PROCESS OF INCIDENT TREATMENT

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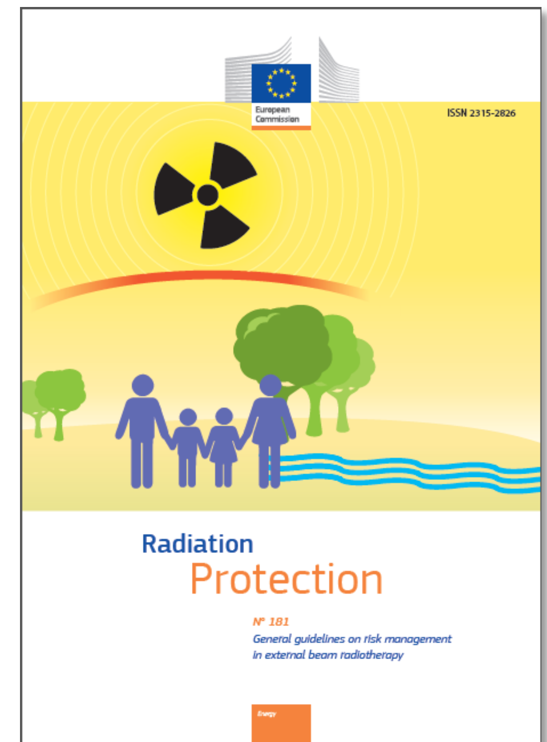
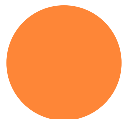
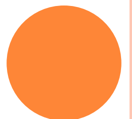
Definition

- Incident= Adverse error-event:
  - *"Event involving accidental or unintended medical exposures"*
  - *"Event that results in unintended harm – either minor or serious – to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient."*





INCIDENTS HAPPEN…



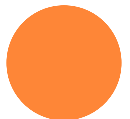
What do I need to do?

Immediate actions

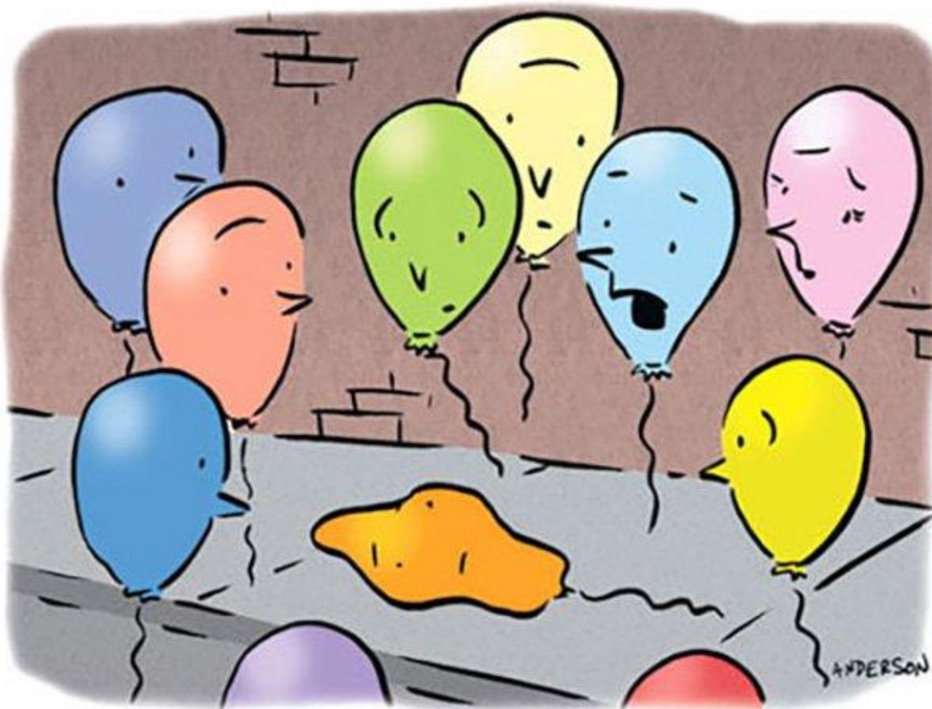
Short term actions

Medium term actions

Long term actions

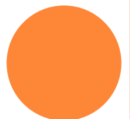


Immediate actions



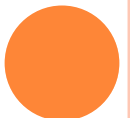
"Everyone back! Give him some air!"

