Who should coordinate, data collection and analysis from a national event reporting system?

- 21% A. NRC
- 14% B. FDA
- 65% C. A new entity with oversight over all medical events
Does your facility track errors (reportable, non reportable and close calls)?

16%  A. Only reportable errors
77%  B. Reportable and non reportable errors
4%   C. Do not track
3%   D. Not sure
If a national event database were to be developed would you report?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>A. Yes, I would report voluntarily and anonymously</td>
</tr>
<tr>
<td>0%</td>
<td>B. No</td>
</tr>
<tr>
<td>10%</td>
<td>C. No, but would report to my state if required</td>
</tr>
</tbody>
</table>
The environment at the radiation treatment console in my facility is:

7%  A. Not prone to distraction, and without need for major change

52%  B. Somewhat prone to distraction that could be easily remedied

41%  C. Significantly prone to distraction not easily remedied
A “time-out” should be required in the delivery process for complex treatments (SBRT, IMRT, SRS, HDR)

72%  A. Yes Definitely in all cases

24%  B. Yes, but only for cases above some complexity threshold

5%  C. No this is over kill
At my facility we perform patient specific quality assurance measurements prior to the patient starting treatment for IMRT

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>83%</td>
<td>A. Always</td>
</tr>
<tr>
<td>13%</td>
<td>B. Most of the time</td>
</tr>
<tr>
<td>4%</td>
<td>C. Sometimes</td>
</tr>
</tbody>
</table>
At my facility we perform patient specific quality assurance measurements prior to a change or treatment for IMRT

74% A. Always
18% B. Most of the time
8% C. Sometimes
At my facility we perform patient specific quality assurance review prior to the patient starting treatment for HDR

| 88% | A. Always |
| 6%  | B. Most of the time |
| 6%  | C. Sometimes |
To reduce catastrophic errors, additional QA steps that are not currently described in documents available from the AAPM, ASTRO or the ACR are required?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. No, everything we need is currently available</td>
<td>4%</td>
</tr>
<tr>
<td>B. No, but the necessary QA information is scattered in too many places to be useful</td>
<td>52%</td>
</tr>
<tr>
<td>C. Yes, the documents available are inadequate or incomplete</td>
<td>43%</td>
</tr>
</tbody>
</table>
Does your facility provide sufficient resources for safety-related testing and training?

10% A. Yes - staffing levels, access to equipment, scheduled time for training are available

60% B. No, staffing levels are inadequate

0% C. No, we don’t have access to equipment

30% D. No, there is no time in the schedule for training
Which of the following would contribute most to a culture of safety?

11% A. Effective safety communication
12% B. Encouraging the reporting of problems
30% C. Personal responsibility and attitudes toward safety
46% D. Leadership demonstrate a commitment to safety.
People in my work group feel free to openly communicate about errors without fear of punishment:

- 59% A. Agree
- 21% B. Neither agree nor disagree
- 19% C. Disagree
Radiation therapists are adequately trained to monitor the computer systems that deliver radiation treatment?

43% A. Yes almost all therapists are fully trained for this

36% B. Maybe 50% of the RTT are fully trained for this

21% C. No most RTT are not fully prepared for this
Is there a limit on how much information radiation therapists can reasonably be expected to verify at each treatment session?

25% A. No, as long as the material is organized and presented clearly it can be managed

75% B. Yes, even with improved computer assistance, there will be a limit beyond which the therapist can not be expected to verify fully.
What is an appropriate frequency and scope of user training to ensure patient safety?

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>85%</td>
<td>A. Annual hands-on review of delivery procedures and failure modes</td>
</tr>
<tr>
<td>11%</td>
<td>B. Annual lectures on safety and failure modes</td>
</tr>
<tr>
<td>3%</td>
<td>C. One time hands – on training at the installation of a new technology</td>
</tr>
<tr>
<td>0%</td>
<td>D. One time class room only training at the installation of a new technology</td>
</tr>
</tbody>
</table>
At my facility, the staff therapists are qualified: registered RTT

- **91%** A. Yes all of them are
- **5%**  B. At least half of them are
- **1%**  C. Less than half
- **3%**  D. I don’t know
At my facility, the medical physicists are qualified: Board Certified

- 49% A. Yes all of them are
- 44% B. At least half of them are
- 6% C. Less than half
- 1% D. I don’t know
Our practice is accredited by ACR or ACRO

37%  A. Yes
56%  B. No
6%   C. I don’t know
When complex modalities are used that require a well-working team (e.g., intensity modulation radiation therapy (IMRT, SBRT, HDR)), how can the competency of the team best be assessed?

- **12%** A. Performance evaluation of each team member individually
- **27%** B. Measurement of team’s outcomes
- **28%** C. Observation of team performance through simulation
- **34%** D. Practice accreditation that includes special credentialing for the procedure
Practice accreditation based on Minimum Practice Standards should be required to improve safety and standardization among radiation therapy practices.

- **86%** A. Yes
- **8%** B. Good idea, but it would be too costly to achieve
- **2%** C. No
- **5%** D. I don’t know
I have a good understanding of the manufacturer technology validation process for FDA 510(k) pre market notification

15% A. Yes I understand it
41% B. I know a little about it
44% C. I have no clue what they do for 510(k)
Is the interoperability between computer systems in radiation oncology a serious problem

2% A. Not at all
37% B. Somewhat
61% C. Very much so