# Introduction of a "Good Catch" Reporting System As a Component of Radiation Oncology Quality Improvement and Patient Safety


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# What is a Good Catch?

A { condition / defect / event / situation / miscommunication } that could have or did result in { harm / delay / rework / waste / an error }

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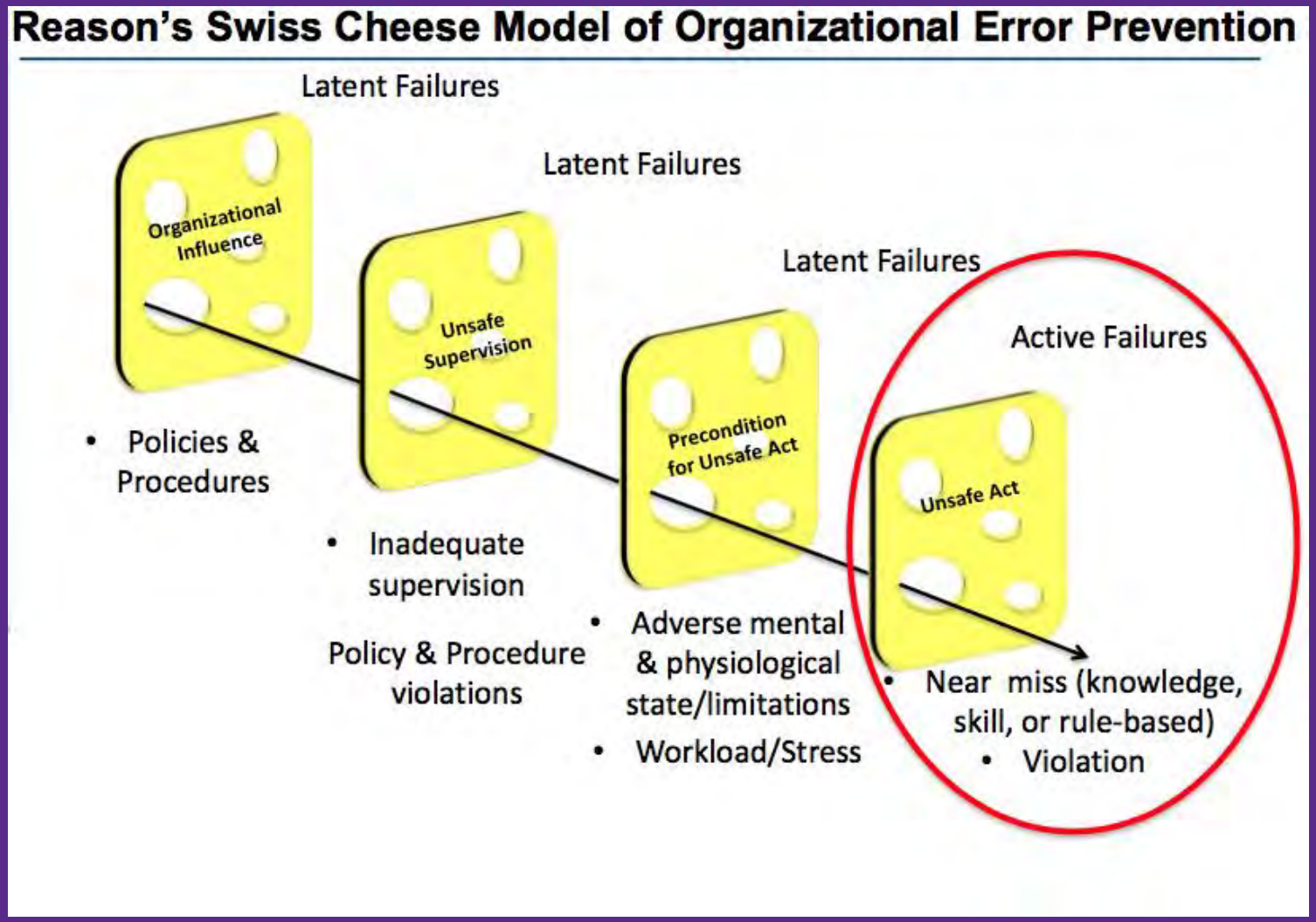
# Radiation Oncology Error Propagation

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# Reporting Model:

- Any staff member can submit a Good catch
- Good catches are assigned to a champion for initial review.
- Details and possible interventions are added and the Good catch is then reviewed by the Good Catch committee.
- The good catch committee reports significant good catches and recommendations to the department's Continuous Quality Improvement team.