1. Characterize the incident
2. Inform:
   - The team/management
   - The patient
   - (AFCN/FANC)



1. Incident characterisation

- Type of incident: dosimetric incident? Volume error? Other?
- Severity of consequence
  - Short term effects/ Long term effects/ Death
  - Use of scales



TAXONOMY SCALE

ASN-SFRO SCALE APPLICATION

	EVENTS (UNPREDICTED, UNEXPECTED)	CAUSES	CONSEQUENCES (CTCAE V3.0 GRADE)
5 to 7* ACCIDENT	Death	Dose (or irradiated volume) much greater than normal resulting in complications or sequelae incompatible with life	Death
4** ACCIDENT	Serious life-threatening event, disabling complication or sequela	Dose or irradiated volume much greater than the tolerable doses or volumes	Serious unexpected or unpredictable acute or delayed effect, grade 4
3** INCIDENT	Event resulting in severe alteration of one or more organs or functions	Dose or irradiated volume greater than the tolerable doses or volumes	Severe unexpedted or unpredictable acute or delayed effect, grade 3
2** INCIDENT	Event resulting in or likely to result in moderate alteration of an organ or function	Dose greater than the recommended doses, or irradiation of a volume that may lead to unexpected but moderate complications	Moderate unexpedted or unpredictable acute or delayed effect, grade 2, minimal or absence of alteration of quality of life
1 EVENT	Event with dosimetric consequences but no expected clinical consequences	Dose or volume error (e.g. dose error or target error in a session not compensable over the treatment as a whole)	No symptoms expected
0 EVENT	Event with no consequences for the patient	Dose error (number of monitor units, filter, etc.) compensated over the treatment as a whole. Error of identification of a patient treated for the same pathology (compensable)	

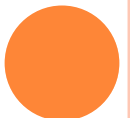
*In the case of deaths of several patients:
- the minimum level 5 is raised to 6 if the number of patients is greater than 1 but less than or equal to 10;
- the minimum level 5 is raised to 7 if the number of patients is greater than 10.

** If the number of patients is greater than 1, a + sign is added to the assigned level (example: 3 become 3+).

https://www.asn.fr/annual_report/2010gb/files/ASN-SFRO-scale_2010.pdf

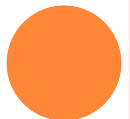
1. Incident characterisation

- Type of incident: dosimetric incident? Volume error? Other?
- Severity of consequence
  - Short term effects/ Long term effects/ Death
  - Use of scales
- Correctability
  - → immediate corrective actions



2. INFORM → THE TEAM/MANAGEMENT

- Respect hierarchical structure/procedures
- Incident Reporting and Learning system
- Setting up of a multidisciplinary team
- Decide on immediate corrective actions
- (insurance)

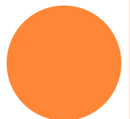


2. Inform → the patient

What the patients wants:

- « Full apology »
- « Honest and transparent communication »
- « Knowledge of the changes that have been made »

Transparency, Compassion, and Truth in Medical Errors » - Leilani Schweitzer



https://www.youtube.com/watch?v=qmaY9DEzBzI

COMMUNICATION WITH VICTIMS – WHO, WHEN AND WHAT

- Someone who is
  - Known to the patient
  - Familiar with the facts of the incident and the patients care
  - Senior
  - Good at interpersonal skills / communicating bad news
  - Able to offer reassurance and feedback
  - Willing to maintain a relationship with the patient
  - Trained in open disclosure

Courtesy of Pierre Scalliet

COMMUNICATION WITH VICTIMS – WHO, **WHEN** AND WHAT

- As soon as possible after the event
- Patient
  - Clinical condition
  - Emotional and psychological state
  - Availability of support person
  - Preference
  - Privacy and comfort
- Staff
  - Availability of key staff
  - Availability of support staff

Courtesy of Pierre Scalliet

COMMUNICATION WITH VICTIMS – WHO, WHEN AND **WHAT**

- Content of Disclosure Meeting:
  - Advise patient of identity and role of all staff at meeting
  - Express sympathy and regret for what has happened
  - Disclose the known and agreed **facts**
  - Be aware of their understanding, answer questions
  - Listen and respond to concerns of the patient

Courtesy of Pierre Scalliet

Communication with victims – Who, when and WHAT

- Content of Disclosure Meeting:
  - Discuss the next steps in treatment
  - Inform the patient about short- and long term effects
  - Reassure the patient that the incident will be thoroughly investigated, that they will be informed of results, and that changes will be made to prevent further recurrence
  - Offer support
  - Information on how to proceed further, e.g. complaints process

Courtesy of Pierre Scalliet

Who are the victims of an error?

