September 2020 through March 2021 Therapeutic and Diagnostic Machine Medical Reportable Events (MRE)	
Therapeutic	
1.	A patient was treated with another patient's plan. The planned patient treatment dose was not altered after review of the delivered dose. On 10/7/20 patient A's left supraclave and left chest wall were treated with patient B's left supraclave and left chest wall fields. Both patients were of same body habitus. Patient A was wearing mask and cap and came for treatment at 1:30pm, which was patient B's time slot. Front desk receptionist checked in the wrong patient (patient A) and wrong patient (patient A) responded. This resulted in an unintended overdose to normal tissue. Corrective actions include. prior to setting up patients for treatment, therapists will bring patients physically in front of the record and verify monitor and ask their names and birth dates and double check this information on the monitor before setting them up for treatment. (10/2020)
2.	A treatment was misaligned by 4 cm causing a dose deviation of >50% for one treatment due to incorrect isocenter entered into the Mosaiq record and verify system. Corrective actions include, when importing a cone down or boost plan, the dosimetrist will verify that the site setup for the original plan has remained approved with an approval date that aligns with the start of the large volume treatment. When checking a cone down or boost plan, the checking physicist will also verify that the Site Setup for the original plan has remained approved with an approval date that aligns with the start of the large volume treatment. (12/2020)
3.	A patient was to be receive a 5-fraction boost treatment to the right breast seroma site, with a 5.0cm inferior shift from the patient's tattoos demarcating the isocenter placed during the CT simulation. The value on the field verification sheet noted a shift of 0.5cm. Patient was treated for a single fraction 4.5cm more superiorly than intended. The dose deviated from intended by >50% for a single fraction of the breast boost plan. Corrective actions include, all shifts will be noted with the appropriate leading and trailing zeros (e.g. 0.5 & 5.0). SSDs greater than 5mm from the expected values will be verified by a physicist or dosimetrist prior to treating the first fraction. And finally, the manually written patient shift will be removed from the field verification sheet. (12/2020)
4.	A patient was to receive 10 fractions, treated daily, except for weekends and holidays. The electronic health record, Epic, will not schedule an appt if there are no slots available and does not flag the scheduler to inform them of such. The first appt was on 3/8/2021. The second appt was not until 3/17/2021. All therapists were informed of this software issue and its potential impact on a patient's schedule. Two therapists will verify that the patient has been scheduled appropriately – a first time when scheduling the treatments and a second time when providing the patient with their printed schedule. Additionally, the department escalated the issue with Epic IT team to see if there are any settings or configurations that could be changed to prevent this in the future. (3/2021)
Diagnostic	
There were no diagnostic events during this time frame.	