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# Good Catch v1.0

## VCC RADIATION ONCOLOGY "GOOD CATCH" REPORT

**Instructions:**

1. The involved staff should complete the Report while facts are still fresh and submit to their Incident Team Leader.
2. The Incident Team Leader is responsible for reviewing the Report and assessing if immediate action is required.
3. The Report must be completed, reviewed by the Clinical Manager & distributed **within 14 days.**
4. The Clinical Manager is responsible for gaining commitment from those responsible for action completion.
5. The Incident Team will review all Reports for the month and prepare a report to the Quality and Safety Committee.
6. Do not include any personal medical information, on this form.

| Inc. Date | Inc. Time | Inc. Day | Exact Location of Incident | Clinical Area of Incident |
|---|---|---|---|---|
| | | | | |

| Date Incident Reported | Witness(es) Names, if any | Report # |
|---|---|---|
| | | |

**Incident Details Section:** Check the Appropriate Boxes (see Instructions 5 and 6 for guidance)

**1. Involved person(s)**

- ☐ Patient: _____
- ☐ Visitor: _____
- ☐ Staff: _____
- ☐ Student: _____
- ☐ Visiting Worker: _____

**2. Incident Area Classification (check one)**

- ☐ Medical
- ☐ Physics
- ☐ Simulation
- ☐ Dosimetry
- ☐ Treatment
- ☐ Nursing
- ☐ Equipment
- ☐ Other: _____

**3. Please briefly describe the incident:**

**4. What was your response and/or actions taken to intervene?**

**5. What other forms were filled out? (i.e. pt. incidence report,)**

**6. Who did you notify (check all that apply)**

- ☐ Your Supervisor
- ☐ Physics
- ☐ Attending Physician
- ☐ Other: _____

**7. Signature:**

Name _____
(Print)

Signature: _____

Date: _____

## VCC RADIATION ONCOLOGY "GOOD CATCH" REPORT

**Incident Investigation Section.**

**8. Incident Type**

- ☐ Near Miss
- ☐ Error
- ☐ Radiation/Dose Event

**9. Describe Learning Points from this Incident:**

**10. Incident Severity Classification: (See definitions below)**

- ☐ Low
- ☐ Medium
- ☐ High
- ☐ Critical

**11. What is the Root Cause of This Incident?**

**12. Actions to Prevent this Incident from Happening Again:**

**13. Incident Investigation Team Leader:**

**14. Other Investigation Team Members:**

**15. Has the Report been reviewed and distributed as necessary? (Please describe)**

**16. Have all action items been addressed? (Please describe)**

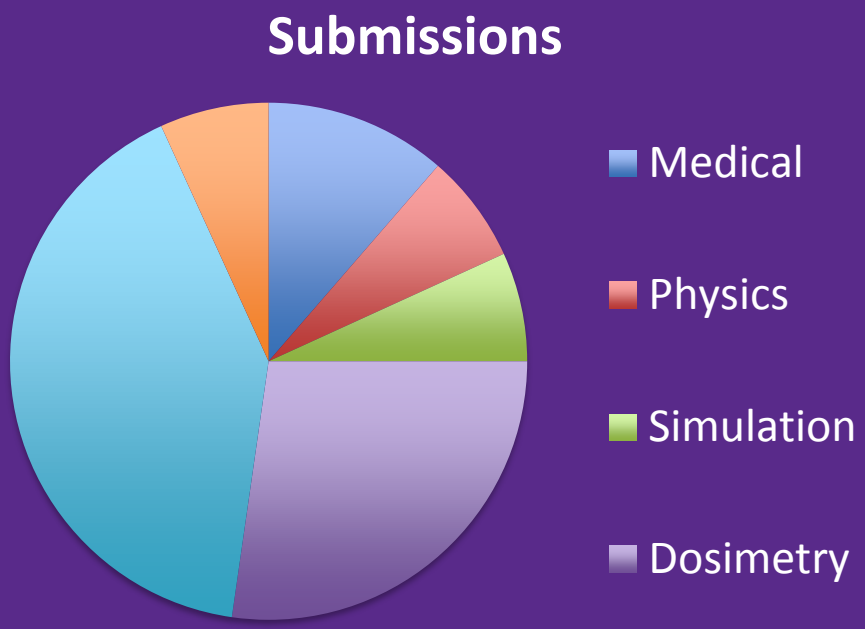
**17. If indicated, has an SBAR or PDCA project been initiated to evaluate effectiveness of action?**

