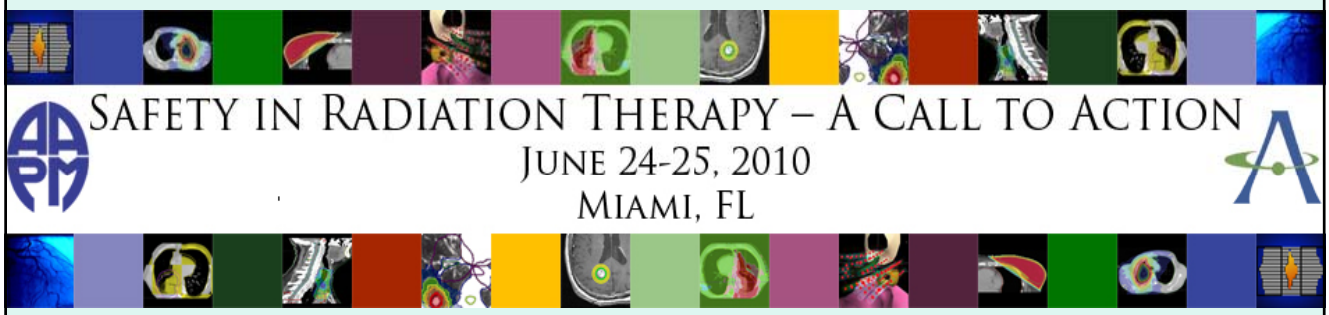
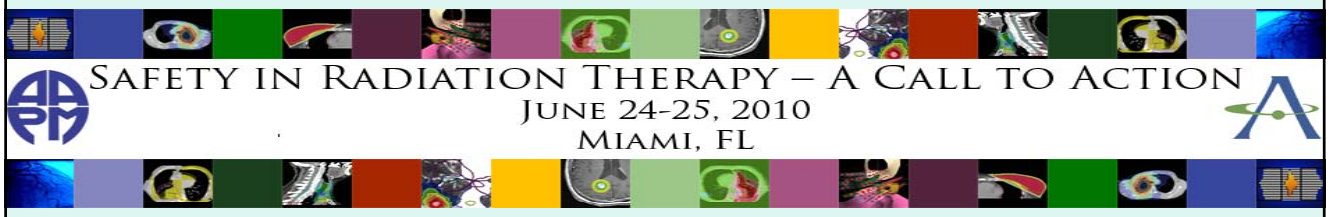


Safety in Radiation Therapy – A Call to Action

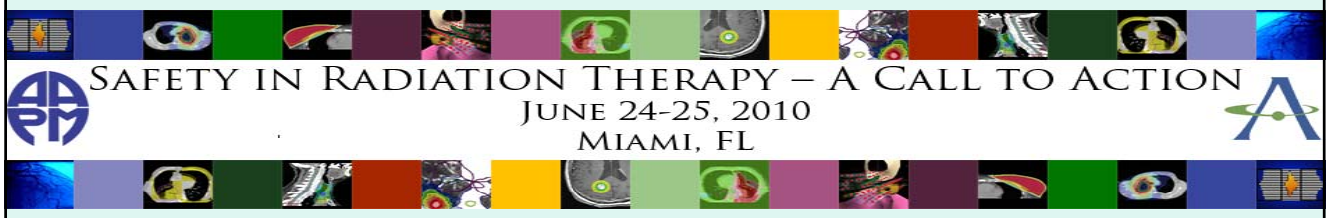
June 24-25, 2010

Miami, FL



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



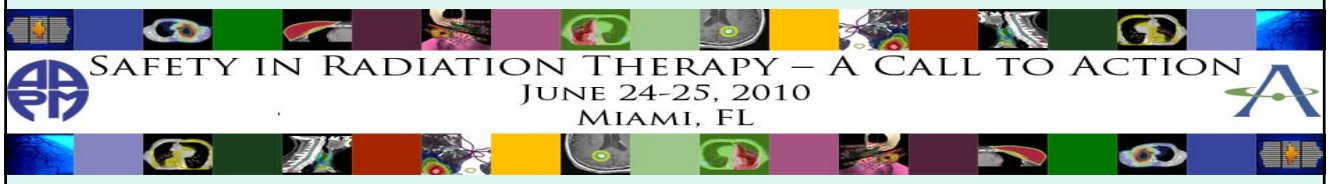
Does your facility track errors (reportable, non reportable and close calls)?

