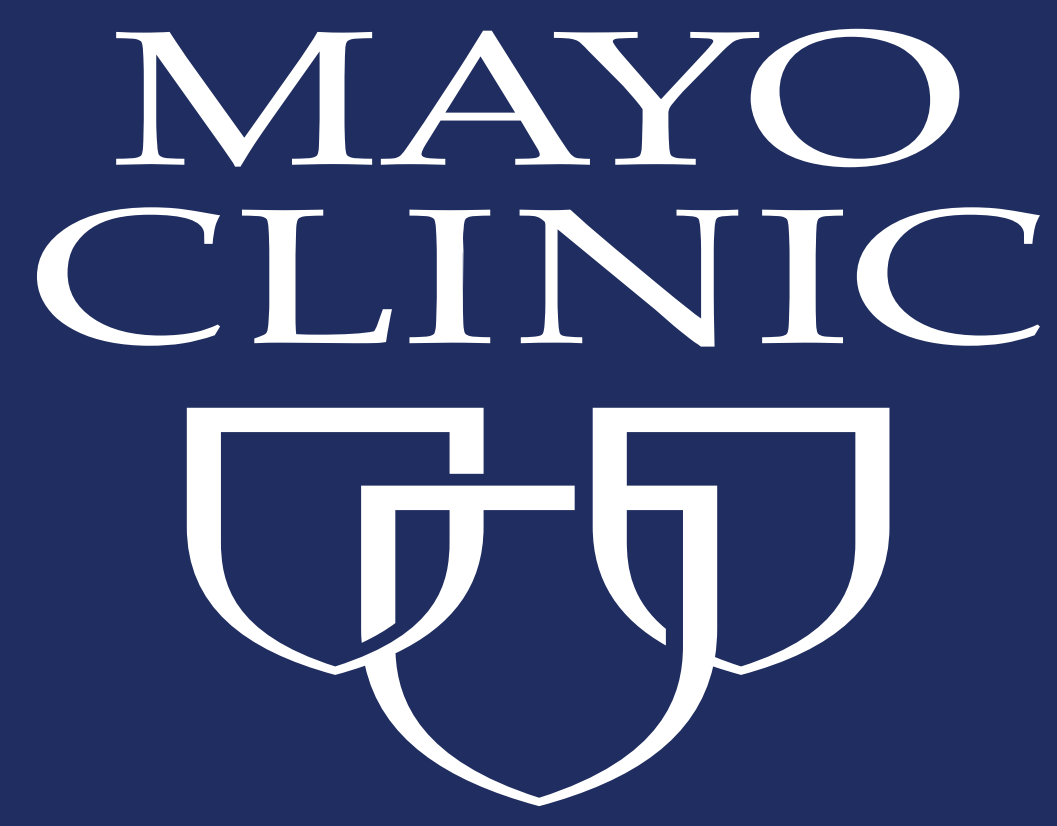




SAIL It! – Implementing a Safety, Improvement, and Learning System

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Background

Purpose: Ensuring patient safety and high quality care is vital to all healthcare organizations. Due to the complexity of Radiation Oncology treatment, there is high potential for harm. An evidence-based safety and quality improvement learning system is necessary to ensure high quality, safe patient care.

Quality = Safety, Service, Outcomes and Satisfaction

Opportunities to improve quality:

- Patient treatment delays
- Communication/handoff gaps
- Scheduling issues
- Missing or incomplete documentation
- Rework

