



# AGGREGATE DATA REPORT

**Quarter 4, 2020** 

October 1 - December 31, 2020

## **Patient Safety Work Product**

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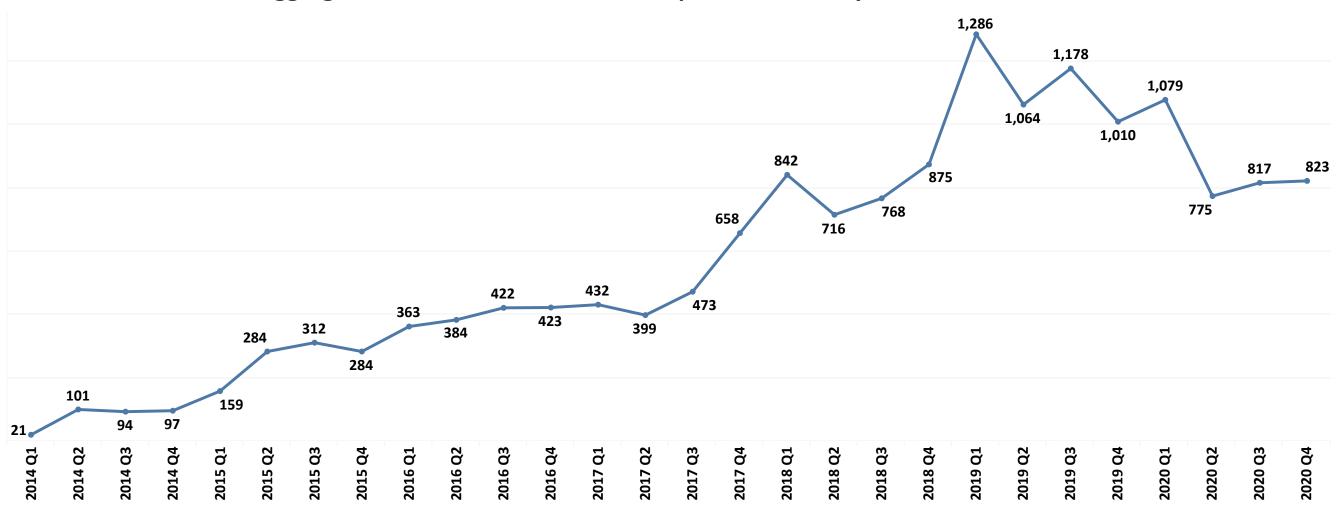
### **Aggregate Report Card**

The timeframes utilized throughout this report are based on the timepoint of event submission (i.e., when the event was initially entered into the RO-ILS Portal, when the "Submit Event" form was completed). The national aggregate database only includes events that have been reviewed and reported to the PSO, which occurs after submission. All information in this report represent data in the national database. For this reason, the amounts provided for previous timeframes may change as older events are reviewed and reported to the PSO.

METRIC	Q3 2020	Q4 2020	AGGREGATE HISTORICAL SUM			
<b>Total Number Of Events</b>	817	823	16139			
Therapeutic Radiation Incident	83	96	2272			
Other Safety Incident	85	92	2030			
Near Miss	112	139	3375			
Unsafe Condition	91	114	2057			
Operational/Process Improvement	446	382	6405			
Most Commonly Identified Workflow Step Where	Treatment Planning	Treatment Planning	Treatment Planning			
Event Occurred	41%	36%	31%			
	(339/817)	(297/823)	(5064/16139)			
Most Commonly Identified Workflow Step Where	Treatment Planning	Treatment Delivery Including Imaging	Treatment Delivery Including Imaging			
Event was Discovered	25%	38%	30%			
	(204/817)	(312/823)	(4904/16139)			
	IMRT/VMAT	IMRT/VMAT	IMRT/VMAT			
Most Commonly Identified Treatment Technique	45%	36%	30%			
Wost commonly identified Treatment Technique	(370/817)	(300/823)	(4847/16139)			
Most Commonly Identified Dose Deviation for	≤ 5% maximum dose deviation to target	≤ 5% maximum dose deviation to target	≤ 5% maximum dose deviation to target			
herapeutic Radiation Incidents that Did Not Effect	85%	92%	86%			
Multiple Patients	(28/33)	(46/50)	(982/1148)			



