Alberta Health Services

UNIVERSITY OF ALBERTA
FACULTY OF MEDICINE & DENTISTRY
Radiation Therapy Program

Quality Summit
October 2018

No Apparent Harm? We Can Do Better!

PLAN · ANALYZE · DO · ACT · Start here

#1 The Background

Approximately 68% of Reporting and Learning System (RLS) reports have a severity rating of "No Apparent Harm". Handling these no harm events can be tricky. They tend to be random, it's not always obvious how to fix them and it's difficult to justify resources for no-impact events. No harm; no foul – right? Most often these reports are simply shared and closed with no changes to the workplace environment.

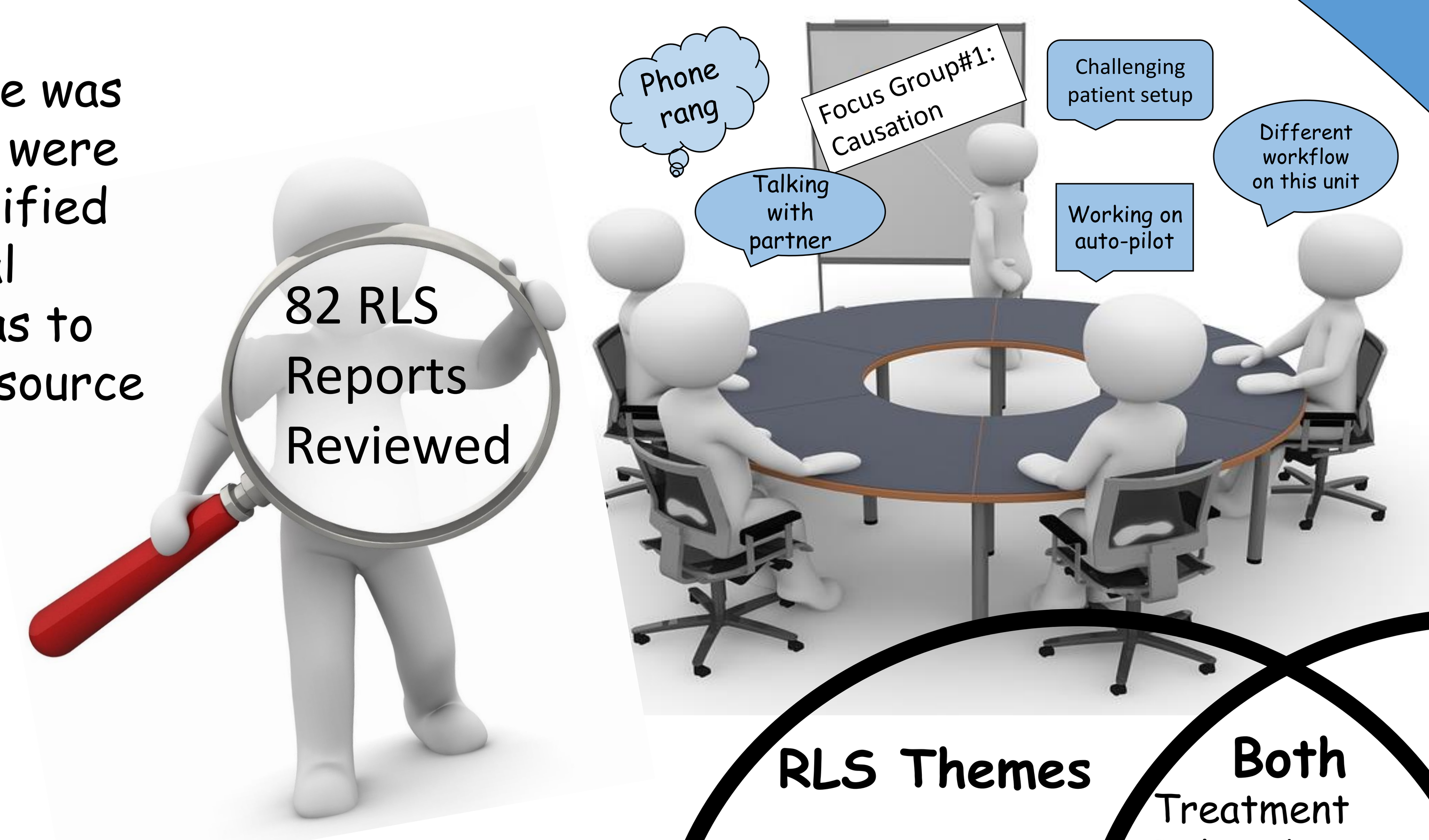
#2 The Team

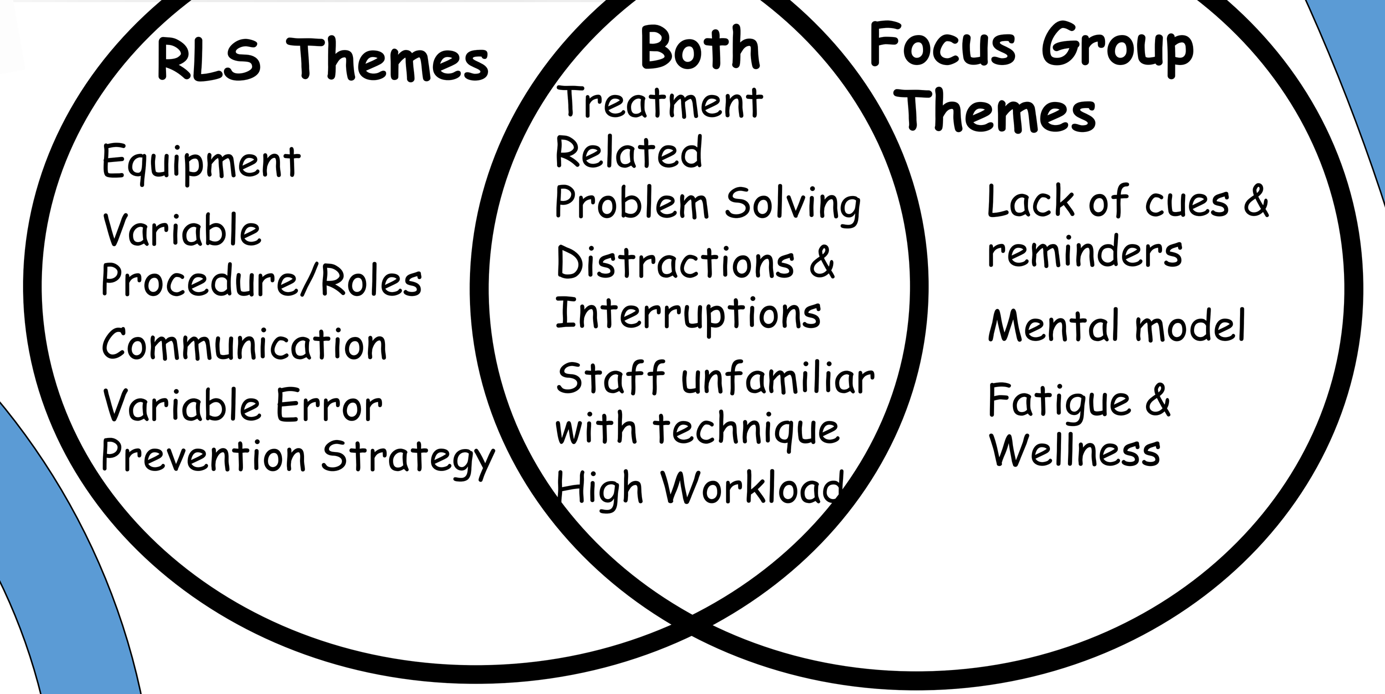
Plus two focus groups of Radiation Therapists and one amazing librarian, Marcus Vaska[6].