16% A. Only reportable errors

77% B. Reportable and non reportable errors

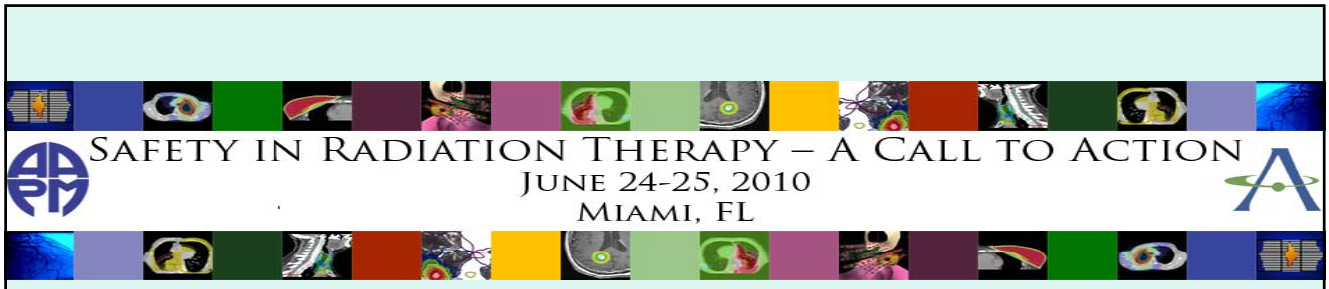
4% C. Do not track

3% D. Not sure



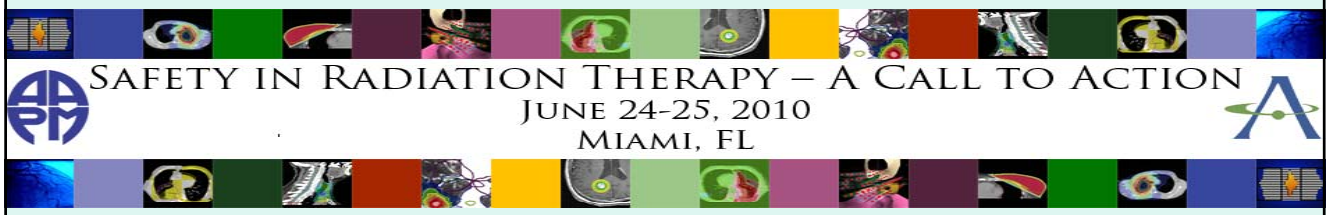
If a national event database were to be developed would you report?

90%	A.	Yes, I would report voluntarily and anonymously
0%	B.	No
10%	C.	No, but would report to my state if required



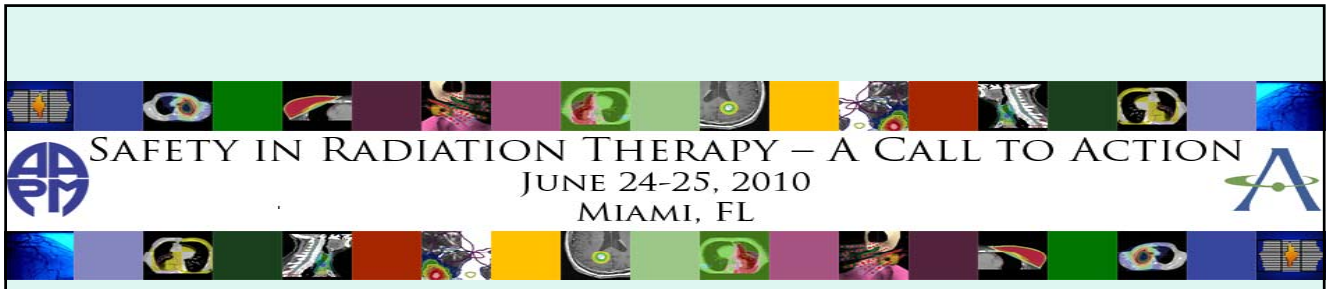
The environment at the radiation treatment console in my facility is:

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



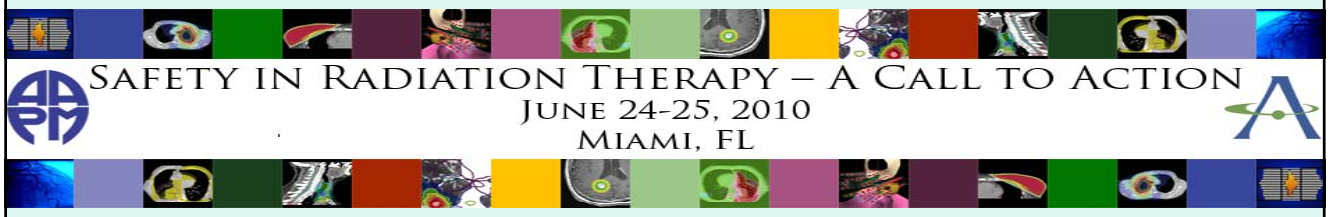
A "time-out" should be required in the delivery process for complex treatments (SBRT, IMRT, SRS, HDR)

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



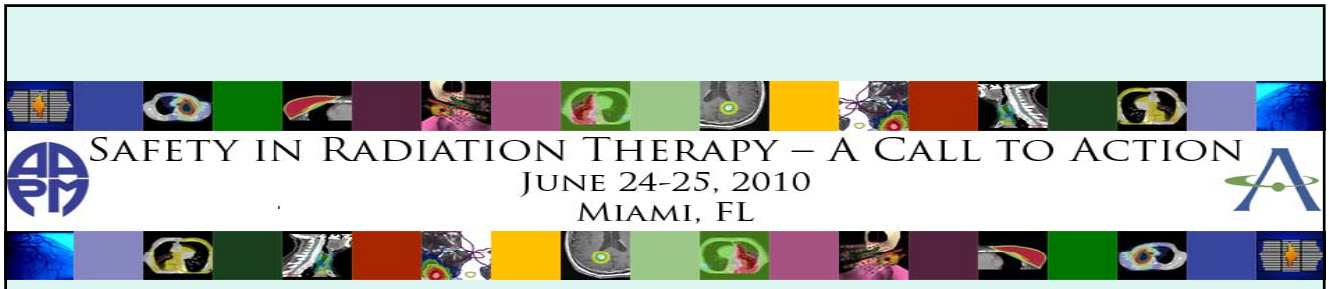
At my facility we perform patient specific quality assurance measurements prior to the patient starting treatment for IMRT

83%	A. Always
13%	B. Most of the time
4%	C. Sometimes



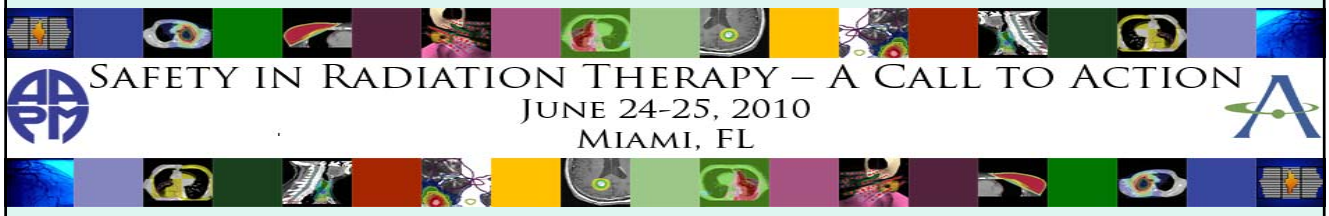
At my facility we perform patient specific quality assurance measurements prior to a change or treatment for IMRT

74%	A. Always
18%	B. Most of the time
8%	C. Sometimes



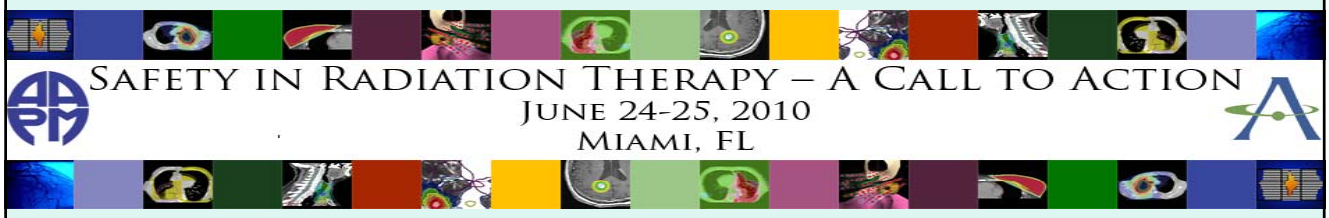
At my facility we perform patient specific quality assurance review prior to the patient starting treatment for HDR