1st victims

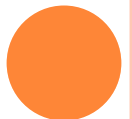
Patient + family/friends

2nd victims

Healthcare professionals

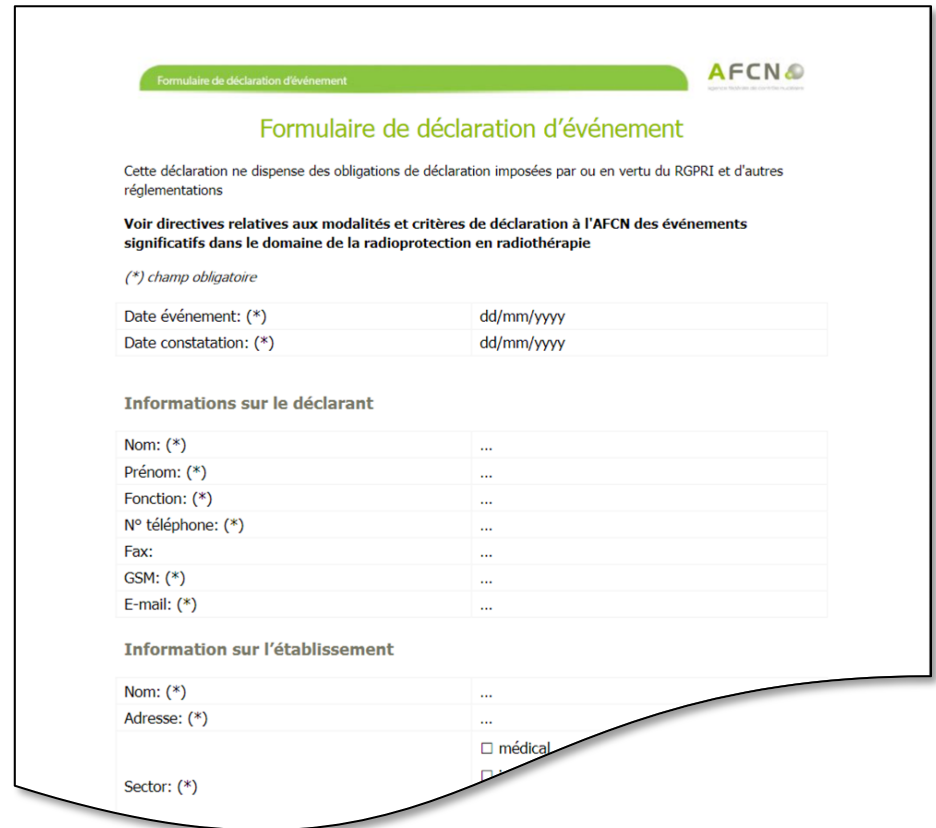
3rd victims

Healthcare organization/other patients



2. INFORM → AFCN/FANC

*"The boundary between an event that needs to be declared to the Agency and one that does not is **not** set in stone – one needs to ask oneself what the potential interest of the lessons learnt is for other departments"*



Formulaire de déclaration d'événement

AFCN

Formulaire de déclaration d'événement

Cette déclaration ne dispense des obligations de déclaration imposées par ou en vertu du RGPRI et d'autres réglementations

Voir directives relatives aux modalités et critères de déclaration à l'AFCN des événements significatifs dans le domaine de la radioprotection en radiothérapie

(*) champ obligatoire

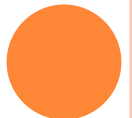
Date événement: (*)	dd/mm/yyyy
Date constatation: (*)	dd/mm/yyyy

Informations sur le déclarant

Nom: (*)	...
Prénom: (*)	...
Fonction: (*)	...
N° téléphone: (*)	...
Fax:	...
GSM: (*)	...
E-mail: (*)	...

