NSIR-RT BULLETIN

Welcome to the electronic bulletin for the National System for Incident Reporting - Radiation Treatment (NSIR-RT). This Bulletin supports continuous learning from incident data through the presentation of data trends and case studies. It will also provide system users with information on program developments and enhancements

Highlights

Reminder: Planned updates to NSIR-RT Minimum Data Set

A scheduled review and update of the NSIR-RT Minimum Data Set will take place soon! If you are a user and have suggestions for changes to the taxonomy, please submit feedback now!

French NSIR-RT to be available in 2020!

If your centre uses a French-language local reporting system, you'll be excited to know that NSIR-RT will be available in French shortly! The system is currently being tested at select centres in Quebec. Contact CIHI for information on how to sign up!

NSIR-RT By The Numbers

Incidents submitted: 4221
Actual incidents: 2632
Near miss: 1242

Severity:
None (2020)
Mild (559)
Moderate (47)
Severe (6)

NSIR-RT Case Study

Second Victim: Supporting staff involved in radiation treatment incidents

The National System for Incident Reporting — Radiation Treatment: Minimum Data Set (MDS) describes the specific data elements used to characterize radiation therapy incidents. Section 6.1 Ameliorating Actions features the coding value "Staff debriefing or counselling". A review of NSIR-RT data can help assess the breadth of the issue and contribute to the understanding of how cancer programs can support staff impacted by adverse events.

What does the NSIR-RT data show?

Of the 4220 incidents in NSIR-RT, 290 included staff debriefing or counselling as an ameliorating action taken after the incident occurred. Descriptions attached to these incidents show a high degree of variability with regards to both incident type and the potential impact on the staff involved. However, there is a notable difference between a simple incident debriefing and counselling. This sparks the question of when each type of response is needed, and what forms they should take.

NSIR-RT Definition

Ameliorating Actions
An action taken, or circumstances altered, to make better or compensate any harm after an incident.
Ameliorating Action – Staff Debriefing or Counselling
An offer of an emotional support, such as spiritual care services, counselling, social work, etc., as needed.

NSIR-RT Advisory Committee

The NSIR-RT Advisory Committee was established in 2017 to oversee the operation and evolution of NSIR-RT to assure that it meets the current and future needs of the Canadian radiation treatment community. Members help monitor system utilization, identify patterns and trends in incident data and support incident reporting, investigation and learning opportunities within Canada and around the world. NSIR-RT Advisory Committee members are:

John Kildea, Chair
McGill University

Erika Brown
Canadian Partnership for Quality Radiotherapy

Louise Bird
Patient Representative

Normand Freniere
CISSS de la Mauricie-et-du-Centre-du-Québec

Alison Giddings
BC Cancer Vancouver Centre

Jordan Hunt
Canadian Institute for Health Information

Eshwar Kumar
New Brunswick Cancer Network

Brian Liszewski
Ontario Health
Cancer Care Ontario

Michael Milosevic
Princess Margaret Cancer Centre

Kathryn Moran
Nova Scotia Cancer Care Program

Spencer Ross
Canadian Institute for Health Information

Christiaan Stevens
Simcoe Muskoka Regional Cancer Program

Because one third of the 290 incidents resulted in at least some harm to the patient (defined as having an overall severity of minor, moderate or severe) it is reasonable to expect that staff involved in the incident may have been adversely impacted as well. In an article recently published on the impact of medical errors on health care providers, Jennifer Robertson suggests that the emotional effects of unintentional errors on providers may include burnout, lack of concentration, poor work performance, posttraumatic stress disorder, depression and even suicidality."[1]

What resources exist?

The Canadian Patient Safety Institute (CPSI) is a not-for-profit organization that exists to raise awareness and propagate safety improvements in health care and has resources available that outline specific steps in the incident reporting process. The Canadian Incident Analysis Framework describes the immediate response phase of the process and recognizes the need to care for and support, not only the patient/family, but also health care providers. "Attending to the safety and well-being of the provider(s) involved and others is also a necessity".[2]

The concepts surrounding health care provider support are further explored in the CPSI Canadian Disclosure Guidelines document. Re-establishing the patient-provider relationship is an important aspect of the healing process following an incident.[3] This is accomplished through effective disclosure and apology. However, this process may be hindered because of a lack of support offered to healthcare providers.[4] Emotional and information support is necessary to ensure the disclosure process can occur smoothly.

Following an incident, sadness, guilt, anger, blame and a lack of support are some of the feelings cited as causes of emotional and physical drain among health care providers.[5]

How can we address this?

Mitigation strategies that organizations can put in place include;

- Access to professional support programs such as employee assistance programs
- Education programs regarding incident analysis and disclosure
- Providing information regarding each incident, including the findings and resolution of the investigation.

Finally, reinforcing the concept of a just culture supports the health care provider and mitigates feelings of guilt and blame.

RT Incident Investigation and Learning Online

Improve Your Incident Analysis Skills in a Few Hours! Did you know that CPQR offers a free, self-guided course in incident investigation, analysis and reporting? Join our expert faculty for a virtual tour of classification systems, root cause analysis and the NSIR-RT. This free course will arm you with tools to implement a consistent and comprehensive approach to incident reporting and investigation locally that aligns with national metrics

When safe care is the core value of an organization there exists a culture of safety. Adding the elements of fairness and support transforms this into a just culture, a balance of responsibility and accountability. [3]

Supporting health care providers following an incident is a key step in the incident reporting and learning process. Equipping staff with the appropriate tools and information for self-care in turn equips them to provide appropriate care to the patient during the time following an incident. Feelings such as, sadness, guilt, anger, blame and a lack of support can be potentially associated with any type of incident and therefore a robust support program should be a resource made available to health care providers in any scenario. Centres are encouraged to study the references below and to ensure that employee assistance programs are brought to the attention of all personnel involved in patient care.

Case Study References

1. Robertson, JJ, Long B. Suffering in Silence: Medical Error and its Impact on Health Care Providers. Journal of Emergency Medicine, 2018; 54(4):402-409.

2. The Incident Analysis Working Group. Canadian Incident Analysis Framework. Edmonton, AB: Canadian Patient Safety Institute; 2012 Available from: https://www.patientsafetyinstitute.ca/en/toolsResources/IncidentAnalysis/Pages/incidentanalysis.aspx

3. Disclosure Working Group. Canadian Disclosure Guidelines: Being open with patients and families. Edmonton, AB: Canadian Patient Safety Institute; 2011.Available from: https://www.patientsafetyinstitute.ca/en/toolsResources/disclosure/Pages/default.aspx

4. Gallagher, TH, Waterman, AD, Ebers, AG, Fraser, VJ, Levinson,W. Patients' and physicians' attitudes regarding the disclosure of medical errors. JAMA. 2003; 289(8):1001-7.

5. American Society of Healthcare Risk Management. Disclosure: What works now and what can work even better. Journal of Healthcare Risk Management, 2004; 24(1):19-26.