

**Information Notice Number 28  
(April 2004)**

**For Florida Radiation Machine Registrants**

**Department of Health, Bureau of Radiation Control**

**QUALITY MANAGEMENT REVIEW FOR RADIATION THERAPY**

There have been an unusually large number of medical events that have common contributing factors. In the interest of improving the Quality Management Program (QMP) at your facility the operating and safety procedures should be reviewed and appropriate changes made.

I. The most critical issue is the failure for the two (sometimes three) therapists to do appropriate crosschecks during the treatment of patients. A crosscheck or double check occurs when an assigned therapist completes a task and another therapist reviews the task to ensure accuracy. The recommendation of having two therapists assigned to a machine is for ensuring quality care. In order to deliver treatments in the scheduled 10-15 minute time slots, the therapists have divided their duties to increase patient flow and often are not making a thorough crosscheck. In some cases the person charting is not recording the MU's delivered, as indicated on the control panel, but transcribing what was on the top of the chart, which differed from the delivered dose.

Crosschecks should occur to verify the:

- Setup of the patient on the treatment couch.
  - Whenever possible a second therapist should verify the setup.
  - Comparison made to the setup pictures available on the RAV system in the room or,
  - Comparison made to the setup pictures available in the Tx chart taken into the room.
- Selection of treatment files at the control panel.
  - File selected at the control is displayed on the RAV system in the room or,
  - The chart is brought out of the room after setup to the controls for comparison.
- Recording the information in the chart.
  - The therapist recording in the chart should verify that the dose, energy and beam modifiers are the same on the control panel as is recorded in the chart.
  - This same information should be compared to the prescription each day of treatment.

II. The second issue is failure to identify the patient by two methods prior to treatment. This failure can be prevented by:

- Establishing written procedures that document which two methods are to be used to identify the patient, preferably a current picture ID.
- Clarifying what method(s) if any, are acceptable as alternatives if one of the primary methods is not available.
- Greeting patients with their full names and using a more familiar tone only after identification is verified. Patient friendly greetings such as "Hello Mr. B." or "How are you today, sweetie?", have directly contributed to errors.

**III.** Digital pictures are available on IMPAC and other RAV systems in the treatment room, but in many cases has not been implemented to the fullest extent available. This technology would aid in both of these issues if:

- Patient identification could be made in the treatment room.
  - By comparing the patient to the displayed picture assigned to the treatment file.
  - This has the additional benefit of assuring that the correct patient file is selected since the same information is displayed in the room and at the treatment console.
- Verify the setup of the patient.
  - By using the digital photographs linked to the treatment file and displayed in the room.
  - After the setup of the patient and before the insertion of wedges, the shape and position of the light-field on the patient should be compared to the setup pictures.

**IV.** If the pictures are not available in the treatment room, then the chart should be taken into the room for the purpose of patient ID and verification of the treatment setup with the setup pictures in the chart. This will help eliminate errors caused by trying to remember the name, the patient picture and the setup instructions and pictures.

The bureau recommends that each facility reviews their procedures and clarifies which two specific methods are to be used to identify the patient and what to do if one of these methods is not available. Each facility should have written procedures requiring and defining crosscheck to be made at each of the key areas of: setup, selection of treatment files, and recording of dose in the chart.

In addition, these procedures should be covered as part of a documented orientation program and included in the in-service training routinely provided.

If you have questions or need guidance, please contact this office at:

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