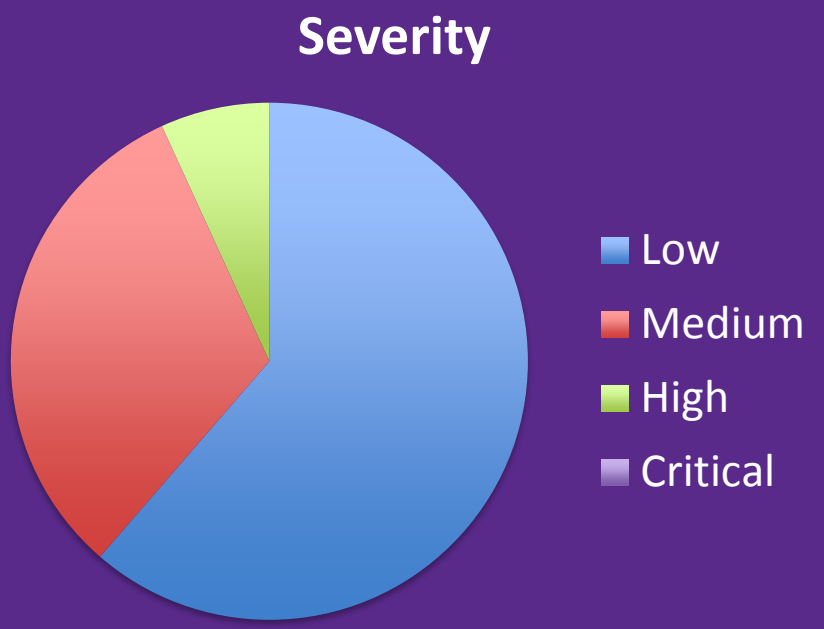
**18. Investigator Signature:** _____ **Date:** _____

