Conclusions: Patient waiting times and unit occupation are of great importance. Those incidents were classified and reviewed by a team and accessory identification. We received 2 incidents reported for the three months:

- Linac 1: on average 13.5 (8/70) minutes (special techniques have been considered);
- Linac 2: on average 19.5 (8/35) minutes;
- Linac 3: on average 40 (18/65) minutes.

We also observed that although patients weren't pleased with the length of time they waited for treatment, they are pleased with the information given by the staff about the reasons they waited so long. Treatment unit occupation times were monitored in a spreadsheet and reported every day. A survey was conducted in order to identify patient waiting times; identify treatment unit occupation and guarantee patient safety and its accessories’ identification.

Purpose: Medical errors can be classified into five categories: poor decision making, poor communication, inadequate patient monitoring, patient misidentification, inability to respond rapidly and poor patient tracking. Employing information technologies in correcting these deficiencies is the current trend in enhancing patient safety. Radio frequency (RF) identification is one option that has significant potential to secure the medical supply chain and improve the safety and efficiency of healthcare processes. It is our purpose to identify patient waiting times; identify treatment unit occupation and guarantee patient safety and its accessories’ identification.

Materials: Patient waiting times were observed during a two-week period in the department. Treatment unit occupation was recorded for a group of 50 patients who were treated daily. Patient and accessory identification was recorded for 2 incidents reported for the three-month period.

Results: Patient waiting times were observed in average 40 (18/65) minutes. Although patients didn’t please with the length of time they waited for treatment, they were pleased with the information given by the staff about the reasons they waited so long. Treatment unit occupation times were recorded. During the period, the department needed to be identified.

Conclusions: The patient safety chart was evaluated by patients as informative. After using the safety charts, scores remained the same; the feeling of being unsafe did not increase when confronted with potential risks. All consented willingly to participate and agreed that safety is partly their own responsibility. Discussions between clinical and non-clinical professionals revealed that patient safety is the responsibility of the whole team.

Purpose: Safety has become a main issue in health care, and more specifically, in the hospital environment. A number of different measures have taken place in daily hospital practice. It is impossible to imagine hospital life to-day without Plan-Do-Check-Act cycle, the safety management system, Risk Inventory and evaluation and projects such as “A Faster Recovery”. But, after careful consideration, are hospitals really as unsafe as all that? International research shows that about 10% of clinical patients experience an adverse event during their stay in hospital, i.e. a non-disease related trauma. 50% of these adverse events could have been prevented by standard care (Vincent, Graham & Woolsey, 2001). The Department of Radiology Oncology at the Leiden University Medical Centre has examined the vulnerabilities contributing to safety in treatment. This investigation has resulted in a patient safety chart stimulating patients to play an active part in improving treatment safety in any given department of Radiation Oncology.

Materials: The baseline part of the study aims at the experience of safety seen from the patient’s perspective (feeling of safety and safety behaviour). Questionnaires were distributed before and after the introduction of the patient safety chart. The second part aims at the feasibility and efficacy of the patient safety chart. Also as an additional aspect we are interested in the environment of patient safety has been discussed. Health professionals need to be fully informed about the conditions of patient participation to turn it into a success. To map out these conditions for patient participation the present study was initiated.

Results: Results from both parts of the study will be presented, as well as several quotes from the discussion. At the baseline score, patients (n=65) did not feel unsafe. On average, they scored high on the safety questions (ratings 4 out of 5). After using the safety charts, scores remained the same; the feeling of being unsafe did not increase when confronted with potential risks. All consented willingly to participate and agreed that safety is partly their own responsibility. Discussions between technologists revealed an unexpected resistance towards patient participation; mostly because it was felt that patient safety was the responsibility of the professional.

Conclusions: The patient safety chart was evaluated by patients as informative: after reading the chart, they were aware of their possible contribution to safety in their own treatment. They advised implementing a patient safety chart needs to be introduced causally, as some of the aspects seem to conflict with professional autonomy. To develop an appropriate model on professional attitude towards responsibilities we will examine the attitude factors in patient participation.

Purpose: The objective of this paper is to present the practical approach to the development, maintenance and improvement of the Integrated Management System in radiation oncology in Greater Poland Cancer Centre. The objective of this paper is to present the practical approach to the development, maintenance and improvement of the Integrated Management System (IMS) in radiation oncology in Greater Poland Cancer Centre.

Materials: Integrated Management System (IMS) includes Quality and Health and Safety Management Systems based on ISO norm 9001 and national guidelines PN-N 18001. Any legal requirements the organization has to comply with or any initiatives the organization is participating in are used to establish IMS. The compliance of the organization’s management system with national and international standards has been verified by an internal auditing process and on-site visits since 2001. Audits’ outcome, non-conformances reports and health and safety protocols were the main research material. The analysis of internal audits’ results and the study of organizational health and safety protocols present main problems discovered within the irradiation process.

Results: The objective of the management system is to improve the organization and safety of radiotherapy process. The detailed audits’ outcome analysis and non-conformances’ study showed that the main identified problems were: the lack of patient’s and medical physicist’s authorization of patients’ irradiation protocols, the lack of patient’s agreement for radiotherapy process, the change of the patient’s personal data in irradiation medical protocol and in VARIS system, the wrong personal identification number of...