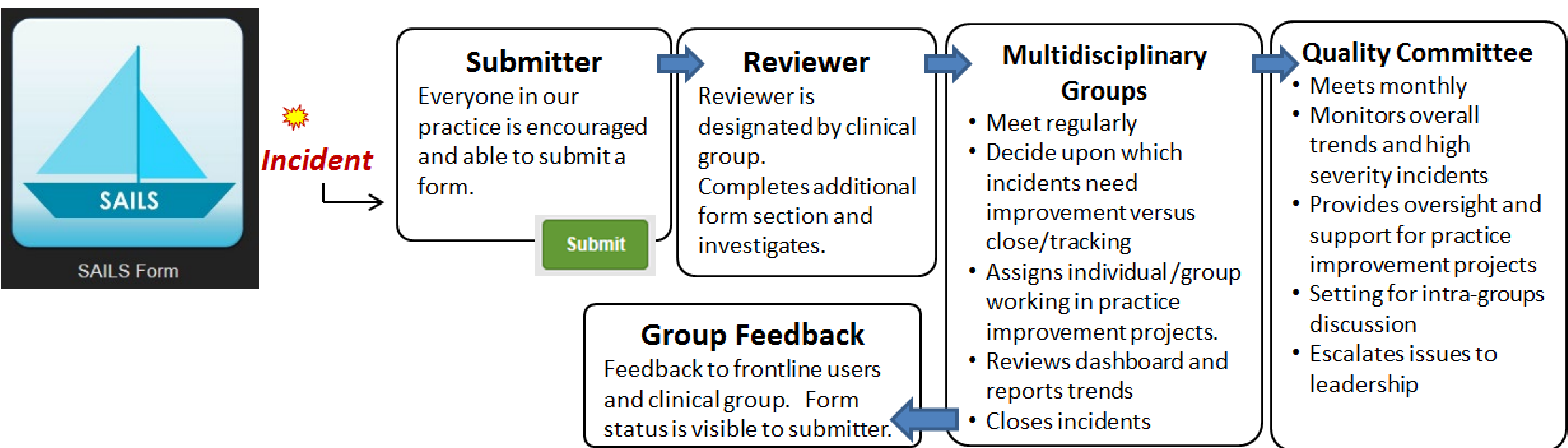
Goal: To successfully implement an electronic evidence-based safety and quality improvement system (measured by the number of quality related process improvements from staff reported incidents). Current state is challenging to quantify because there is a lack of documented improvements that resulted from reported incidents. Two documented improvements were compiled for 2018. The goal is to achieve one documented improvement per month.

Background: Radiation Oncology at Mayo Clinic Rochester provides care to > 6,000 patients each year utilizing Proton, Photon, Brachy, IORT and Gamma Knife technologies. The department has > 300 employees and it can be challenging to manage opportunities across multiple locations and technologies.

Methodology

- 1. Form the team:** Representation from each discipline formed a project team. The team was led by a Physicist and Operations Manager.
- 2. Gather feedback:** A staff survey was utilized to summarize current system issues into these key themes: lack of system, nothing is done with the submission, time to report, uncertainty about what should be reported, lack of communication, varying processes for reporting and follow up, lack of documented improvements.
- 3. Develop the system:** System includes an electronic submission form, a triaging process, and a review process for guiding improvement projects (Figure 1).
- 4. Education/Communication:** Training materials were shared with staff and stored on the department webpage to ensure users are informed about what and how to report.
- 5. Change management:**
 - *Awareness:* Communicated the purpose/why in workgroup meetings, department newsletter and via webpage.
 - *Desire:* Shared the “What’s In It For Me” including: positive impact on the practice, ability to prevent issues from re-occurring and improving patient experience/safety.
 - *Knowledge:* Developed “How To” documents, documenting the process flow, and workgroup leaders provided verbal education to staff.
 - *Ability:* Workgroups tested using the system and provided feedback. System usage is monitored
 - *Reinforcement:* Display status of the report and what changes are made as a result (transparency and action for the incident reporter). Submission data and implemented changes are highlighted in dashboards, reports, and stories are shared through newsletter and group meetings.

Figure 1: Safety, Improvement, and Learning System (SAILS)



