



Local reporting of radiotherapy patient safety incidents

July 2010

Survey Report

1. Introduction

In April 2007, a joint steering group was convened to undertake a project to improve patient safety in radiotherapy. Members included representatives from the National Patient Safety Agency (NPSA), Royal College of Radiologist (RCR), Society College of Radiographers (SCoR), Institute of Physics and Engineering Medicine (IPEM) and the Health Protection Agency (HPA), along with other key stakeholders.

Part of the work this group identified, was to improve the quality, quantity and consistency of voluntary reporting by trusts of radiotherapy incidents, including near misses to the NPSA's National Reporting and Learning System (NRLS).

To improve understanding of variations in current local and national reporting cultures, a survey of all NHS radiotherapy departments in England and Wales (56 departments) was conducted. The results of this survey are presented below.

2. Methods

A questionnaire to collect information on local reporting of radiotherapy incidents was developed by the joint steering group. The questionnaire was sent by email to the radiotherapy department managers of all UK radiotherapy service providers, and copied to their heads of service. The survey was carried out between 22 April and 19 May 2008.

Since only NHS organisations within England and Wales routinely report patient safety incidents to the NRLS, this analysis solely consists of their responses.

3. Survey Findings

Forty seven NHS radiotherapy departments in England and Wales completed and returned the questionnaires, equating to a response rate of 84%.

a) Local reporting of radiotherapy incidents

Each of the 47 radiotherapy services who responded had a quality management system* (QMS). The majority (87%) also had their QMS externally accredited.

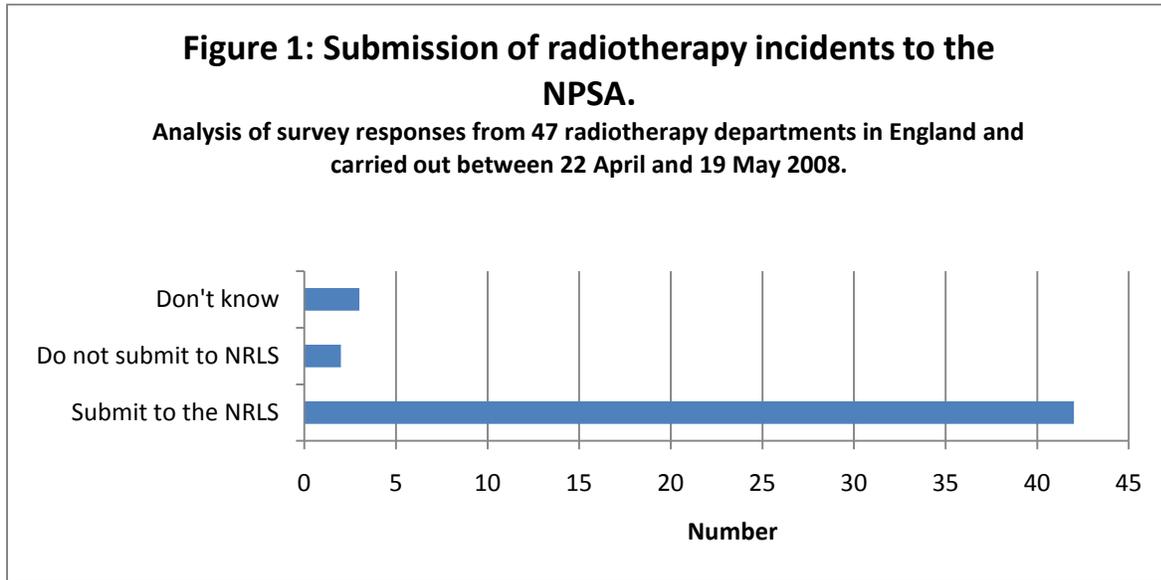
There appears to be no standardised method of local reporting, some radiotherapy services use a mixture of methods. However, the majority of radiotherapy services (72 %) reported all incidents to their trust risk management service. Of the 13 radiotherapy services who reported only a selection of incidents, the choice of which incidents to report was based on whether the incident was considered a risk of harm, the severity of the incident, whether the incident was a near miss or an actual incident, and the implication of the incident at trust level.

There were a variety of mechanisms and methods used for guidance and reporting incidents locally.

* The Department of Trade and Industry define QMS as: "A set of co-ordinated activities to direct and control an organisation in order to continually improve the effectiveness and efficiency of its performance."

