Statens strålskyddsinstitut
Swedish Radiation Protection Authority

Sven.Richter@.ssi.se

Gunilla.Hellström@.ssi.se

ERRARE HUMANUM EST

It Is Inhuman Not To Make Mistakes

Sven Richter and Gunilla Hellström

Swedish Radiation Protection Authority

Not many errors or mistakes are reported per hospital in Sweden. With a little more than 9 million inhabitants on a large area it is difficult for the local hospital to have an overview of what errors and mistakes are common and of general interest. It is also diffucult to make compilations from error statistics since error reporting is scarse. People tend not to report and sometimes are not aware of what authority they should report to.

Improving Safety Culture

You can learn a lot from your own mistakes as well as from others. In the all time ongoing work to improve the radiation protection (safety) culture and reach optimized protection, ALARA, the feedback to the healthcare sector from experiences is a most important tool.

Policy

The Swedish Radiation Protection Authority (SSI) has a policy for error reporting and feedback for everyone involved in radiation procedures at medical institutions.

Every documented error or mistake which has or could have led to an unexpected irradiation of a patient, unborn child, employee or third party person should be reported to SSI.

Requirements

According to the Swedish regulations the license holders must report all accidents and important incidents regarding radiation to SSI. The report should include:

•Description of the incident
•Measures taken
•Analysis of incident
•Doses to irradiated persons

Reports from hospitals

Between the year 2000 and 2004 only 32 incidents, six per year, were reported to SSI. Late 2004 hospitals were encouraged to report everything that they documented. In 2005 the number of reports increased to 27. The incidents were evenly distributed between x-ray diagnostics, nuclear medicine and radiotherapy. Approximately 50% of reported incidents were considered as personal errors.

Actions

To be able to fulfil the ALARA-principle it is important that all medical institutions learn from these reports, and SSI pursues several paths in this regard:

- SSI has a database of reported mistakes to promote simplified analysis
- SSI puts interesting cases on its website
- SSI continuously informs of mistakes at meetings and conferences
- Checking local error management routines is an important part of our inspections.

In order to improve awareness the three authorities involved have agreed on a unified approach and cooperation.

Proposal

To further improve on error analysis a unified European system for error reporting and feedback would be of importance.

The Swedish Radiation Protektion Authority (SSI) has the task of protecting people and the environment from the harmfull effects of radiation. SSI decides the dose limits for the general public and for workers exposed to radiation and also issues regulations which, through inspections, it ensures are being followed. SSI is also responsible for co-ordinating activities in Sweden should an accident occur involving radiation.

The responsibilities for the supervision of medical devices is divided between Medical Products Agency (MPA) and National Board of Health and Welfare (SoS). The supervision of manufacturers and products is a responsibility for MPA . SoS continuously supervise the professional use in health care.

“Lex Maria”, the Swedish system for reporting medical errors was introduced in 1937.