Results

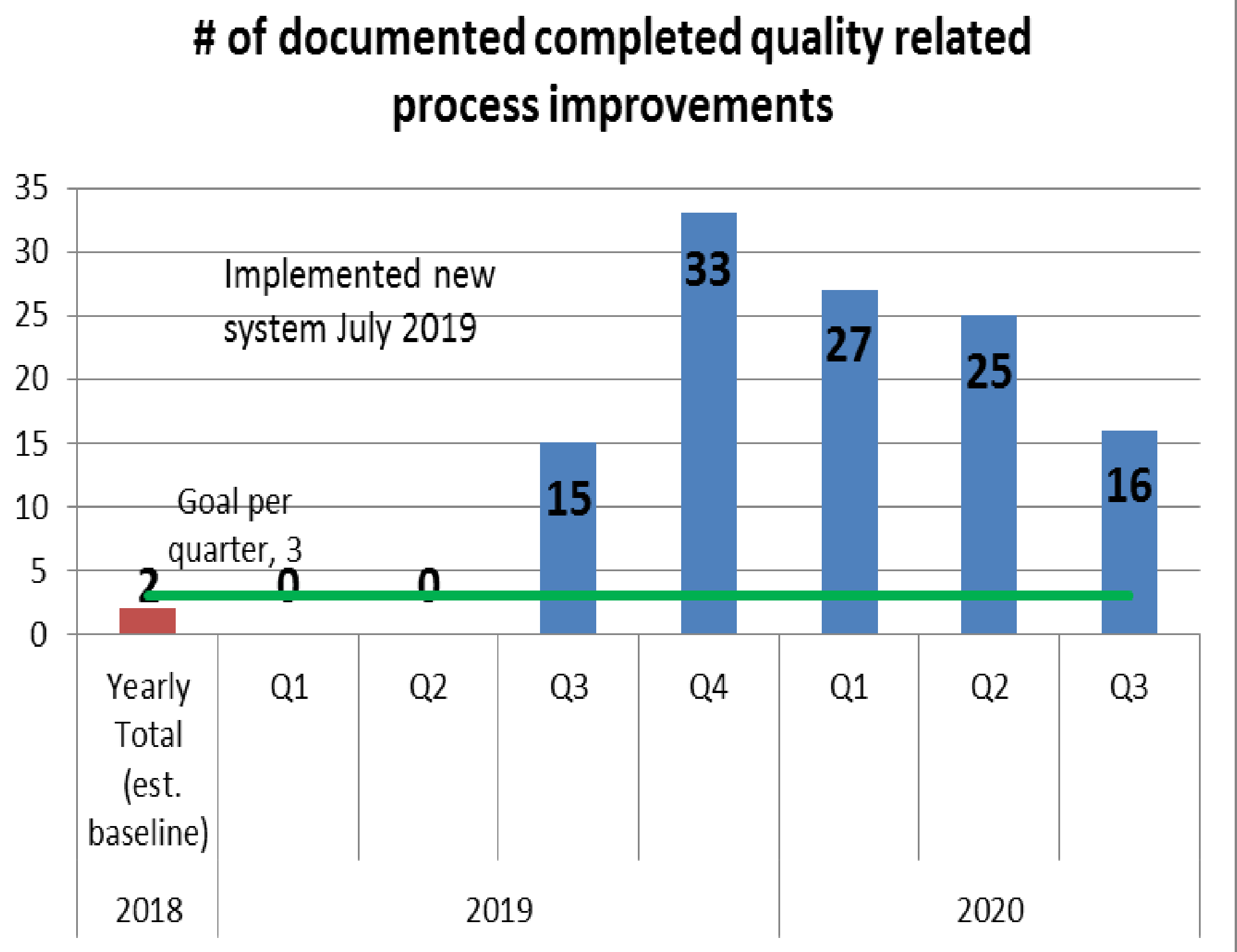
The goal of one documented quality related process improvements completed each month has been exceeded since July 2019 implementation (Figure 2).

Nearly 100 SAILS forms are submitted each month.

Examples of process improvements:

- Updated treatment and simulation protocols and care paths
- Improved scheduling rules
- Enhanced communication pathways
- Created clinic escalation protocols to reduce patient delays

Figure 2: Documented Improvements



Sustainment

- Process improvements are monitored monthly by the Quality Committee to ensure the goal is sustained.
- Additional dashboards and reports monitor the number of submissions and staff submitting quality related incidents to identify trends.
- Quality Committee ensures the department is aware of changes that have been made as a result of reporting.

Lessons Learned

- Engage the entire multidisciplinary team in build and design.
- Think big but start small – test the processes on a small group or reporting type to learn and adjust before impacting the entire department.
- Develop robust feedback loop to frontline staff to demonstrate value and reinforce reporting.
- Identify operational team to maintain and monitor the system.

Acknowledgement

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