THE EXPERIENCE OF PRISMA-RT IN BELGIUM

HERCA Multi-Stakeholder Workshop
October 26-27th 2016

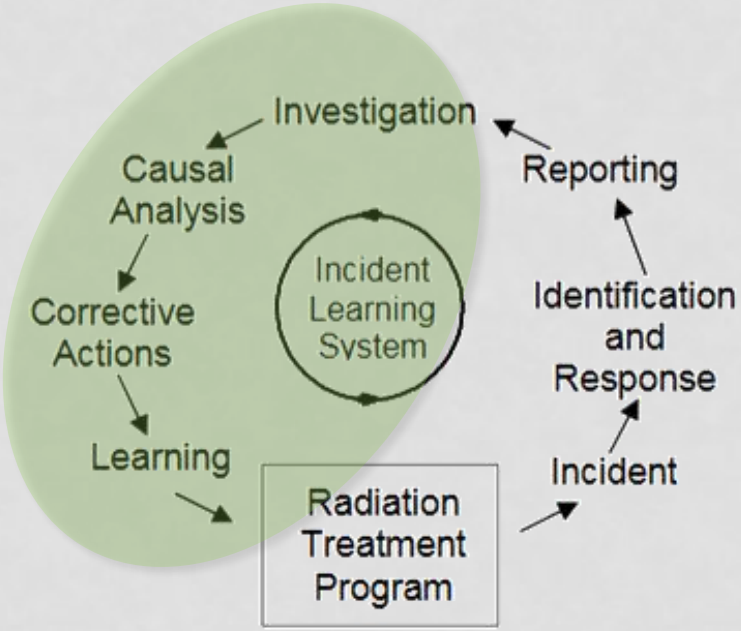
AUDE VAANDERING

OVERVIEW

- PRISMA methodology
- National implementation – PRISMA-RT
- Benchmarking
- Challenges
- Opportunities to learn

PRISMA METHODOLOGY

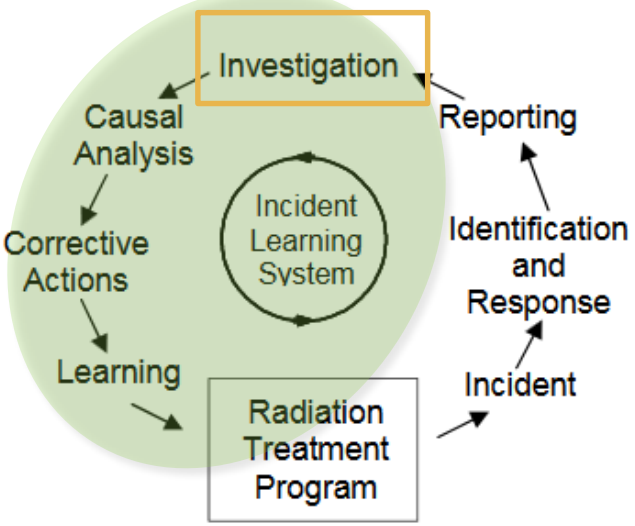
- PRISMA= **P**revention and **R**ecovery **I**nformation **S**ystem for **M**onitoring and **A**nalysis
- PRISMA-**RT**= PRISMA methodology developed for RT (MAASTRO)
- Methodology used for:
  - The [quantitative] analysis of events
  - Determination of corrective actions



Vuuren, W. van, Shea,C.E., Schaaf, T.W. van der (1997) The Developmenent of an incident analysis tool for the medical field. Eindhoven: Technische Universiteit Eindhoven
Dusncombe, P.Taxonomies and Classification Schemes In Incident Learning Systems Taxonomies : Incident Learning Systems

