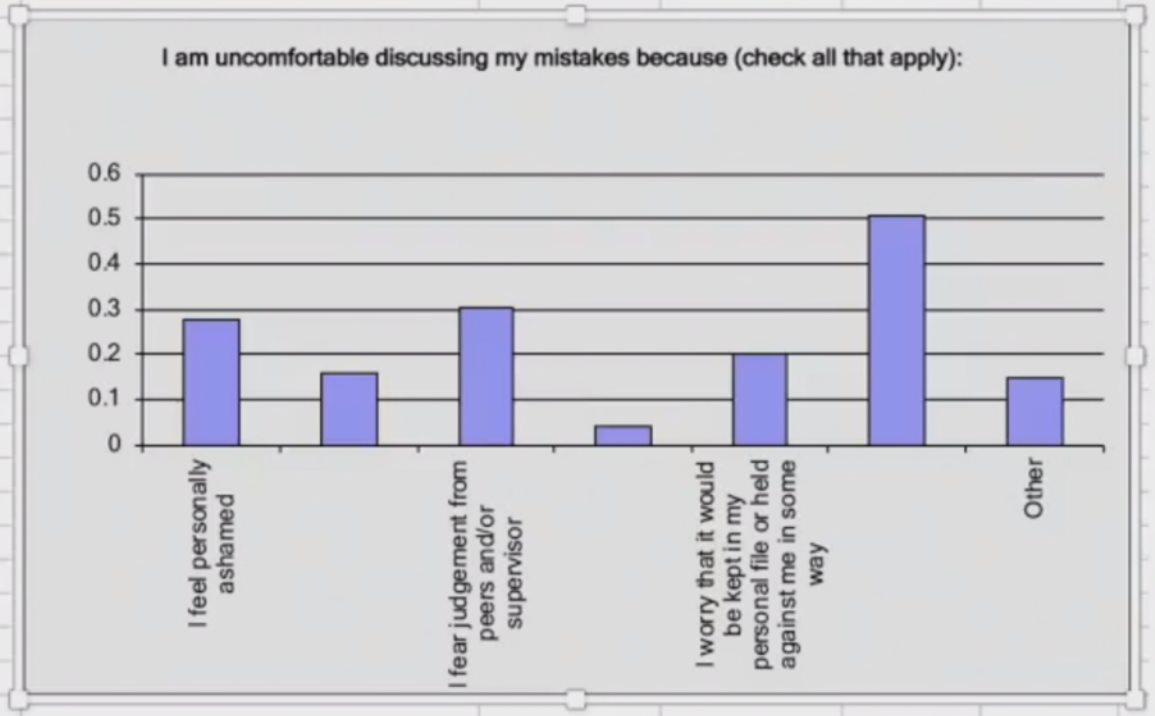
Take Home Points: Communication with disruptive individuals

- With hostile patients, approach with curiosity- Is this misplaced anger or fear masking as anger? is there a medical reason for hostility?
- Importance of thanking for feedback
- Systems approach to disruptive individuals (Shapiro J. Confronting unprofessional behaviour in medicine BMJ 2018; 360 :k1025 doi:10.1136/bmj.k1025)
- Critical need for safety culture

2015 UCSD Internal Data courtesy of Todd Pawlicki, PhD

I am uncomfortable discussing my mistakes because (check all that apply):

Answer Options	Response Percent	Response Count
I feel personally ashamed	27.5%	19
I fear public embarrassment	15.9%	11
I fear judgement from peers and/or supervisor	30.4%	21
My supervisors are unapproachable	4.3%	3
I worry that it would be kept in my personal file or	20.3%	14
No matter the graviety of the mistake, I am	50.7%	35
Other	14.5%	10
answered question		69
skipped question		2



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