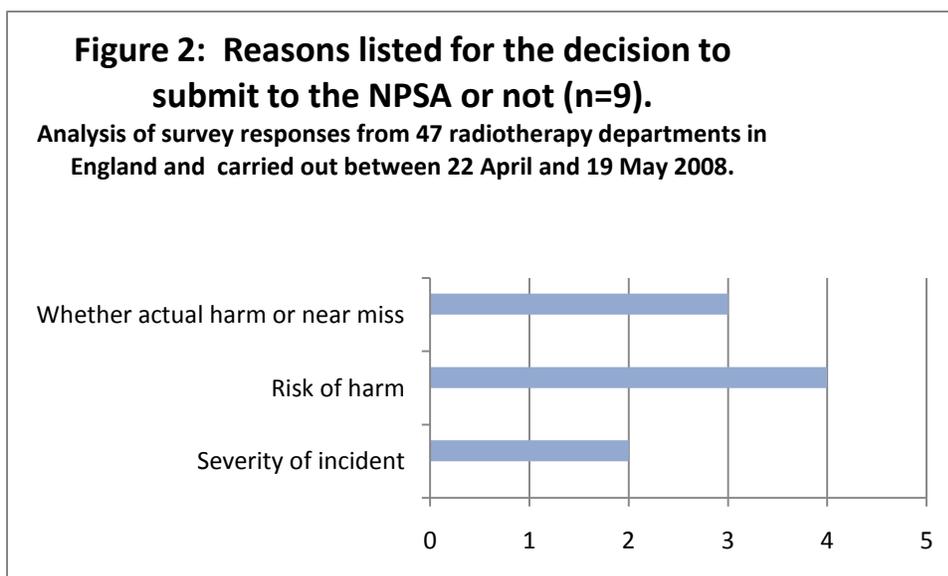
b) Reporting radiotherapy incidents to the NPSA

Forty two of the 47 responders submitted radiotherapy incidents from their trusts to the NRLS, two said they do not submit to the NRLS at all and three trusts were not sure if they submitted or not (Figure 1).