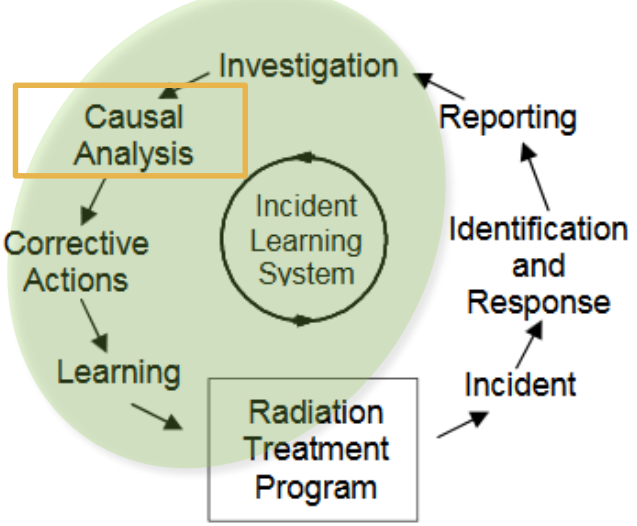
PRISMA METHODOLOGY

1. Description of the event



PRISMA METHODOLOGY

1. Description of the event
2. **Determination of the root causes**

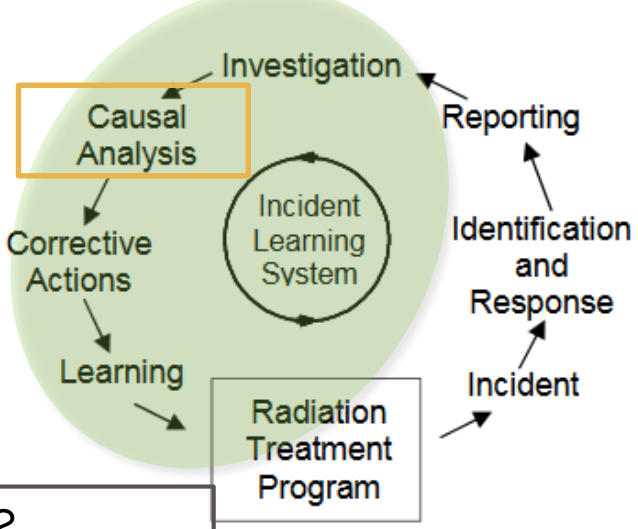


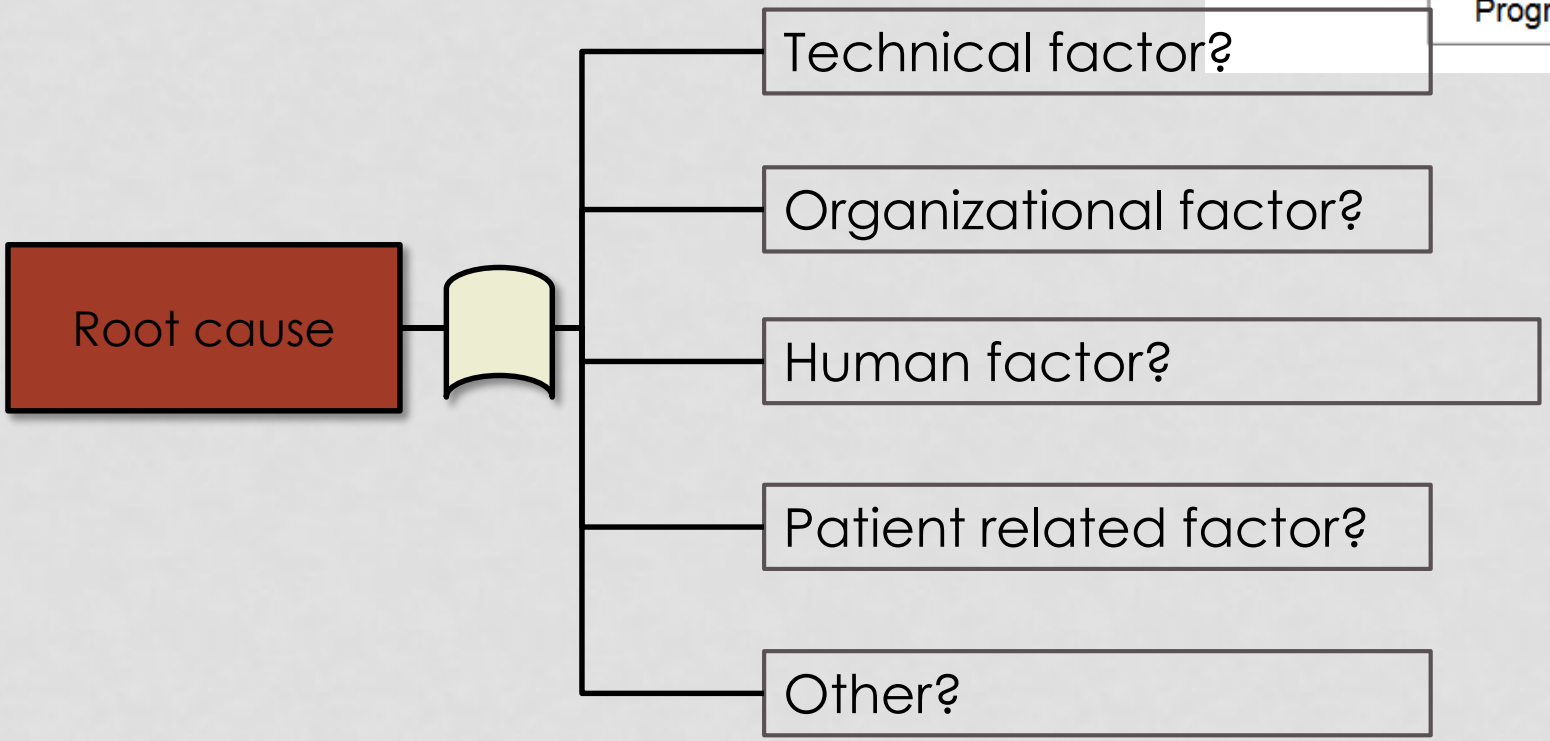
- Patient irradiated using data of another patient
  - Patient A called but patient B entered
    - Patient was deaf
    - Patient was called through intercom
  - Incorrect verification of the patient
    - Patient was already in the LINAC room