Information sur l'établissement

Nom: (*)	...
Adresse: (*)	...
Sector: (*)	☐ médical

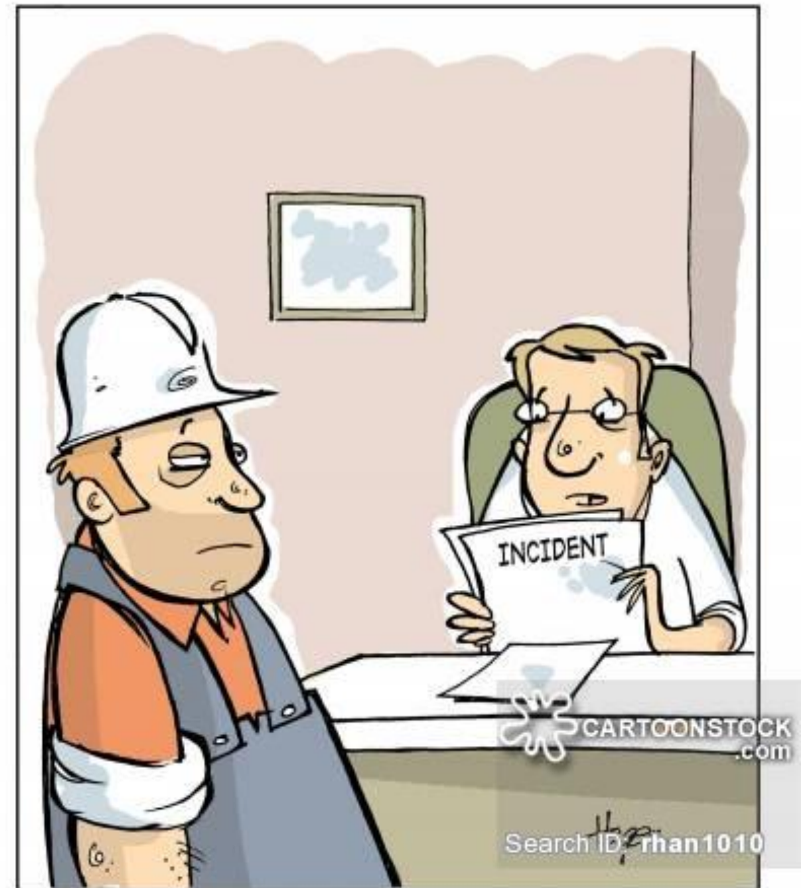


AFCN

agence fédérale de contrôle nucléaire

Short term actions

1. Investigate
2. Analyze



I'M GOING TO NEED A LITTLE MORE FOR THE ROOT CAUSE THAN, ***WHO'DA THUNK***.

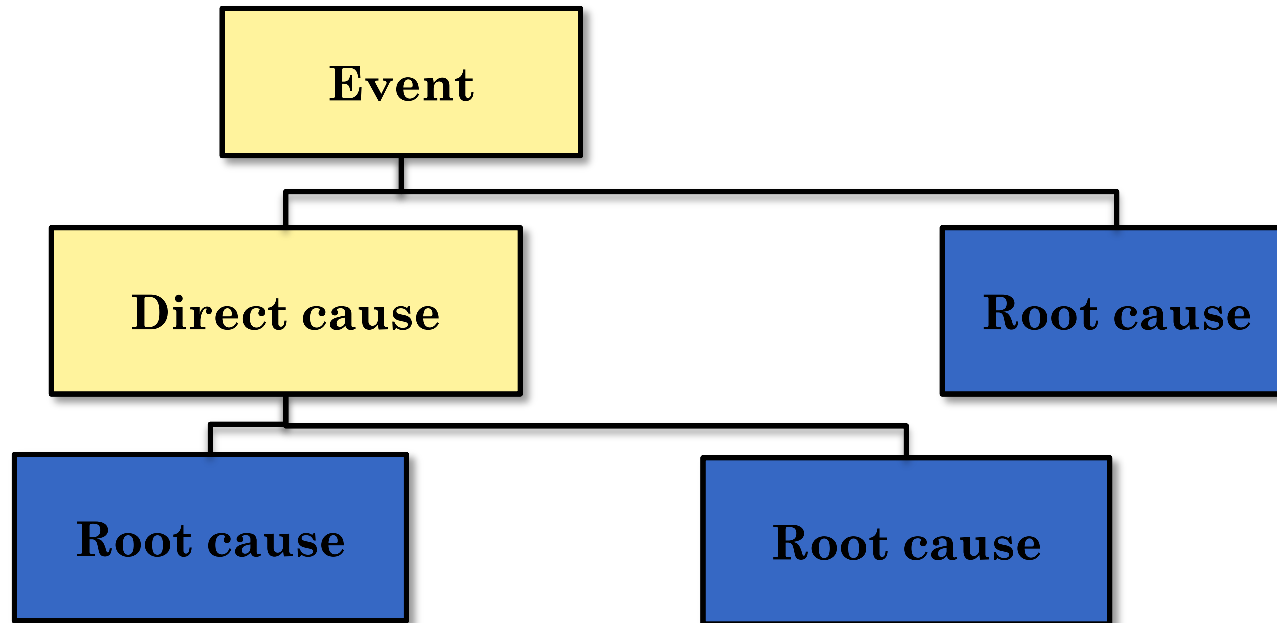
1. Investigate

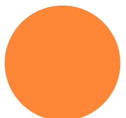
"What happened? What even led up to the error?"