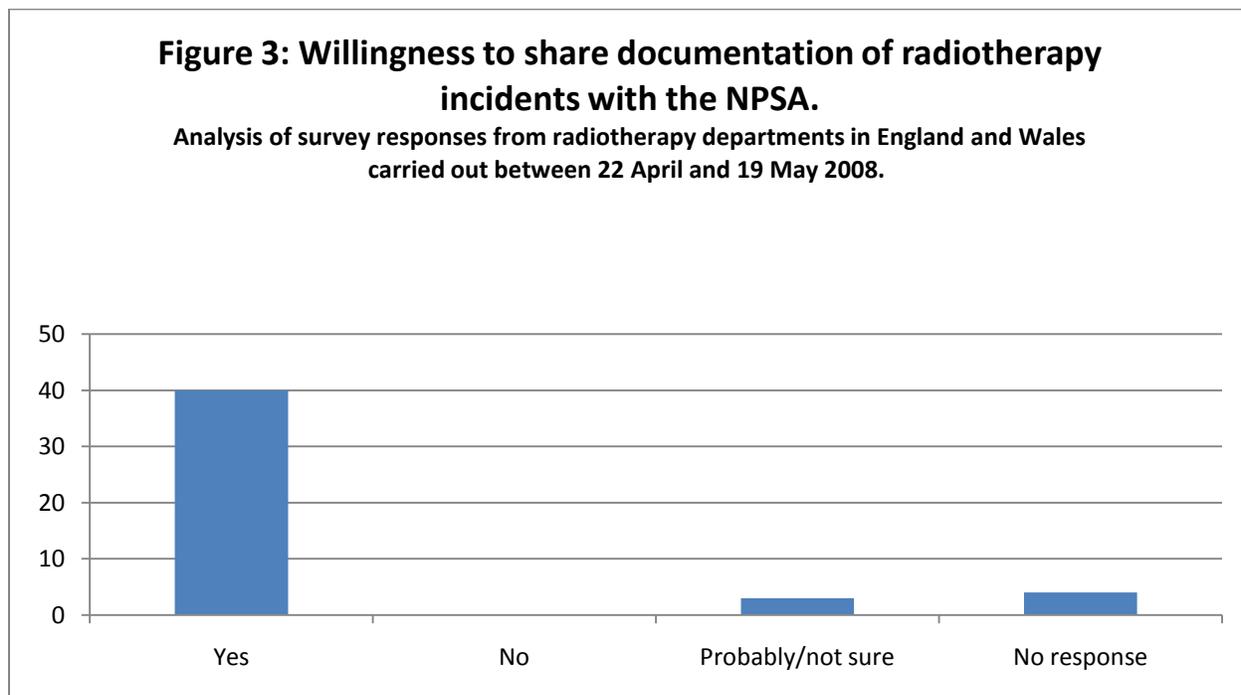


Of the 42 radiotherapy services who submitted incidents to the NRLS, 33 submitted all incidents and nine submitted only a selection.

Of the nine radiotherapy services who submitted only a selection of incidents to the NRLS, the choice of which incident to submit was based on the severity of the incident, risk of harm or whether it was a near miss or an actual incident (Figure 2).



The majority of the responders (85%) would be willing to share documentation of radiotherapy incidents with the NPSA (Figure 3). A total of 34 of the responding organisations (72%) use Datix as the vendor system for submitting documentation of radiotherapy incidents to the NRLS. Other vendor systems used included: Ulysses (11%), Prism (2%) and Sentinel (4%). One organisation had a bespoke system and five organisations had no vendor system.



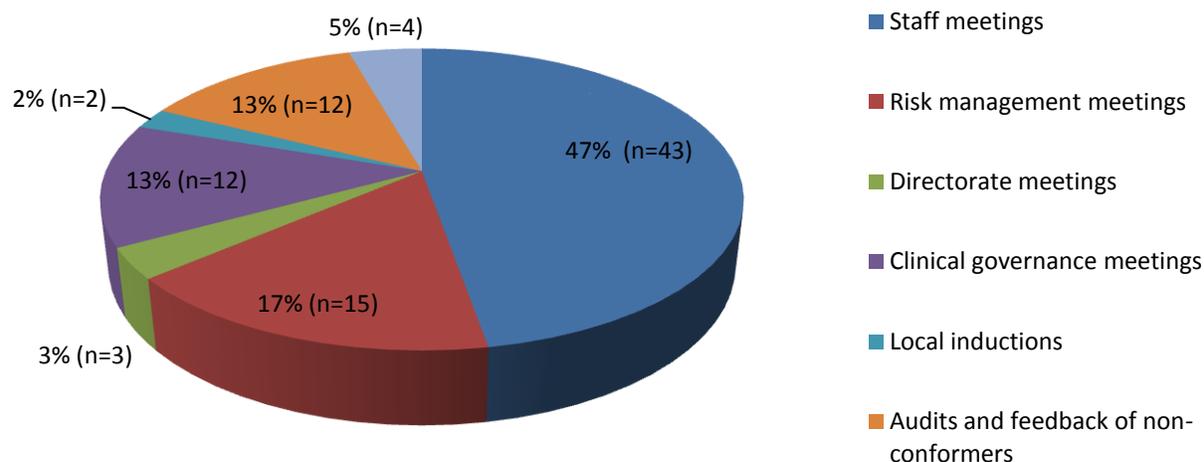
c) Learning from radiotherapy incidents

Various methods were adopted for disseminating and communicating lessons learnt from radiotherapy incidents at different level of the organisations.

Within the radiotherapy service, the majority of the responders shared lessons from incidents at staff meetings or risk management meetings. Other means of sharing radiotherapy incidents within organisations included directorate and clinical governance meetings, audit and feedback of non-conformance, quarterly reports and through local induction (Figure 4).

Figure 4: Means of communicating and sharing lessons from radiotherapy incidents within radiotherapy services.

Analysis of survey responses from 47 radiotherapy departments in England and Wales carried out between 22 April and 19 May 2008.