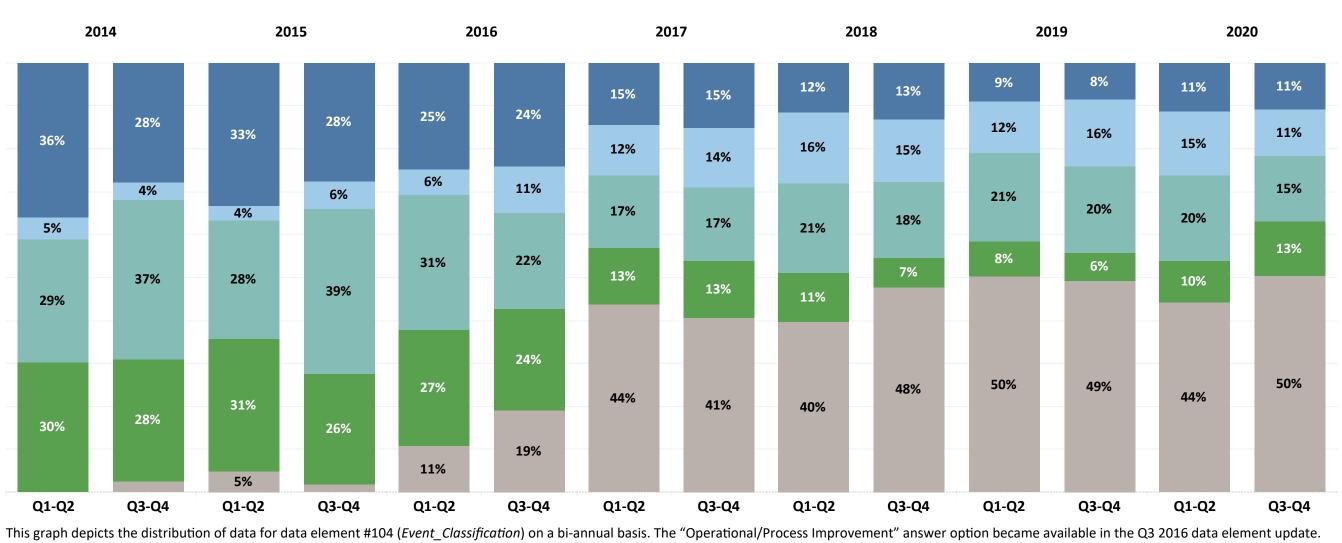
#### **Aggregate: Total Number of Events Reported to PSO by Quarter Submitted**



This graph displays how many events were submitted, reviewed, and reported to the PSO per quarter based on the date of submission.



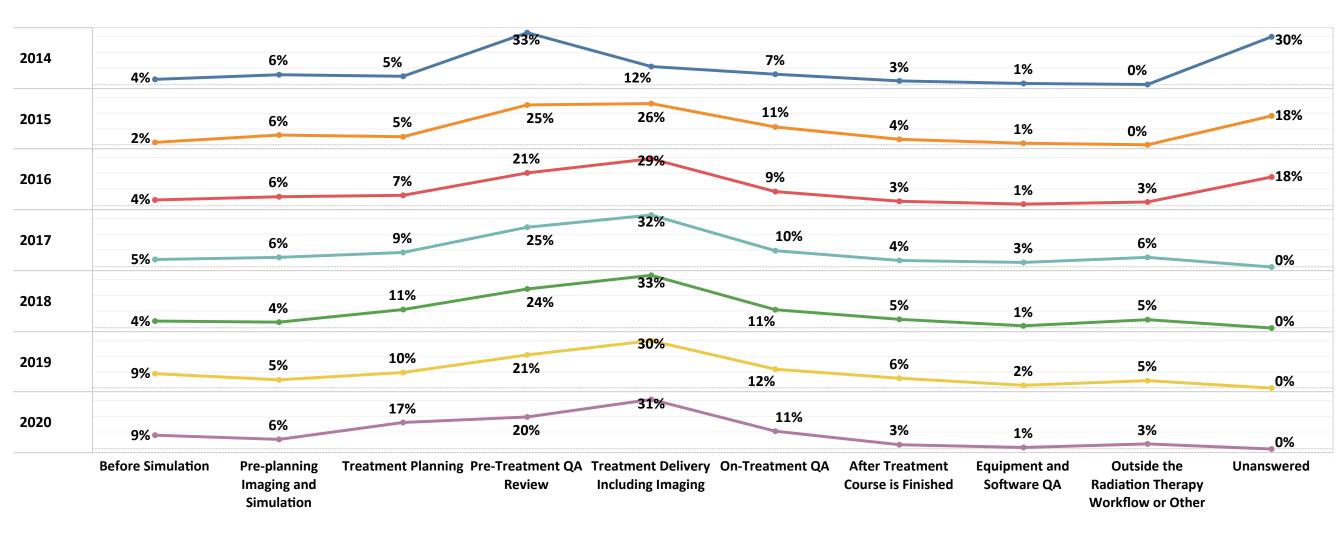
#### **Aggregate: Event Classification**



Therapeutic Radiation Incident Other Safety Incident Near-miss Unsafe condition Operational/Process Improvement