**19. Manager Signature:** _____ **Date:** _____

# Good Catch v1.0

- 8/3/17 – 10/31/17
- 44 Good Catches submitted
- Weekly meetings

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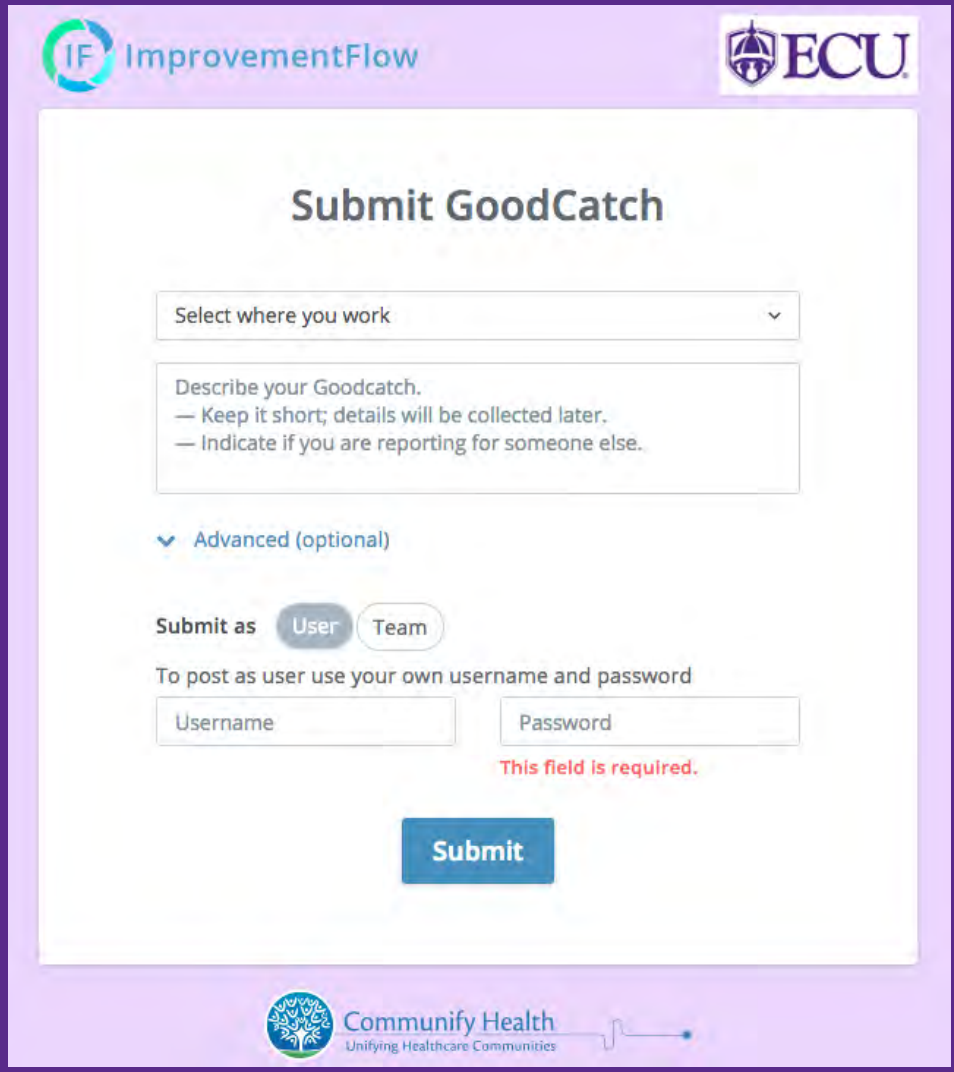
# Good Catch v2.0

- Communify Health
  - ImprovementFlow

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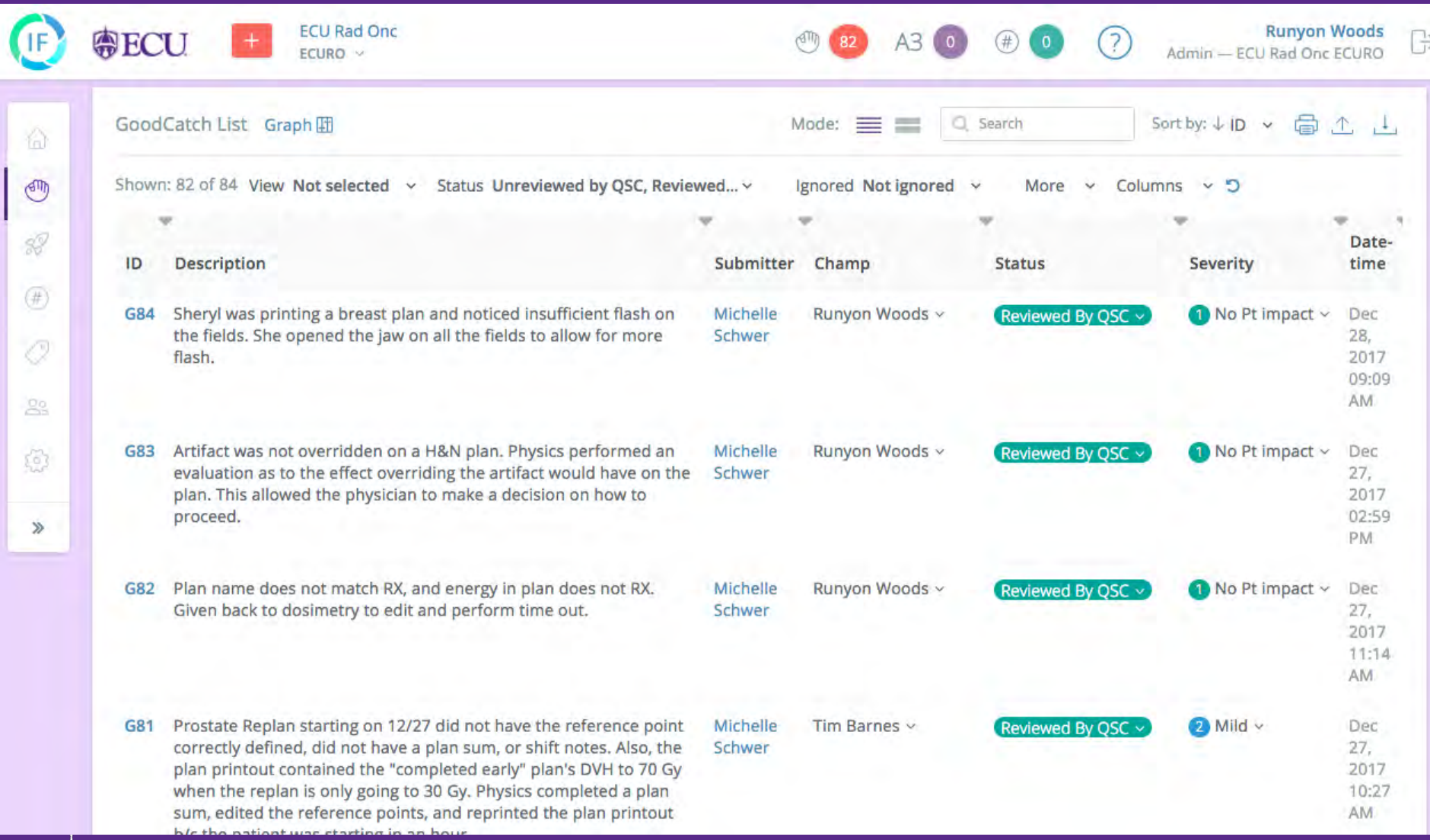
# Good Catches