88%	A. Always
6%	B. Most of the time
6%	C. Sometimes



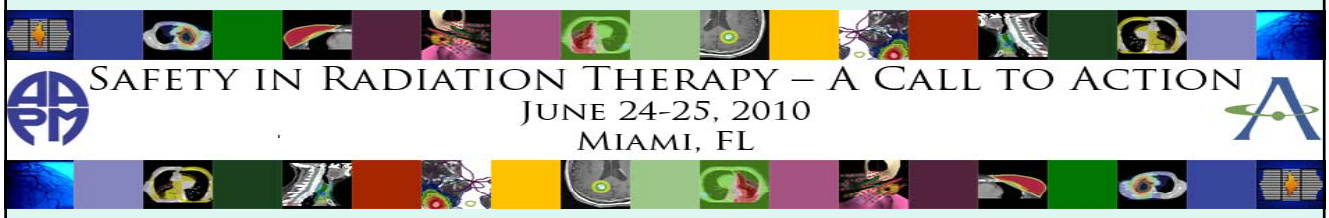
To reduce catastrophic errors, additional QA steps that are not currently described in documents available from the AAPM, ASTRO or the ACR are required?

4%	A. No, everything we need is currently available
52%	B. No, but the necessary QA information is scattered in too many places to be useful
43%	C. Yes, the documents available are inadequate or incomplete



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



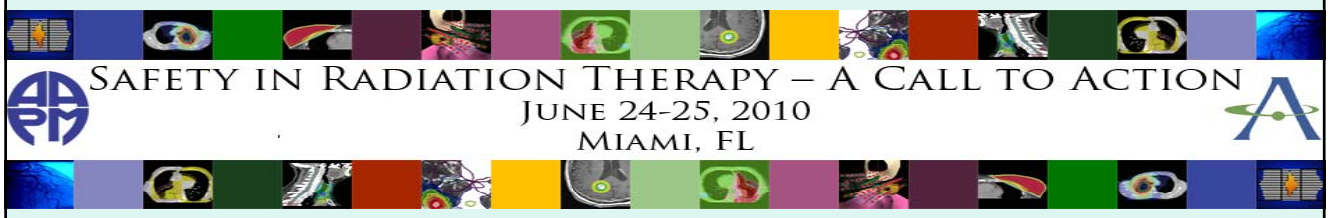
Which of the following would contribute most to a culture of safety?

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.**

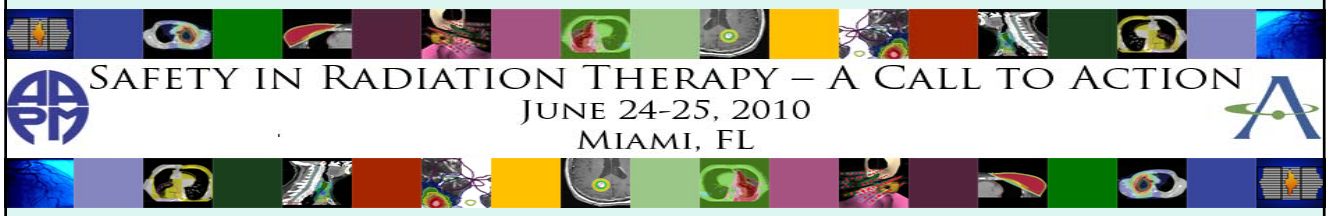


People in my work group feel free to openly communication about errors without fear of punishment:

59% **A. Agree**

21% **B. Neither agree nor disagree**

19% **C. Disagree**

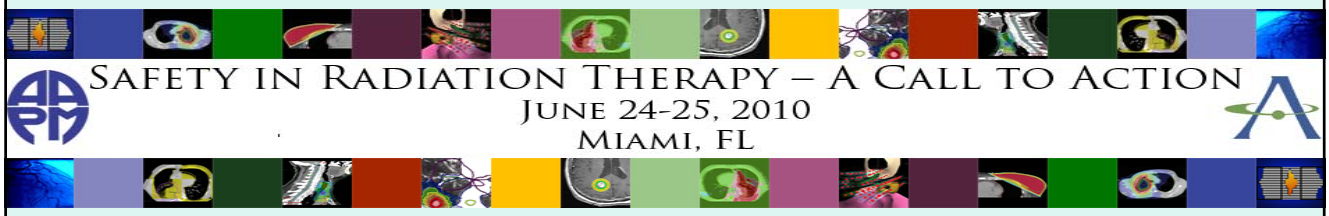


Radiation therapists are adequately trained to monitor the computer systems that deliver radiation treatment?