    - The second team thought that the first team had already checked
      - Incorrect communication
  - Change of teams during the treatment session
    - Allowed in the procedure
    - Programme was too full
    - Machine failure
    - Too many things to do during treatment

Courtesy of Petra Reijnders

PRISMA METHODOLOGY

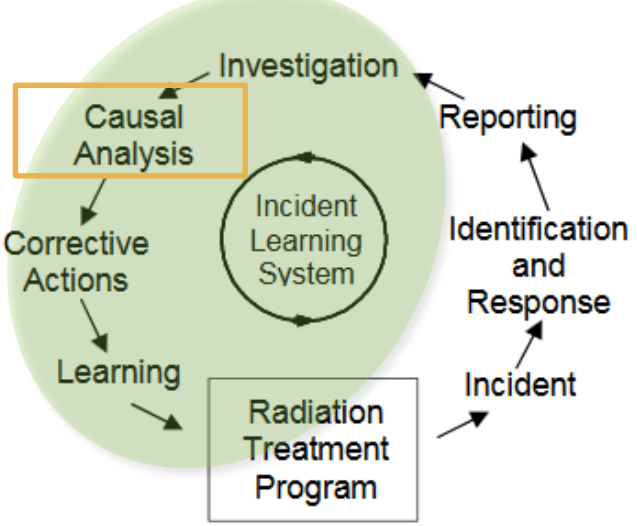
1. Description of the event
2. Determination of the root causes
3. **Root cause classification (Eindhoven)**