| ID | Description | Submitter | Champ | Status | Severity | Date-time |
|---|---|---|---|---|---|---|
| G84 | Sheryl was printing a breast plan and noticed insufficient flash on the fields. She opened the jaw on all the fields to allow for more flash. | Michelle Schwer | Runyon Woods | Reviewed By QSC | 1 No Pt impact | Dec 28, 2017 09:09 AM |
| G83 | Artifact was not overridden on a H&N plan. Physics performed an evaluation as to the effect overriding the artifact would have on the plan. This allowed the physician to make a decision on how to proceed. | Michelle Schwer | Runyon Woods | Reviewed By QSC | 1 No Pt impact | Dec 27, 2017 02:59 PM |
| G82 | Plan name does not match RX, and energy in plan does not RX. Given back to dosimetry to edit and perform time out. | Michelle Schwer | Runyon Woods | Reviewed By QSC | 1 No Pt impact | Dec 27, 2017 11:14 AM |
| G81 | Prostate Replan starting on 12/27 did not have the reference point correctly defined, did not have a plan sum, or shift notes. Also, the plan printout contained the "completed early" plan's DVH to 70 Gy when the replan is only going to 30 Gy. Physics completed a plan sum, edited the reference points, and reprinted the plan printout b/c the patient was starting in an hour | Michelle Schwer | Tim Barnes | Reviewed By QSC | 2 Mild | Dec 27, 2017 10:27 AM |

