COURSE REVIEW

ROSIS (Radiation Oncology Safety Information System)

by Chin Loon Ong

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Before arriving in Dublin, I prepared my three wishes in case I could capture a leprechaun. In the city full of lively bars and local beer breweries, I thought that I might tip over this magical creature and a pint of Guinness beer would accidentally fall into my hand. Yes, accident, not all of them are bad! Unfortunately, in radiation treatment, most of our accidents are bad, worse still, they can lead to very serious consequences.

With the expectation of learning all the practical skills related to patient safety in radiation oncology, I arrived on Monday morning at the Trinity College Discipline of Radiation Therapy, School of Medicine at St James Hospital. The course started with the concept of risk and risk management. There is no better way to realise the impact of radiotherapy incidents than by looking back at their history. Not only did the speakers provide brief information on each incident, they also offered different perspectives to consider. One speaker presented a major incident happening in her own institute, providing a great overview of the cause of the incident and how it was discovered, and the management and communication of the incident with the patients, employees and press. For the group exercise, one incident involving a single patient was discussed in detail and each group was assigned to do a root-cause analysis. Doing such an exercise with participants from different international backgrounds offered me a very different insight, which triggered me to think outside the box.

In the next few days, different aspects related to patient safety and incidents were dealt with, such as communication, human factors and organisational cultures. A variety of reporting systems employed by different institutes were also presented. Furthermore, the speakers also introduced different methods to analyse an incident, together with the practical skill set needed. The importance of reporting and learning to improve safety was also highlighted. The interactive sessions were most certainly the highlight of this course. The exercise on Safety Profile Assessment generated a lot of discussion, which provided us with an idea of where each profession stands when it comes to safety issues and awareness in different institutes. A role-playing session had us stepping into the shoes of different parties and viewed a particular incident in a very comprehensive manner.

The Celtic night social evening was a great Irish experience. Traditional Irish songs and dances with the local cuisines and beers could never go wrong. As part of the show, a colleague volunteered to dance on stage with a professional Irish dancer. Luckily, she did do a prospective Failure Mode and Effects Analysis, so that a high speed turning dance move only led her to a near-miss (light-headedness) instead of a real incident (falling off the stage).

Very often, treatment safety has been taken for granted. With the implementation of all the sophisticated technologies, we assumed that all ▼

treatments should go as planned. This course and the history of Dublin city have taught me three important principles regarding patient safety. First, always plan ahead or else you will end up having the millennium spire completed three year after the new millennium. Secondly, ignoring all unsafe acts and (near-miss) incidents would be like having the coach house blocking out the view of slum from the castle. Finally, always get to the root of an incident even if you have to go to the Vatican to find out who Father Pat Noise is. Even though I left the city with my initial three wishes ungranted, and not having found any spell book in the library of Hogwarts, I did pick up some very useful practical skills, and better yet, I am more self-aware now when it comes to patient safety issues.

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