PRISMA METHODOLOGY

1. Description of the event
2. Determination of the root causes
3. **Root cause classification (Eindhoven)**



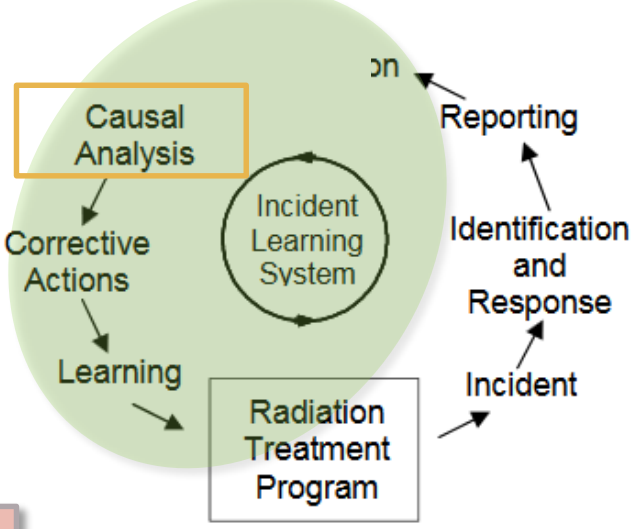
Patient irradiated using data of another patient

- Patient A called but patient B entered
  - Patient was deaf — **PRF**
  - Patient was called through intercom — **TD**
- Incorrect verification of the patient
  - Patient was already in the LINAC room — **HRI**
  - The second team thought that the first team had already checked
    - Incorrect communication — **HRC**
- Change of teams during the treatment session
  - **OP** — Allowed in the procedure
  - **OM** — Programme was too full
  - **TD** — Machine failure
  - **OP** — Too many things to do during treatment

Courtesy of Petra Reijnders

PRISMA METHODOLOGY

1. Description of the event
2. Determination of the root causes
3. Root cause classification
4. **Attribution of context variables**



Patient was called through intercom

PRF

Patient was already in the LINAC room

TD

Incorrect communication

HRC

Too many things to do during treatment

OP

General context variables
Process/step

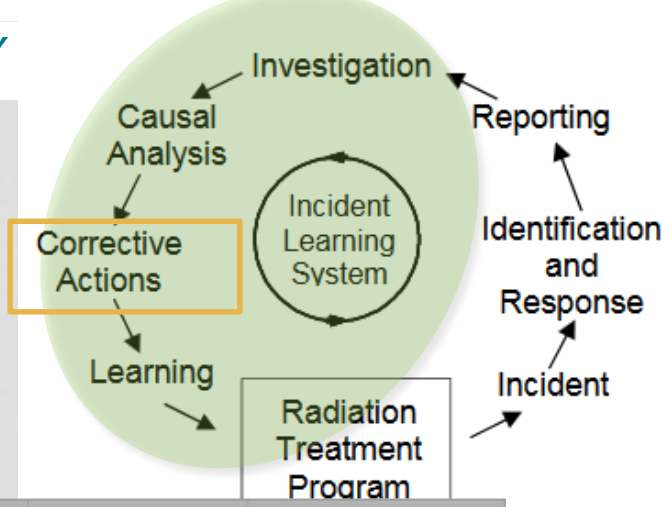
Technical context variables
Type/Usage/origin/vendor