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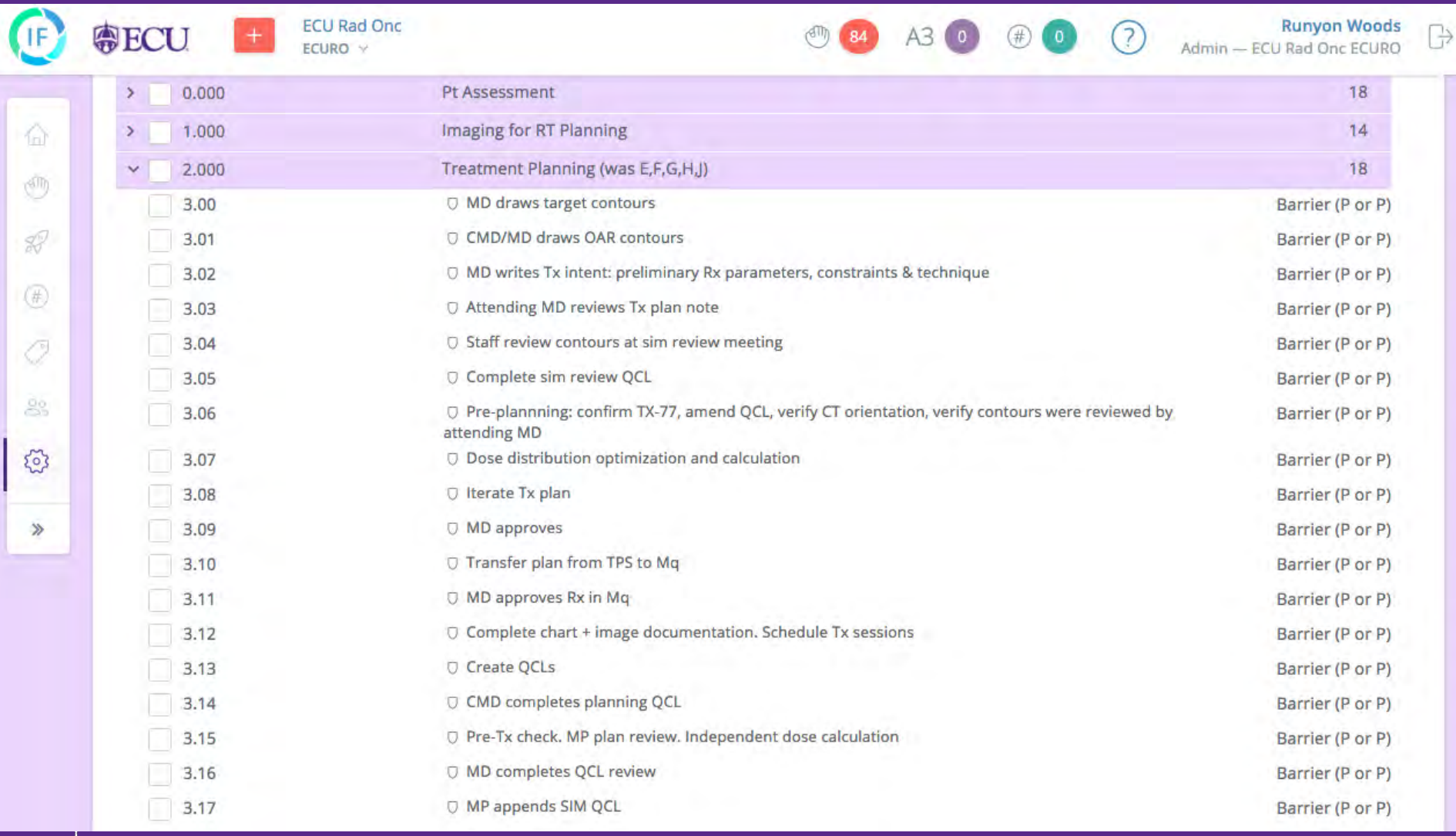
# Good Catch v2.0

- As of 1/22/18
- 86 Good Catches submitted by departmental staff.
- Allows for greater organization and identification of *origin* of error

# Good Catch v2.0: Care Path




| | | | |
|---|---|---|---|
| 0.000 | Pt Assessment | | 18 |
| 1.000 | Imaging for RT Planning | | 14 |
| 2.000 | Treatment Planning (was E,F,G,H,J) | | 18 |
| 3.00 | MD draws target contours | | Barrier (P or P) |
| 3.01 | CMD/MD draws OAR contours | | Barrier (P or P) |
| 3.02 | MD writes Tx intent: preliminary Rx parameters, constraints & technique | | Barrier (P or P) |
| 3.03 | Attending MD reviews Tx plan note | | Barrier (P or P) |
| 3.04 | Staff review contours at sim review meeting | | Barrier (P or P) |
| 3.05 | Complete sim review QCL | | Barrier (P or P) |
| 3.06 | Pre-plannning: confirm TX-77, amend QCL, verify CT orientation, verify contours were reviewed by attending MD | | Barrier (P or P) |
| 3.07 | Dose distribution optimization and calculation | | Barrier (P or P) |
| 3.08 | Iterate Tx plan | | Barrier (P or P) |
| 3.09 | MD approves | | Barrier (P or P) |
| 3.10 | Transfer plan from TPS to Mq | | Barrier (P or P) |
| 3.11 | MD approves Rx in Mq | | Barrier (P or P) |
| 3.12 | Complete chart + image documentation. Schedule Tx sessions | | Barrier (P or P) |
| 3.13 | Create QCLs | | Barrier (P or P) |
| 3.14 | CMD completes planning QCL | | Barrier (P or P) |
| 3.15 | Pre-Tx check. MP plan review. Independent dose calculation | | Barrier (P or P) |
| 3.16 | MD completes QCL review | | Barrier (P or P) |
| 3.17 | MP appends SIM QCL | | Barrier (P or P) |