#3 The Opportunity

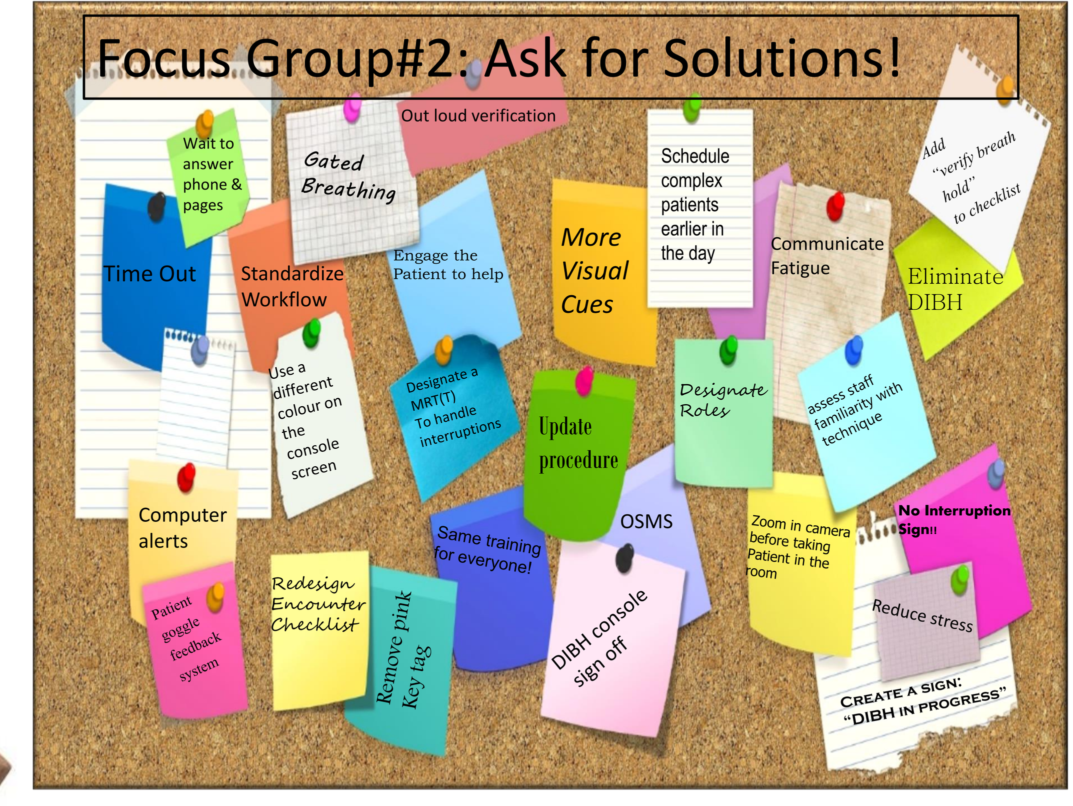
We had a sporadic error trend in one of our radiation treatment techniques. The error rate was 0.3% but over a 5 year period 82 RLS reports were filed. Although all of these reports were classified as "No Apparent Harm" there was an emotional impact to both patients and staff. Our goal was to study the human error pattern and explore resource friendly solutions.

#4 Why was this happening?