- Set up a time line
- Complete missing information
  - Interview
  - Document/log review

2. Analyze

- Determine the "why's"

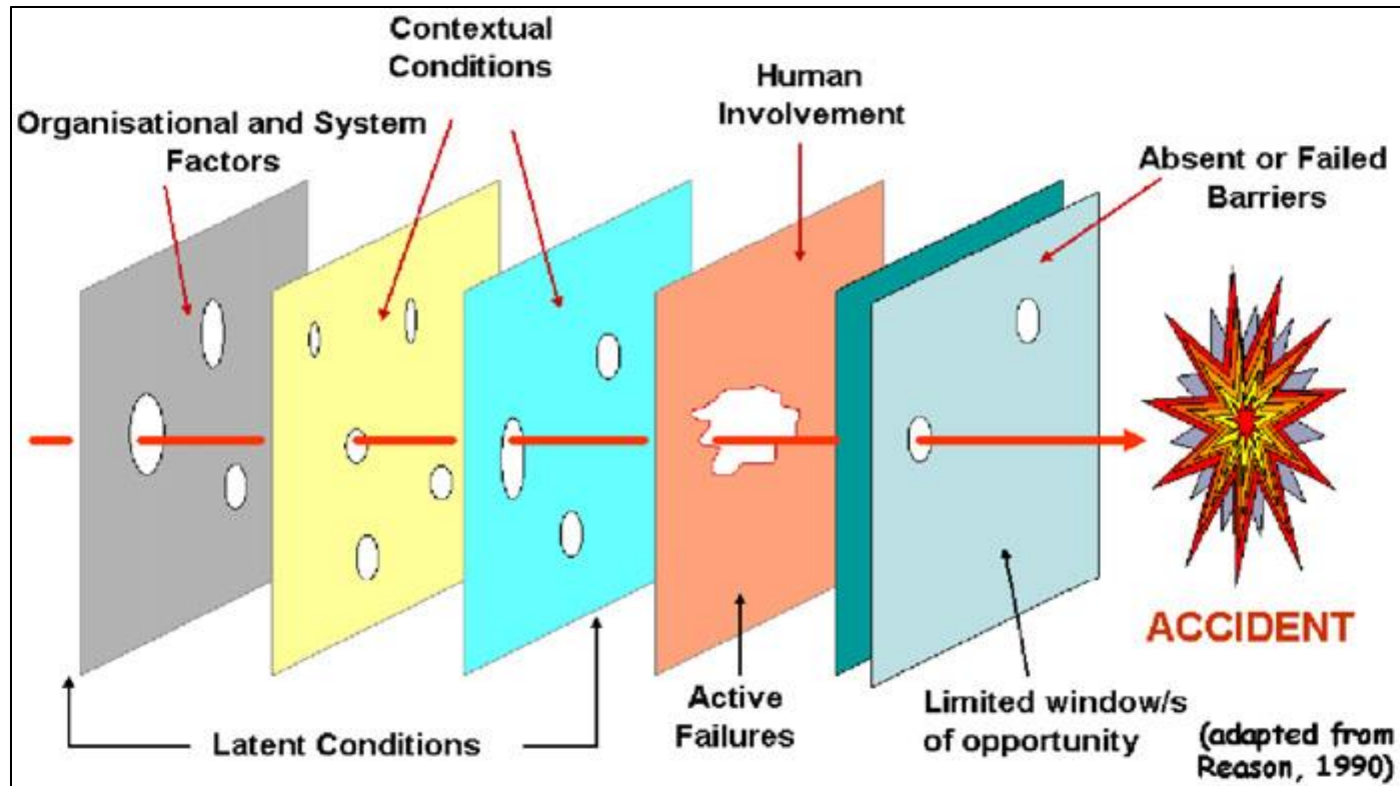




MEDIUM TERM ACTIONS

- Establish corrective/preventive actions

BARRIERS TO ERROR PROPAGATION



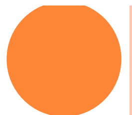
https://www.semanticscholar.org/paper/EUROCONTROL-Systemic-Occurrence-Analysis-(SOAM)-A-Licu-Cioran/7b4afd5c051f8135f90717ea2dcd721e2afcc097/figure/2

Medium term actions

Table 3. Classification/Action Matrix [Personal communication with van der Schaaf; March 2005].