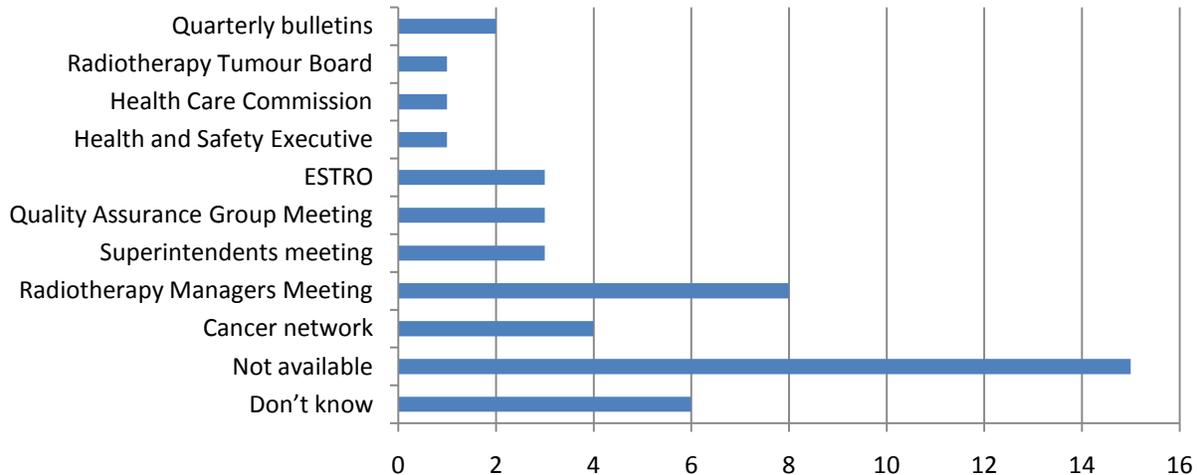
Note: Total response does not tally with the number of responders as some departments use more than one method.

Within organisations, trust risk management group meetings and clinical quality and effectiveness meetings were the most popular means of disseminating and communicating lessons learnt from radiotherapy incidents. Audit and feedback of non-conformers, emails and radiotherapy managers meeting were the least popular methods used. Two organisations had no means of communicating and learning from incidents.

The survey showed that very little sharing of lessons from radiotherapy incidents occurred outside the organisations, for example, within Cancer Networks. Fifteen trusts had no means of communicating and sharing lessons from radiotherapy incidents outside their organisation, five trusts did not know how lessons are shared externally. Of the trusts sharing lessons from incidents externally, radiotherapy managers meetings (n=8) were the most popular method. The least popular methods were through the Health and Safety Executives (HSE), The European Society for Therapeutic Radiology and Oncology (ESTRO) and the Care Quality Commission (under the umbrella of the Care Quality Commission since April 2009) (Figure 5).

Figure 5: Means of communicating and sharing lessons from radiotherapy incidents externally.

Analysis of survey responses from 47 radiotherapy departments in England and carried out between 22 April and 19 May 2008.



d) Challenges identified by respondents to reporting

Some of the challenges to reporting mentioned by the respondents included:

- Difficulties in transcribing information from trust hand written reports to the electronic database.
- Some databases do not have sufficient granularity, hence the need to run a separate but linked system.
- Some databases are not radiotherapy specific and difficult to complete for some types of incidents, some mandatory boxes just did not apply.

4. Recommendations made by respondents to improve reporting

Some common themes in the recommendations made by respondents to improve reporting were identified as follows:

- Timely and sensitive feedback to the radiotherapy community on analysis of national reporting.
- Further shared learning from radiotherapy incidents to influence clinical practice.
- Provision of guidance on implementation of *Towards Safer Radiotherapy*¹ classification and coding.
- Provision of guidance on how to include *Towards Safer Radiotherapy*² classification and coding in report for NRLS.
- Provision of advice on how to streamline submission of radiotherapy incident reports locally and nationally to NRLS.

5. Conclusion

The level of response to this questionnaire demonstrates the commitment of radiotherapy departments in England and Wales to improve both local and national reporting cultures to enable further shared learning from radiotherapy incidents. This information has been used to guide the work of the joint steering group for patient safety in radiotherapy published in a series of articles designed to improve patient safety in radiotherapy³.

References

1. Royal College of Radiologists, Society and College of Radiographers, Institute of Physics and Engineering in Medicine, National Patient Safety Agency, British Institute of Radiology (2008) .*Towards Safer Radiotherapy* . Royal College of Radiologists, London. Available from: www.nrls.npsa.nhs.uk/resources
2. National Patient Safety Agency (2009) Radiology and Radiotherapy. Available at: www.nrls.npsa.nhs.uk/resources/clinical-specialty/radiology-and-radiotherapy/