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Feedback letter [March 2009](#)

This Newsletter – ROSIS in the Scientific Literature

Reminder: The fifth ROSIS short course “**Working towards safer healthcare delivery: minimising the impact of incidents in radiotherapy**” will be held from 11th-14th [May 2009](#). Places are limited, please see www.rosis.info for further information, or contact one of the ROSIS group.

Dear ROSIS Contact,

It has been a while since our last Newsletter, but that’s not to say we haven’t been busy in the meantime!

We have been finalising the details and technical aspects of our new website and reporting system. As with most IT projects, this has taken longer than we hoped, but it will be live and online this summer. The ROSIS group led an FP7 funding proposal last December under the third call of the Cooperation, Health programme: Area 3.1.2 – Improve the quality and safety of hospital care. We await the outcome of this later this year.

In this newsletter, we would like to highlight the growing number of publications which have analysed ROSIS reports or draw attention to the potential impact of ROSIS. This is a commendable achievement on the part of the ROSIS Clinics, and we would like to extend our congratulations to all those Clinics who have contributed to the system, sharing their experience with others, adding to the knowledge in this area, and improving the safety of radiation therapy.

Remember that you can search the full ROSIS database at <http://www.rosis.info>

Keep the database alive and report your incidents! Reporting is confidential in relation to clinic. If you have forgotten your password, please contact ola@eircom.net

Best regards from the ROSIS group:

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If you do not wish to receive further emails from ROSIS, please state so in a reply to this message, and you will be removed from this mailing list.

If you have not received this message directly from ROSIS but would like to be added to our mailing list, please contact us at snichuin@tcd.ie .

Over the past years, ROSIS reports have been analysed and used in the literature to learn from past mistakes, or the system has been used as an example of a radiotherapy reporting system. Some of these publications are presented below:

2009

- ICRP: Preventing accidental exposures from new external beam radiation therapy technologies - Draft 8

A Task Group of the International Commission of Radiological Protection has drafted a report on new technologies in radiotherapy and the impact of these on safety in radiotherapy. A number of recommendations are given on how to achieve safer treatment of patients. As a basis for these recommendations, among other items, a number of ROSIS reports are highlighted and referred to. In the main text, reports submitted to ROSIS related to virtual simulation and intra-operative radiotherapy are used to exemplify potential pitfalls with these technologies. In the Appendix, there are many more ROSIS reports exemplifying safety issues involving e.g. record and verify systems, soft wedges, multileaf collimators, computerized treatment planning system tools, imaging for treatment planning and virtual simulation. The draft report is posted on the ICRP website for public consultation until 24 April 2009:

http://www.icrp.org/docs/Accidental_exposure_new_RT_techniques.pdf

- WHO: Radiotherapy Risk Profile – Technical Manual

A risk profile for radiotherapy was developed by the World Health Organisation World Alliance for Patient Safety where an assessment of the extent of harm caused by radiotherapy internationally has been made. When performing an evidence-based review of current practice, ROSIS was utilized as a “major source (N=854) of the recent incidents”. The full report is available online:

http://www.who.int/patientsafety/activities/technical/radiotherapy_risk_profile.pdf

2008

- The Royal College of Radiologists. Towards Safer Radiotherapy. The Royal College of Radiologists, BCFO(08)1. London. 2008.

A multidisciplinary working party, consisting of several organizations in the UK, was set up by the RCR to review safety in radiotherapy and make recommendations to make the treatment safer. ROSIS is mentioned in this report as an example of a “current voluntary reporting system in the UK”. The full report is available online:

https://www.rcr.ac.uk/docs/oncology/pdf/Towards_saferRT_final.pdf

ROSI is also in the references of the scientific publications below:

2007

- Williams, MV. Improving patient safety in radiotherapy by learning from near misses, incidents and errors. British Journal of Radiology 2007;80:297-301.
- Williams, MV. Radiotherapy near misses, incidents and errors: Radiotherapy incident at Glasgow. Clinical Oncology 2007;19:1-3.

2006

- Ekaette, EU, Lee, RC, Cooke, DL, Kelly, KL, Dunscombe, PB. Risk analysis in radiation treatment: Application of a new taxonomic structure. Radiotherapy and Oncology 2006;80:282-287.
- Tylko, K, Blennerhassett, M. How the NHS could better protect the safety of radiotherapy patients. Health Care Risk Rep 2006;12:18-19.

Future ROSIS Developments:

A limitation of the current system (and others) is that the analysis is limited due to the nature and extent of information collected. The next generation of ROSIS has been designed to capture more specific information, yielding a much greater capability for analysis, and more valuable and useful lessons for patient safety in Radiation Therapy.

ROSI will be provided in languages other than English. If anyone would like to contribute to this by doing a once-off translation of the department and report forms, please contact a member of the ROSIS group.