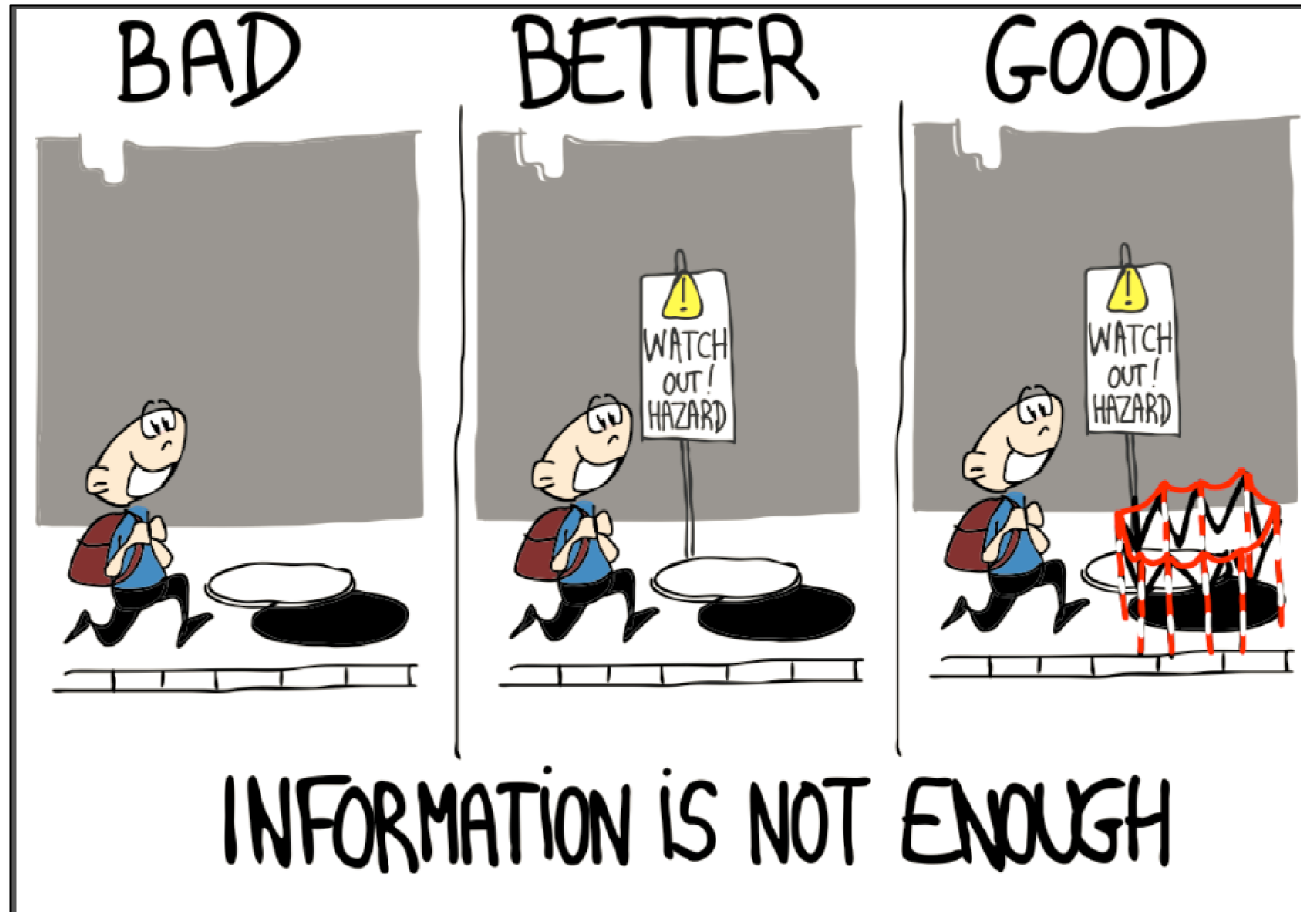
Classification code	Technology / Equipment	Procedures	Information and Communication	Training	Motivation	Escalation	Reflection
T-EX						×	
TD	×						
TC	×						
TM	×						
O-EX						×	
OK						×	
OP		×					
OM						×	
OC							×
H-EX						×	
HKK			×		NO		
HRQ				×			
HRC				×			
HRV				×			
HRI				×			
HRM				×			
HSS	×				NO		
HST	×				NO		
PRF[1]							
X							

[1] If particular patient related factors (such as language problems) that cannot be prevented by the patients themselves recur, then these problems should be solved at an organisational level (i.e. escalation).