Human context variables
Role/training

Organizational context variables
Priority/procedure

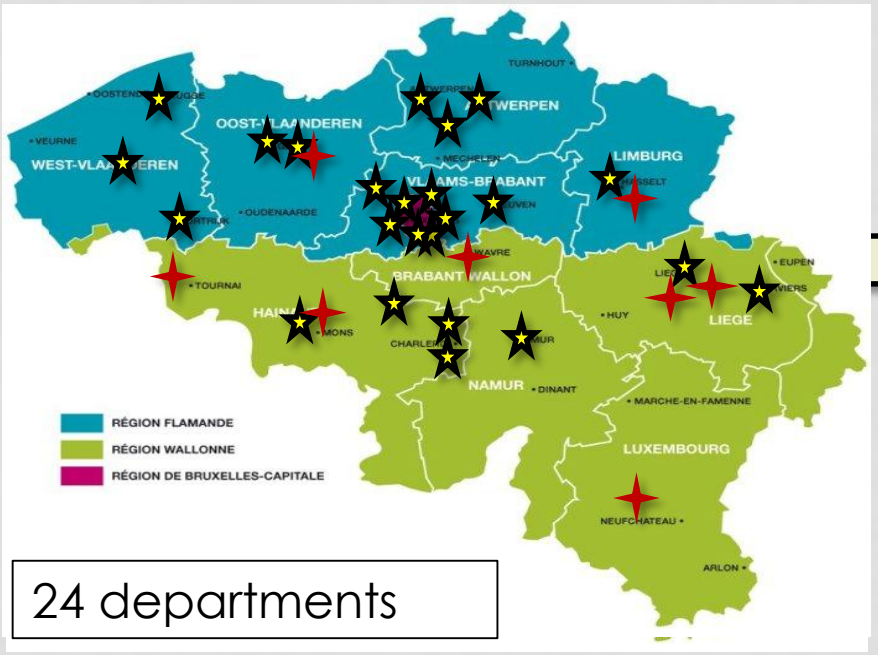
PRISMA METHODOLOGY

1. Description of the event
2. Determination of the root causes
3. Root cause classification
4. Attribution of context variables
5. **Translation into corrective actions**



Classification Code	Technical	Procedure	Information & Communication	Training	Motivation
TD	X				
TC	X				
TM	X				
OK		X			
OP		X			
OM		X			
OC		X	(X)		
HKK			X		No
HRQ			X		No
HRC			(X)	X	
HRV				X	
HRI				X	
HRM				X	
HSS	X				No
HST	X				No