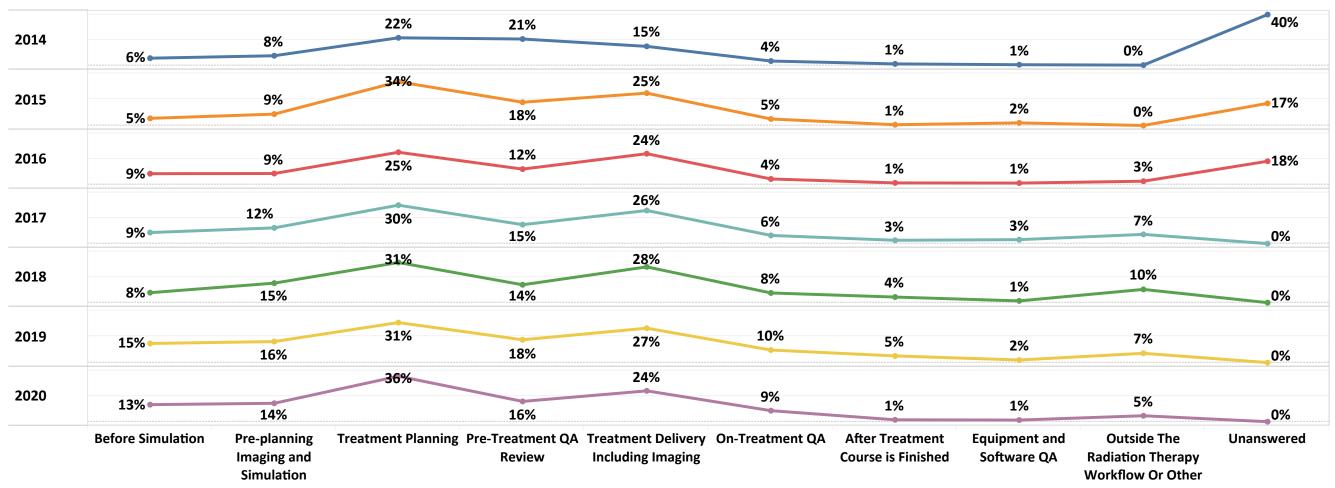
#### **Aggregate: Workflow Step Where Event Discovered**



This data is based on data element #207 (*Discovered\_Workflow*), presented in yearly increments. As a part of the Q3 2016 data element update, this question became required and an answer option of "Outside the Radiation therapy Workflow or Other" was added.



#### Aggregate: Workflow Step(s) Where Event Occurred



This graph depicts the frequency of answer options for data element #208 (Occurred\_Workflow) based on the calendar year it was submitted. Users have the option to select more than one answer option, therefore, there is a potential for each year's total percentage to be greater than 100%. As a part of the Q3 2016 data element update, this question became required and an answer option of "Outside the Radiation therapy Workflow or Other" was added.