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

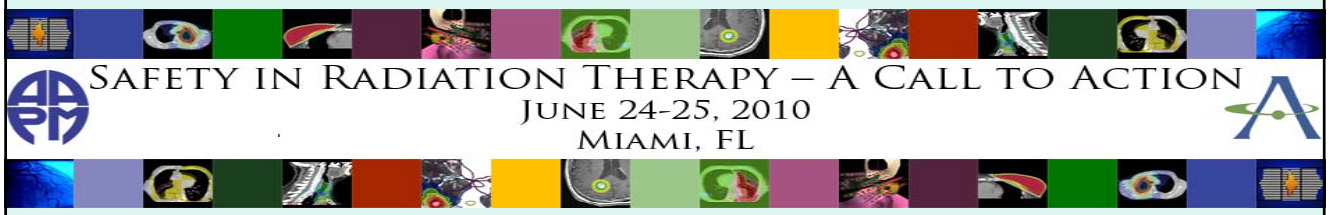
36% B. Maybe 50% of the RTT are fully trained for this

21% C. No most RTT are not fully prepared for this



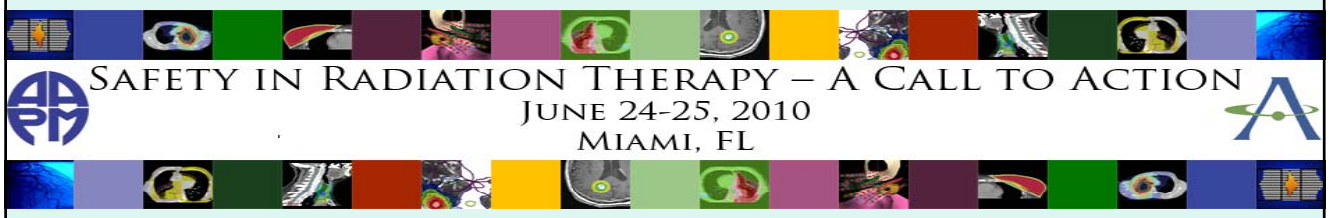
Is there a limit on how much information radiation therapists can reasonably be expected to verify at each treatment session?

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.



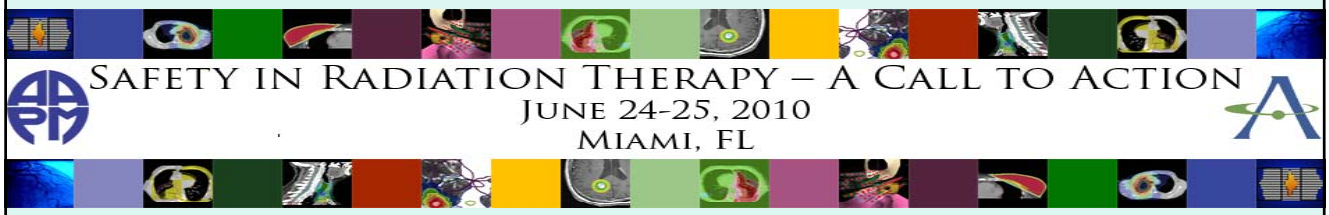
What is an appropriate frequency and scope of user training to ensure patient safety?

85%	A. Annual hands-on review of delivery procedures and failure modes
11%	B. Annual lectures on safety and failure modes
3%	C. One time hands – on training at the installation of a new technology
0%	D. One time class room only training at the installation of a new technology



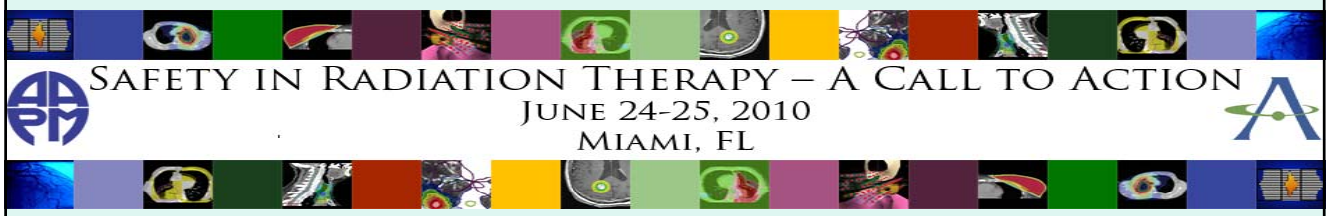
At my facility, the staff therapists are qualified: registered RTT