NATIONAL IMPLEMENTATION



24 departments

Plan Cancer
Kankerplan

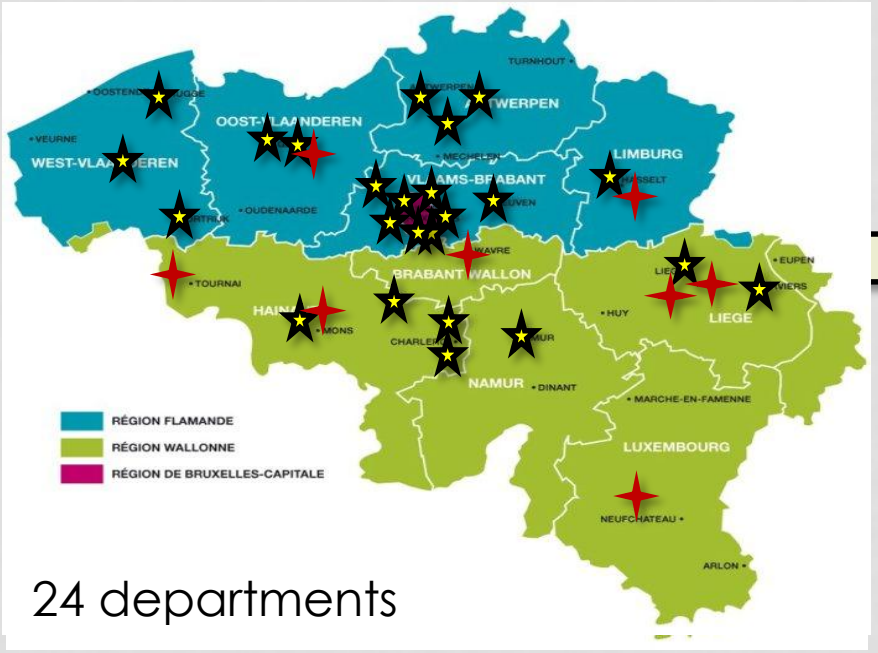
Central registration of events

PRISMART.be

the patient safety company

adheco

NATIONAL IMPLEMENTATION



24 departments

Plan Cancer
Kankerplan

Central registration of events

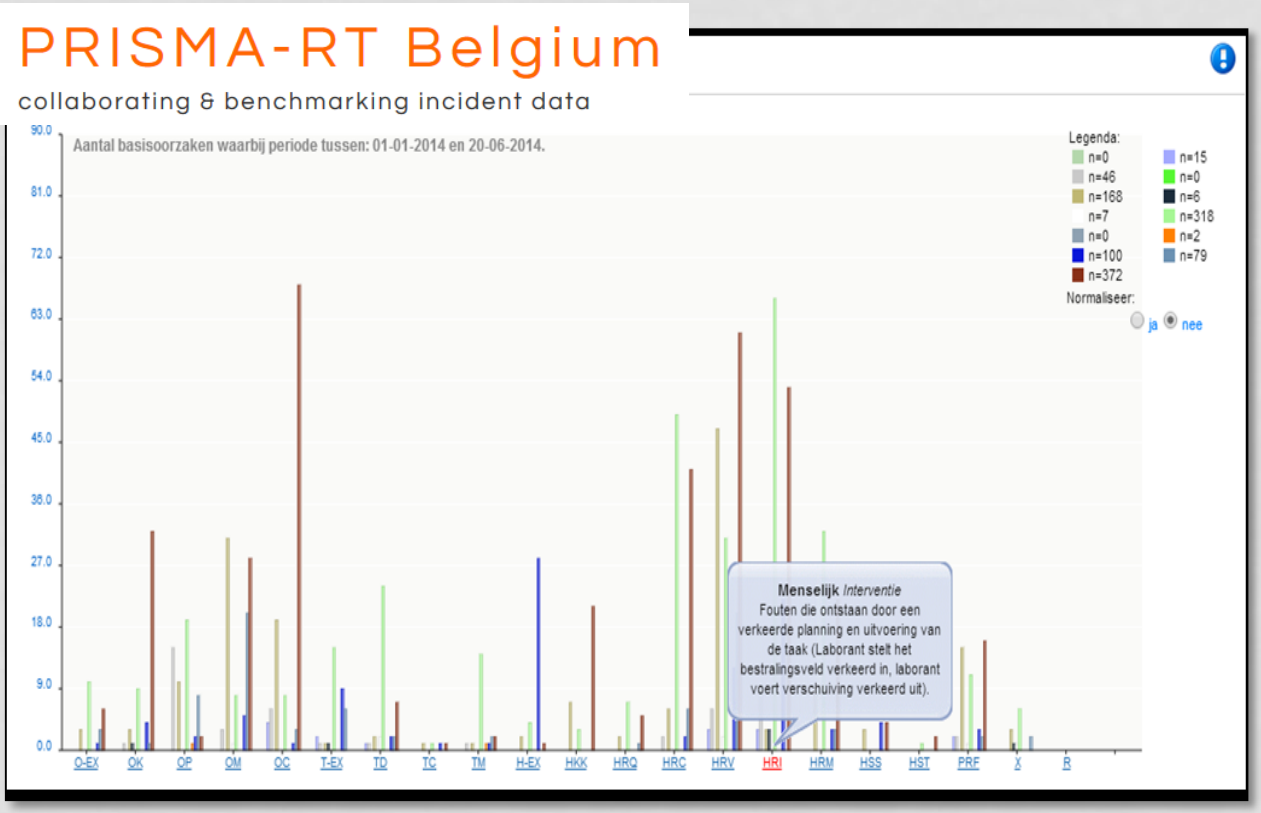
PRISM-RT.be

the patient safety company

adheco

Benchmarking

BENCHMARKING



B*enchmarking system* (=PRISMA-RT Netherlands)

- Sharing of root cause analysis of events, **not** of events themselves
- Importation of:
  - Date of events
  - Root causes classifications
  - Context variables

CHALLENGES

- Establishment of a Board of experts
  - Adaptation of platform to Belgian context
  - Training
  - Golden standard
  - Communication