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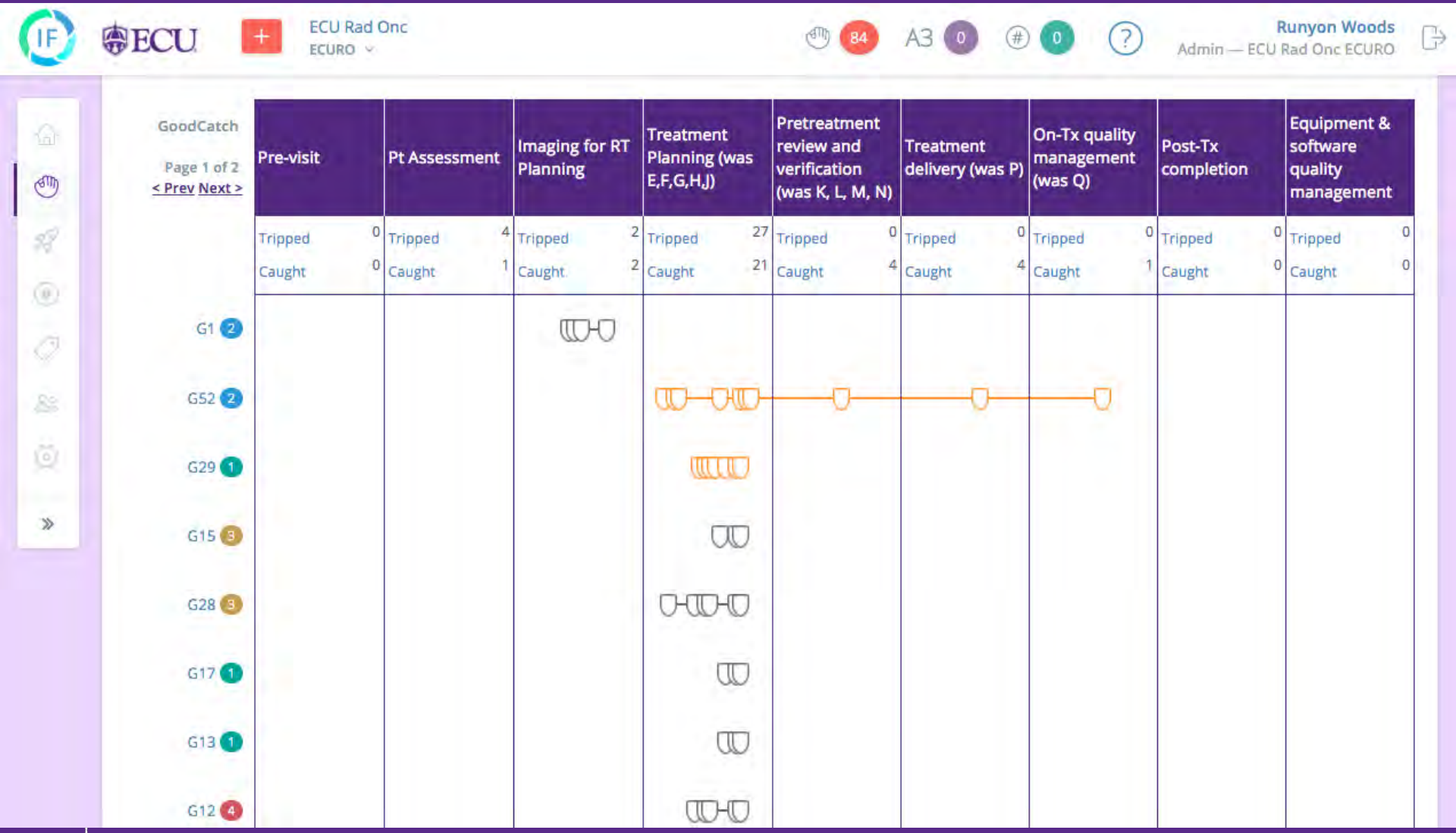
# Good Catch v2.0: Care Path



