September 2023 through February 2024 Therapeutic and Diagnostic Medical Reportable Events (MRE)	
Diagnostic	
1.	On September 23 a patient received 19.113 Gy to the abdomen/pelvis during stent placement of the iliac arteries during 75.2 minutes of fluoroscopy time. The patient had near 100% occlusion of both sides. The corrective action discussed with staff is that the technologist will verbally confirm with the performing physician when a patient receives a dose of 5 Gy. Then again at 10 Gy and will continue to do so every 5 Gy after.
2.	On November 23 a patient received a skin dose of 26 Gy after 61 minutes of fluoroscopy time. This was due to the complexity of procedure. The surgeon contacted vendors to utilize more ultrasound to reduce fluoroscopy time. Additional training will be given to the catheter lab staff and physicians, emphasizing awareness of patient positioning, fluoroscopy times, and methods to minimize patient dose and communication between staff and physicians.
Therapeutic	
1.	On January 24 a patient received a dose of 148 cGy to an incorrect site. A triangulation point was selected over the abdomen for daily alignment. After triangulation, there should have been a 16 cm shift of isocenter toward the patient's head for treatment, however this shift was not completed. Field one (posterior) of two (anterior & posterior) was delivered to the wrong anatomical region. The error was caught prior to treating the second field (anterior) and treatment was suspended temporarily at that time. The patient received the intended therapy approximately 2 hours later. Corrective actions include reeducation involving a change in policy where daily patient treatment schedules will be established to eliminate/minimize the times a therapist(s) is/are required to treat a patient they are unfamiliar with. Steps have also been implemented to follow in the case that staffing results in therapist(s) treating unfamiliar patients.
2.	A patient was prescribed 30 daily treatments to the brain. After receiving 19 treatments the patient was then admitted to a different facility where she received the next 2 treatments but the other 9 were not scheduled. The patient then missed the next 3 treatments. Treatments were resumed on 1/23/24 with all remaining fractions scheduled. This scheduling error occurred due to a lack of communication between facilities. The following actions will be implemented when a patient transfers between radiation oncology locations: 1. All appointments of the treatment course will be added to the receiving location’s schedule. 2. An alert will be added to the patient’s treatment chart in Aria, stating that the patient has been transferred from another site, and to verify that the next day’s treatment has been scheduled. 3. Nurses to continue to monitor the list of currently admitted inpatients and alert the radiation therapists when a patient has been discharged.
3.	On February 2 patient A had a scheduled treatment time of 1:10 PM but checked-in early at 12:16 PM. Patient B had a scheduled treatment at 12:30 PM, but according to clinic records, did not check in for his appointment until 12:34 PM. At approximately 12:30 PM, two treating therapists (Therapists 1 and 2) asked for Patient B to come to the machine for treatment. However, patient A responded to the therapists, even though they had requested Patient B. Therapists 1 and 2 both claim they addressed Patient A by B’s name. Patient A received one incorrect treatment to the prostate. The corrective action for this event has been to re-educate all therapists about UPMC policy for patient identification and treatment verification. This policy requires that the patient's name and date-of-birth be provided by the patient before each treatment, and that therapists confirm this data with the information displayed by the treatment machine.