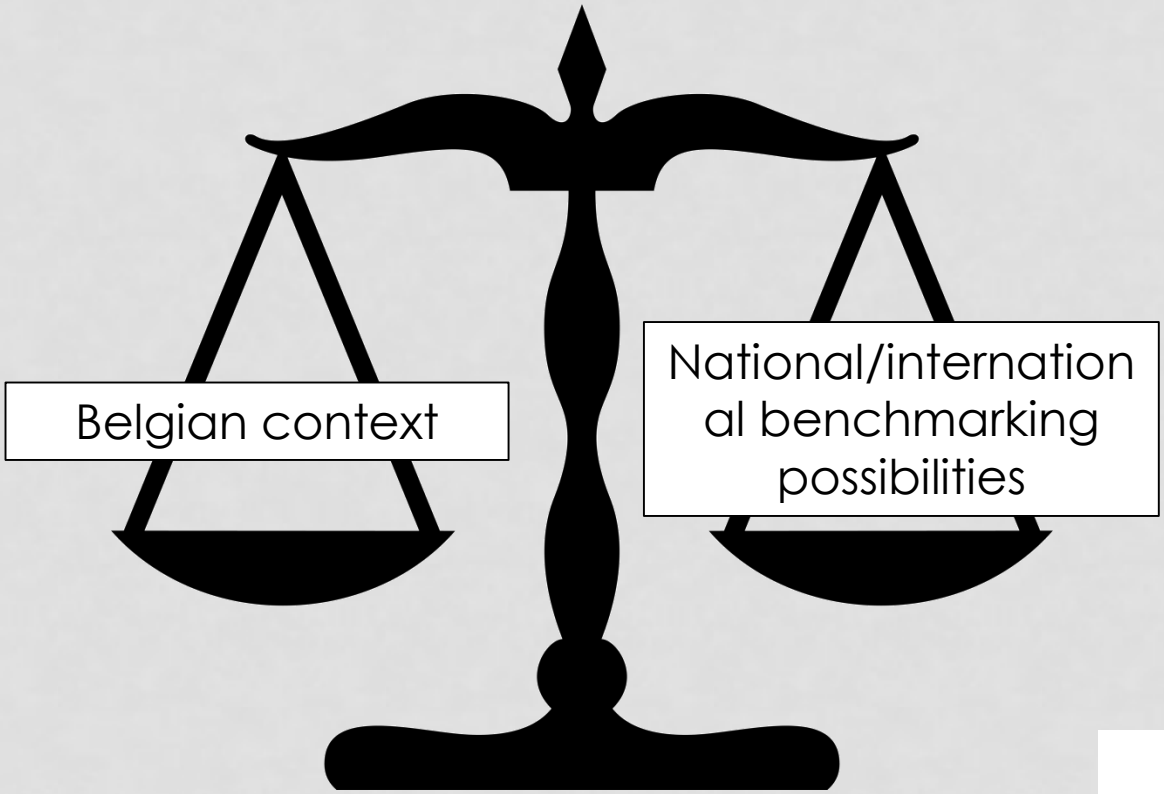
CHALLENGES

- Establishment of a Board of experts
  - Adaptation of platform to Belgian context
  - Training
  - Golden standard
  - Communication

- Conformation to Ministry of Health (FOD/SPF) and hospital requirements
  - Absence of PRISMA-RT organization
  - Pre-existing patient safety initiatives
  - Unwilling to adopt PRISMA-RT web platform
  - Problems with data storage

Courtesy of Frederik Vanhoutte

CHALLENGES


Belgian context
National/international benchmarking possibilities

OPPORTUNITIES TO LEARN

- Exchange of best practice (cfr the Netherlands)
- National initiatives for the improvement of practices/processes
  → International
- Communication with authorities

CONCLUSION

- PRISMA methodology is an quantitative method for analysing and learning from events

- The national implementation of PRISMA-RT in Belgium allows for the establishment of a benchmarking central database

- Benchmarking will allows departments to improve their process on a:
  - Departmental level
  - National level