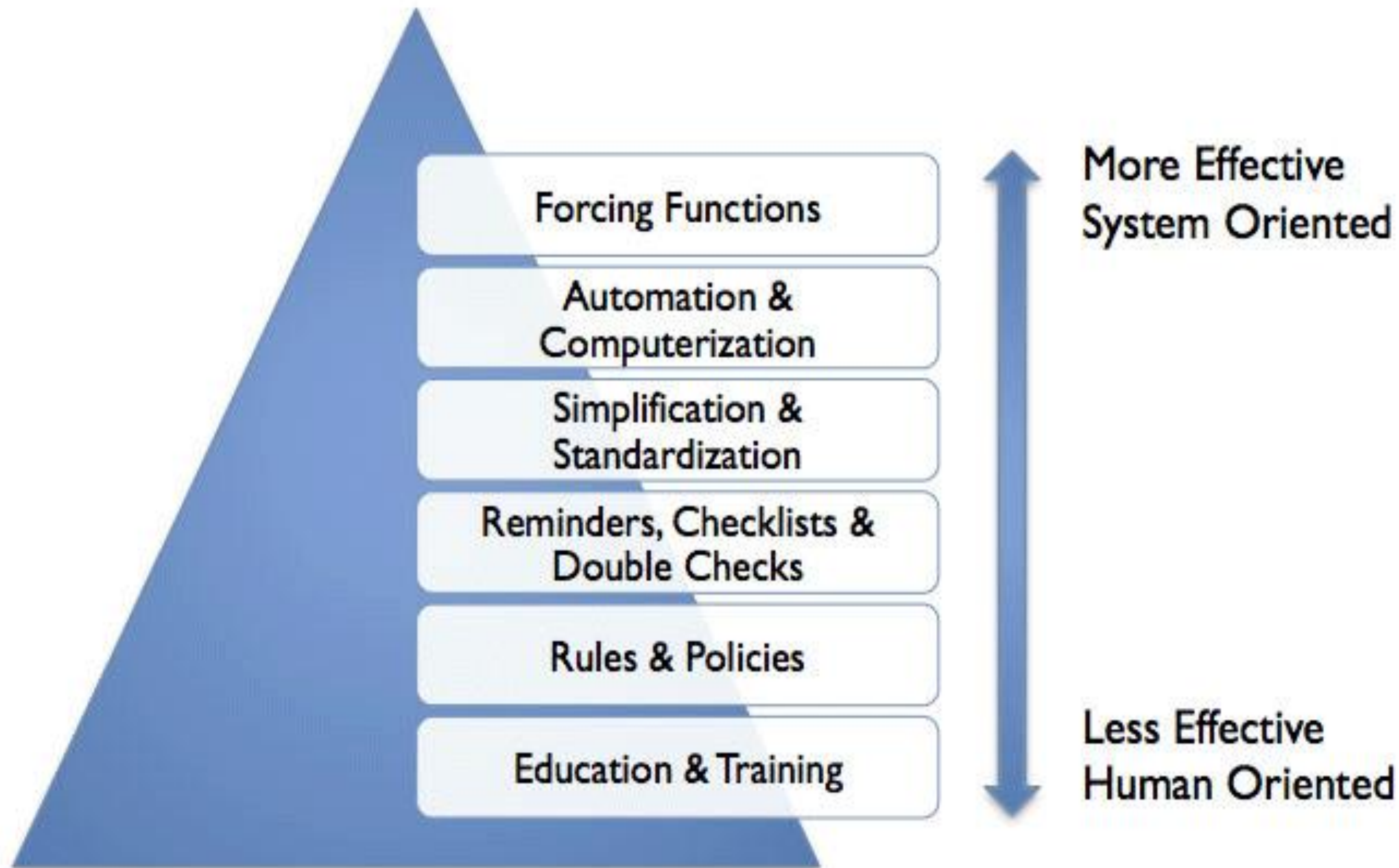
http://www.who.int/patientsafety/taxonomy/PRISMA_Medical.pdf

Barriers to error propagation



https://www.arcadiadata.com/blog/post-trade-reporting-title-vii/title-vii-image/

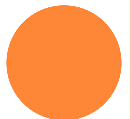
Efficiency of Barriers



Institute for Safe Medical Medication practices. Medication error prevention "toolbox". Med Safe Alert 1999;4:1.