# Good Catch evaluation Leads to a Solution

- Multiple GC's submitted identified the need for a "timeout" between physicians and dosimetrists
  - Patient plans were proceeding without corrected prescriptions
- Introduced the "4 P's" Timeout
  - Prescription?
  - Pacemaker?
  - Pregnant?
  - Prior Radiation?

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# Staff Recognition and Cultural Change

- GC Program allows for a verifiable way to commend staff for excellent work
- Drives a culture of staff engagement and safety
- Increases staff awareness and promotes individual ownership of processes
- “Good catch of the month” in progress…

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# Not Just for Errors!

- G.C. # 70:
  - The Omnipaque used for Oral contrast usually comes on 50 mL bottles. We only need 10 mL for some of our scans. Since the remaining must be discarded once opened there is a substantial amount of product and money wasted. After discussing with Diagnostic Radiology they said that 50 mL was the smallest amount available so they do the same (throw away remaining of a 50ml bottle). After further searching on Mkessons ordering website Omnipaque is in fact available in 10 mL bottles which only cost $16 each, as opposed to $51 per bottle for the 50ml. This will save the dept $35/bottle when only a small amount is needed.

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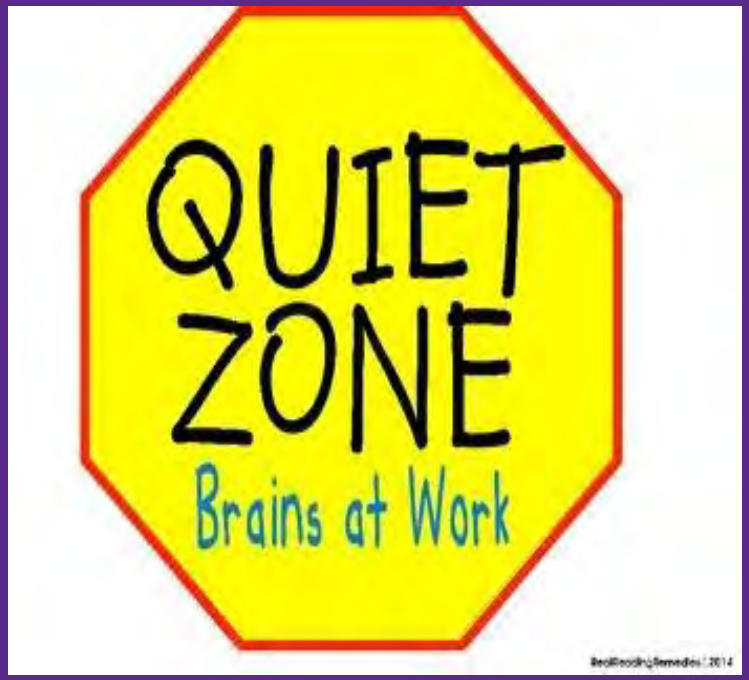
# Sometimes it's the small things!!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# Summary

- Still evolving as an important part of the CQI program within our department
- Organization of GC's is greatly improved with new software
- Submissions are increasing
  - Encompassing more than just errors, but suggestions for improvements in all areas
- Team members feel empowered to drive change for the better
- More staff education and training is needed to expand the program.

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# Thank You!

- Questions??
- References:
- "Implementing a Good Catch Program in an Integrated Health System", Debbie Barnard et al. Healthcare Quarterly Vol. 9, Special Issue, October 2006.
- "Patient Safety Reporting Systems: Sustained Quality Improvement Using a Multidisciplinary Team and "Good Catch" Awards. Kurt R Herzer, et al. The Joint Commission Journal on Qulaity and Patient Safety, August 2012, Volume 38, Number 8.
- "To Err is Human Building a Safer Health System", Institute of Medicine, 1999.

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