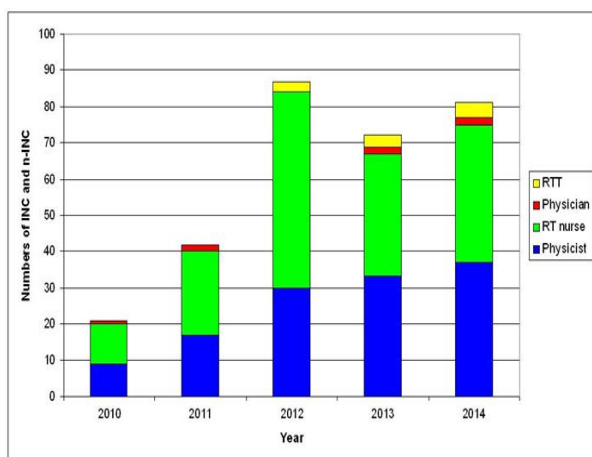


gives an easy overview and makes it possible to spot trends and risk factors. Staff is actively encouraged to report INCs and n-INCs. A monthly multidisciplinary staff meeting is used to disseminate lessons learned and resulting amendments to internal guidelines and work flows. Here, we attempt to show the effect of such a system by examining INC reporting rates over a 5 year time period, from the initiation of the setup to today. The distribution of reported INC between staff groups will be examined. Besides that we placed a question in a general anonymously questionnaire where we ask concerning the culture of learning regarding INC.

Results: In the results we see a clear trend. Numbers of INC and n-INC reported are increasing through the years from 2010 to 2014. It seemed that the number shows stagnating for now. All staff groups have been participating through the years.



Staffs answer on our question regarding INC showed that the RT nurses agreed or totally agreed on 'The culture in our department makes it easy to learn from others INCs' in 91% of the cases and physicists agreed or totally agreed on that in 66% of the cases.

Conclusions: We experienced, that to use information gained in a learning matter, two things are needed: the INC reporting must be as complete as possible, i.e. all staff groups must be participating, and lessons learned should be disseminated through the organisation in an optimal way to assure and improve future workflow. We have shown, that a culture where we can discuss INCs and n-INCs in an open way, without involved parties feeling quilt; results in participation among staff groups in reporting INC. The multidisciplinary participation gives a differentiated picture of risk facts in the department and the systematic handling of the reported INC allows the RT department to track trends and helps to improve patient safety. Improvement of daily practice encouraged staff to report INCs.

EP-1687

Improving safety culture through incident reporting

K. Betcher¹, S. Lowitz¹

¹Hospital of the University of Pennsylvania, Radiation

Oncology, Philadelphia, USA

Purpose/Objective: An organization's 'safety culture' and approach to errors and events are recognized across industries as key factors influencing safety and quality. This presentation summarizes experiences, insights, and lessons learned three years after developing and implementing a comprehensive incident learning program in a large, multi-site (academic and community) Radiation Oncology department.

Materials and Methods: A 'Condition Reporting' program was developed with key attributes: 1) full staff participation, 2) four carefully defined incident severity levels covering a broad range from significant harm to minor process delays, 3) specific requirements for analysis and response for each severity level, 4) formal processes for review and oversight, and 5) web-based information system for reporting and tracking.

Results: Results show an increasingly healthy culture, a low threshold for reporting, and a decrease in higher-severity events. Between March 2011 and February 2014 a total of 6,260 conditions were reported. AHRQ-based Safety Culture surveys show continual improvement with 8 categories above national average. Response to conditions includes improved treatment techniques, safety checks, workflow, policies, procedures, and education.

Conclusions: An interdisciplinary incident reporting system is an effective tool for fostering a safety culture. By investigating lower level events in a non-punitive yet just manner, proactive actions can be taken contributing to a reduction in higher-severity events and increased employee engagement and ownership.

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Development and evaluation of the educational process of radiation therapy in Slovenia

V. Zager¹, A. Okljesa Lukic¹, N. Bizjak Matosec¹

¹Institute of Oncology Ljubljana, Radiotherapy, Ljubljana, Slovenia

Purpose/Objective: The aim of this research is to present the development of education through history in the field of radiation therapy and to evaluate the number of lectures and hours of clinical training in the past and today.

Materials and Methods: Education of students of radiological technology has always been of utmost importance. The first data on the beginnings of schooling for a profession that is today indicated in the nomenclature of professions as 'engineer or graduated engineers of radiologic technology' are in Slovenia available in 'Kronika Višje šole za rentgenske pomočnike' (*Chronicles of the College for Radiology Assistants*). The study programme was later changed in 1954, 1962, 1975, 1982, and 1992. On the basis of the Higher Education Act from 2004, the first generation of students enrolled in the Bologna study programme - the first-cycle degree programme of Radiologic Technology - in 2008. In 2009, the first generation of students was enrolled in the Bologna study programme of Radiologic Technology, the second-cycle (master's) degree programme. To complete the undergraduate programme, the students must fulfil all their study obligations. They have to write a research project and make a presentation of their work. They finish their studies with a first-cycle degree final exam. Project theses are minor research works conducted by mentored students at the Department of Radiation Therapy and the Faculty of Health