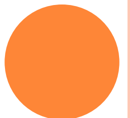
Long term actions

- Evaluate the corrective action plan

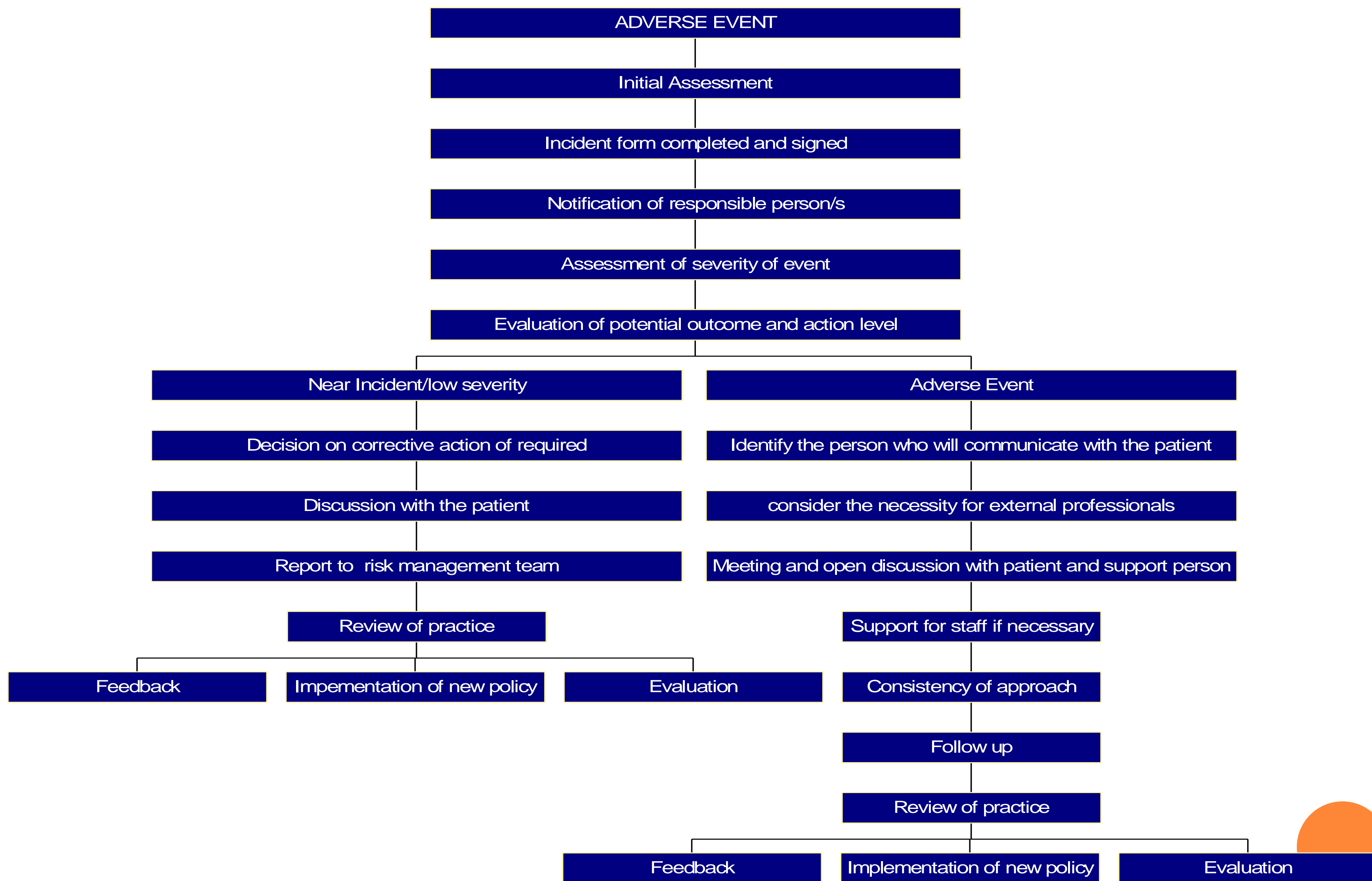


Take home message

- Communication is key:
  - Honest and transparent communication with the patient
  - Communicate with all involved entities
- Thoroughly investigate the incident
- Identify the causes that have led to the incident
- Implement corrective actions and continuously optimise barriers to error propagation



TAKE HOME MESSAGE



Courtesy of Joanne Cunningham