Incidents control in radiotherapy oncology

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Introduction. Radiotherapy units are safe departments subjected to protocols and quality management systems. Nevertheless, the experience shows that equipment failure or human errors still happening. According to data of the IAEA, at least 3000 patients have been affected by radiotherapy incidents and accidents.

Objectives. To investigate the incidents to minimize or avert future treatment errors.

Materials and methods. We show the design and implementation of an internal incidence reporting and management system at the radiotherapy unit of Hospital Meixoeiro. We defined a multidisciplinary team that worked at all the stages of the project. We developed a supporting documentation form to register type of incidence, causes and people involved to analyze the incidents reported, designated a system manager and started commissioning to propose solutions and decrease the incidences.

Results. At the very beginning the nature of non-conformances reported where organizational. 30.43% of our incidences corresponded to failures to start treatment at the right time and soon after we changed our processes, we reduced it to 0%. With the continuous improvement of the patient pathway and the involvement of staff in the reporting culture, recent years almost 100% of the statements were about safety concerns, well incidents or near miss. Nowadays we are involved in the evolution of our system into a more robust one, which can account for an error coding system and the implementation of lessons learned from national and international sources. We observe that there are more incidents because are reported greater number, but have decrease the repeated incidents.

Conclusion. The described experience has been very positive to our organization in terms of safety and staff confidence improvement and we highly encourage a pilot-study of a safety reporting and learning system nationally based.

Influence of techniques in radiotherapy waiting times

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Introduction. Modern techniques, like IMRT, VMAT, Radiosurgery or SBRT require more time to contouring, planning and quality control. Waiting times could be outside of standards one. The purpose is to retrospectively measure radiotherapy times indicators according type of techniques (3D versus others) in a department without LINAC overload.

Methods. Reference benchmark/indicators used were: 1. Cancer waiting times (CWT) from UK National Health Services: 31 days from decision to treat to first definitive treatment, expressed as % seen within target recommended wait times (90–100%). 2. Cancer Standards from UK National Health Services: palliative treatment 2–15 days; radical treatment 15–28 days, expressed also as % seen within target recommended wait times (90–100%). 3. Canadian standards: ready to treat to start of treatment (the time from when the specialist is confident the patient is ready to begin treatment to the time the patient receives treatment (benchmark 28 days) expressed as median and 90th percentile of number of days waited. Sample includes all consecutive patients treated with radiotherapy in our department from May 2011 to December 2012, a total of 1151 patients. We have taken into account planned wait due to personal, medical and work-related reasons or chemotherapy integration and patient's related.

Results. 1. CWT: results expressed as % of the patients treated within target recommended wait time: Total (1151) 96,4%; 3D treatments (523): 98.1%; Other (604): 94.6%. 2. Cancer standards: palliative treatment: total (277) 93.1%; 3D (219) 96.8%, other (58) 79.3%. Radical treatment: total (874): 93%; 3D (310): 96,4%; other (564): 92.5%. 3. Canadian standards: median numbers of days waited: total: 12; 3D: 4; Other: 13; 90th percentile of number of days waited: total 24; 3D: 14; Other 26.

Conclusions. Our results showed that waiting times after modern techniques are longer than 3D but nonetheless we have achieved a high benchmark, except for palliative treatment with modern techniques. Reasons to explain could be low sample number, patient's related and integration with chemotherapy.

Organizational guide of a functional head and neck tumour unit

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Head & neck cancer (HNC) constitutes a high percentage of the cases in the oncology units. The therapeutic progress in HNC comes from good diagnosis and improvements in surgery, radiotherapy and new pharmacological agents, also because of the reduction of morbidity and mortality thanks to the therapeutic progress and organizational measures. This guide is the result of the collaboration between different specialists: Oncologists, ORL, CMF, Plastic Surgery, AP, Radiology, Nutrition, Palliative Care