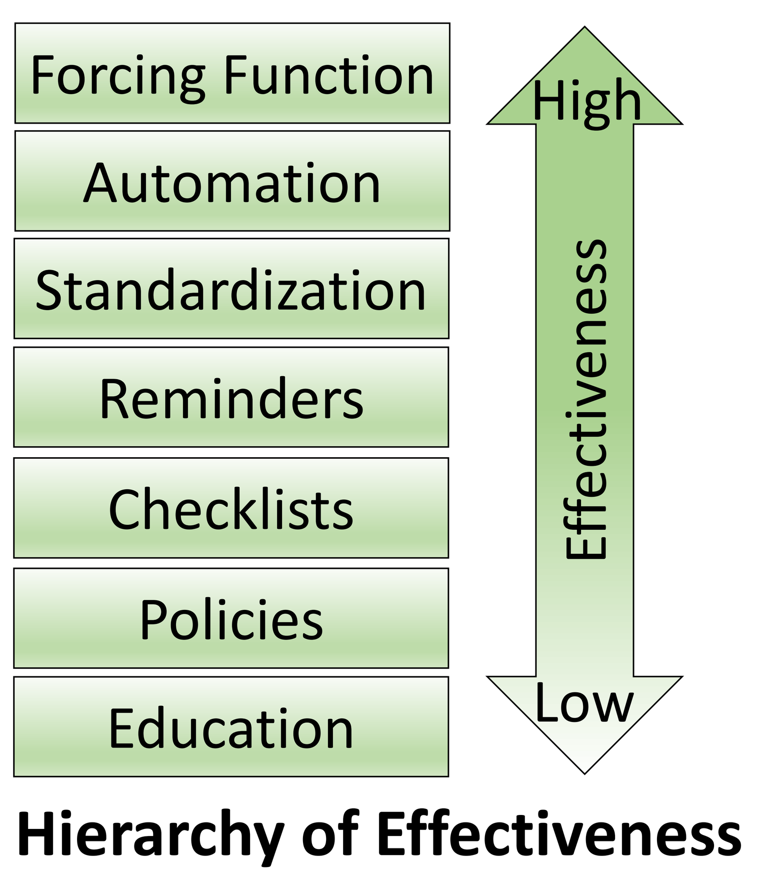




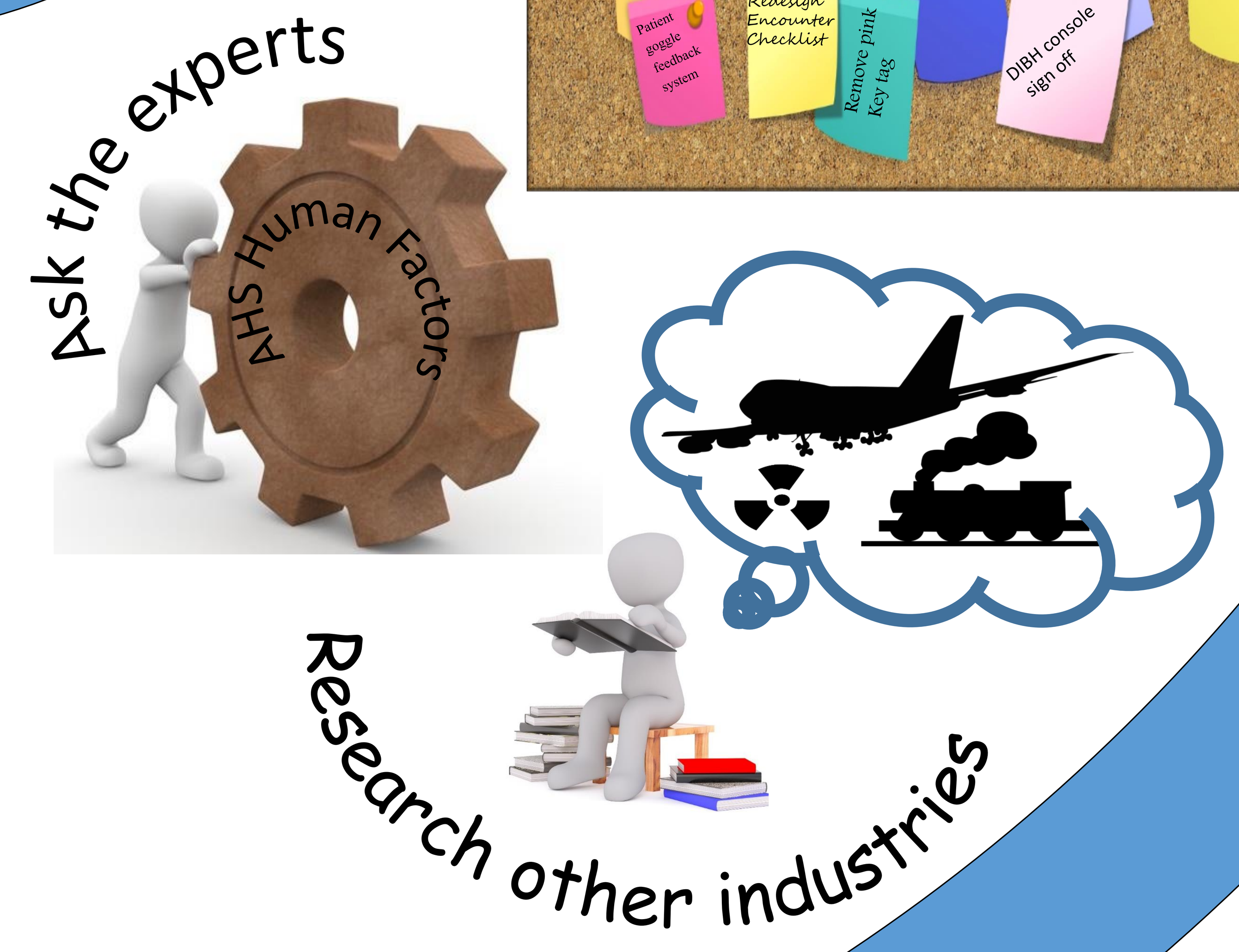
#5 Brainstorming of Ideas



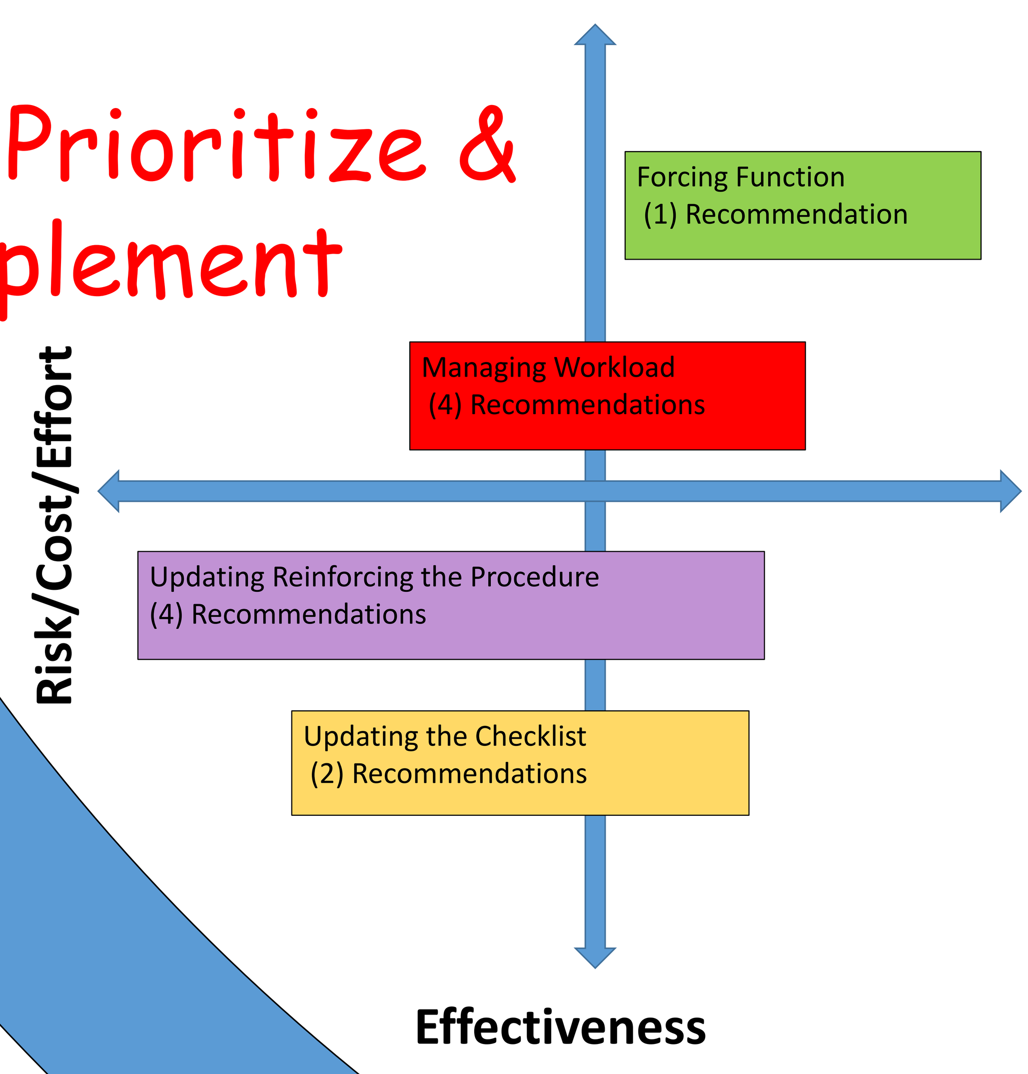
#6 Evaluate the Solutions



Hierarchy of Effectiveness



#7 Prioritize & Implement



Lessons Learned

This was fun. Let's do it again!

- It is much easier to learn from our errors without the stress of a serious adverse event.
- Engaging students in patient safety research = success.
- Front-line staff were engaged, honest and gained experience in system safety practices. RLS reporting rate increased after this project.

Opportunity. Engage. Learn.

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