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



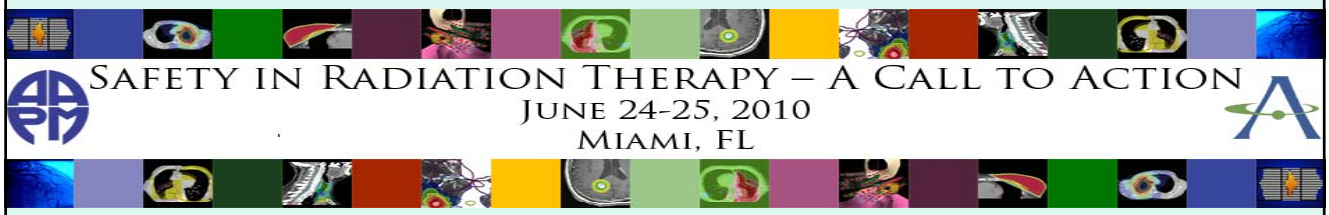
At my facility, the medical physicists are qualified: Board Certified

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



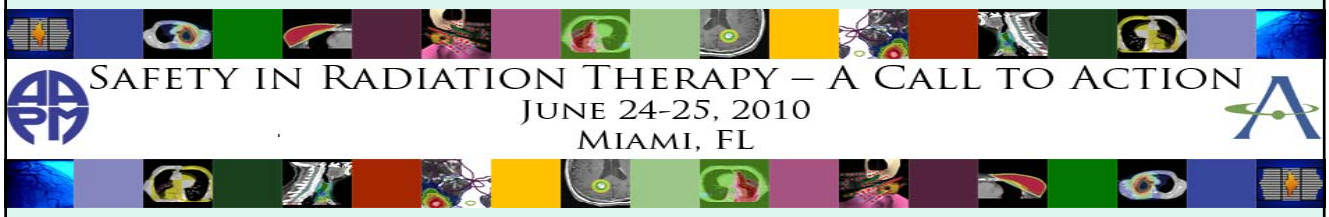
When complex modalities are used that require a well-working team (e.g., intensity modulation radiation therapy (IMRT, SBRT, HDR)), how can the competency of the team best be assessed?

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



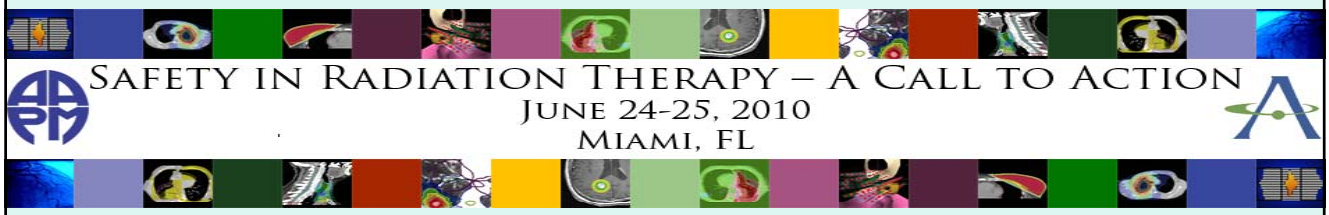
Practice accreditation based on Minimum Practice Standards should be required to improve safety and standardization among radiation therapy practices.

86% A. Yes

8% B. Good idea, but it would be too costly to achieve

2% C. No

5% D. I don't know

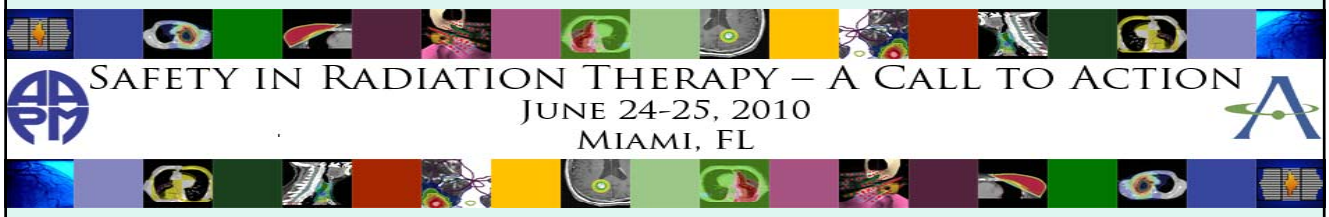


I have a good understanding of the manufacturer technology validation process for FDA 510(k) pre market notification

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