#### **Aggregate: Workflow Step Where Event Occurred & Event Discovered**

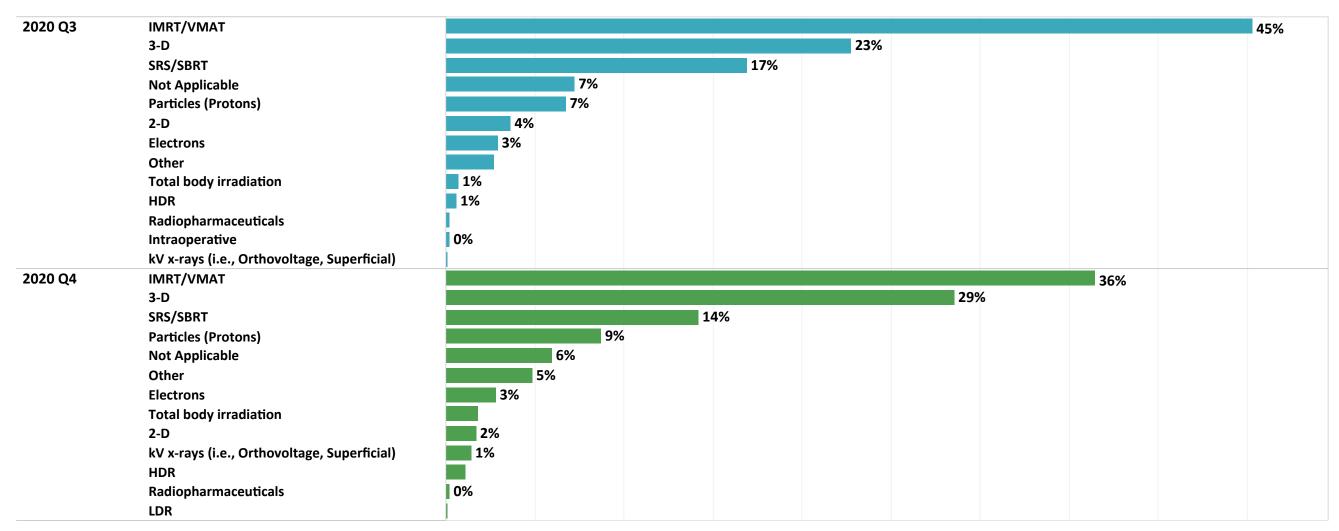
#### **Occurred Workflow**

Quarter	Discovered Workflow	Before Simulation	Pre-planning Imaging and Simulation	Treatment Planning	Pre- Treatment QA Review	Treatment Delivery Including Imaging	On-Treatment QA	After Treatment Course is Finished	Equipment and Software QA	Outside The Radiation Therapy Workflow Or Other	Grand Total
2020 Q4	Before Simulation	90%	5%							5%	100%
	Pre-planning Imaging and Simulation	45%	47%	3%	3%					2%	100%
	Treatment Planning	5%	16%	71%	5%	1%	1%			1%	100%
	Pre-Treatment QA Review	5%	11%	47%	33%	1%			1%	1%	100%
	Treatment Delivery Including Imaging	2%	6%	24%	9%	55%	1%			3%	100%
	On-Treatment QA	3%	7%	19%	11%	29%	30%			1%	100%
	After Treatment Course is Finished	5%	10%	24%	19%	10%	10%	19%		5%	100%
	Equipment and Software QA	17%				17%			50%	17%	100%
	Outside the Radiation Therapy Workflow or Other					10%				90%	100%

This graph displays the overlap of where in the workflow events occurred (208. Occurred\_Workflow) and where it was discovered (207. Discovered\_Workflow) for the most recent quarter. The percentage is based on the total number of events that were discovered in that workflow step (e.g., of events that were discovered "before simulation", X% occurred "before simulation".)



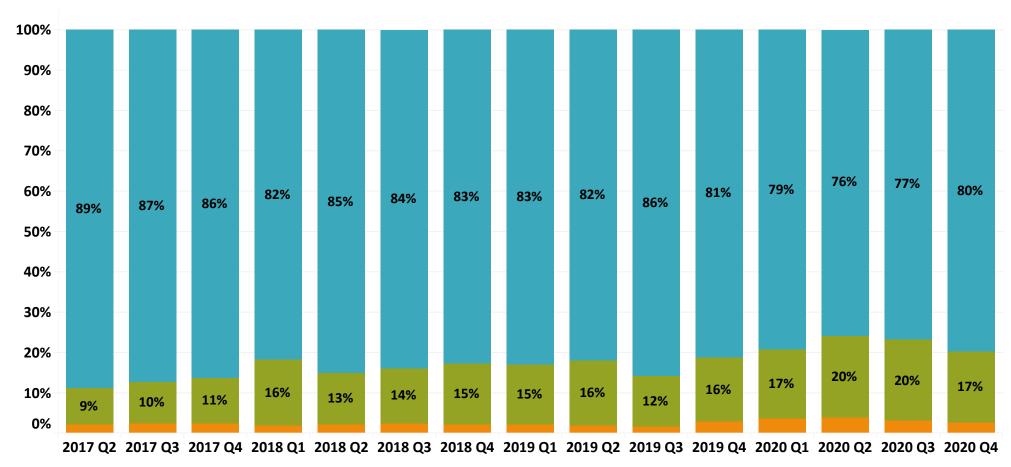
#### **Aggregate: Treatment Technique(s)**



This graph demonstrates the distribution of answers for data element #106 (*Tx\_Technique*) per quarter for the last two quarters. Users may be select more than one technique if pertinent to the event and thus the quarterly percentage total may be greater than 100%.



#### **Aggregate: Significance Scale**



Mild Moderate Quarter Severe 89% 2017 Q2 9% 2% 2017 Q3 **87**% 10% 2% 2017 Q4 86% 11% 2% 2018 Q1 16% 82% 85% 2% 2018 Q2 13% 2% 2018 Q3 84% 14% 2% 2018 Q4 83% 15% 2% 2019 Q1 83% 15% 2019 Q2 2% 82% 16% 2019 Q3 86% 12% 2019 Q4 81% 3% 16% 2020 Q1 4% **79%** 17% 4% 2020 Q2 76% 20% 77% 20% 3% 2020 Q3 3% 2020 Q4 80% 17%

This graph shows the frequency of answers for data element #225 (*Significance\_Scale*) which asks, "In terms of risk to patient safety, how significant was this event?" This question was introduced in Q3 2016. The graph and table provide the severity percentages per quarter since 2017.

Mild Moderate Severe