Radiation Therapy Delivered to Wrong Patient
March 2006

Step 1. Problem Outline

Define the problem

What	Problem(s)	Patient receives therapy meant for another patient
When	Date	March 1, 2006
	Different, unusual, unique	Second therapist took over treatment
Where	Facility, site	?
	Unit, area, equipment	?
	Task being performed	Radiotherapy

Impact to the Goals

Patient Safety	Risk for injury
Employee Impact	?
Compliance	Reportable error
Organization	
Patient Services	Patient received unneccessary radiation
Environmental	?
Property, Equip, Mtls	?
Labor, Time	?
	This incident ?
Frequency	?
	Annualized Cost ?

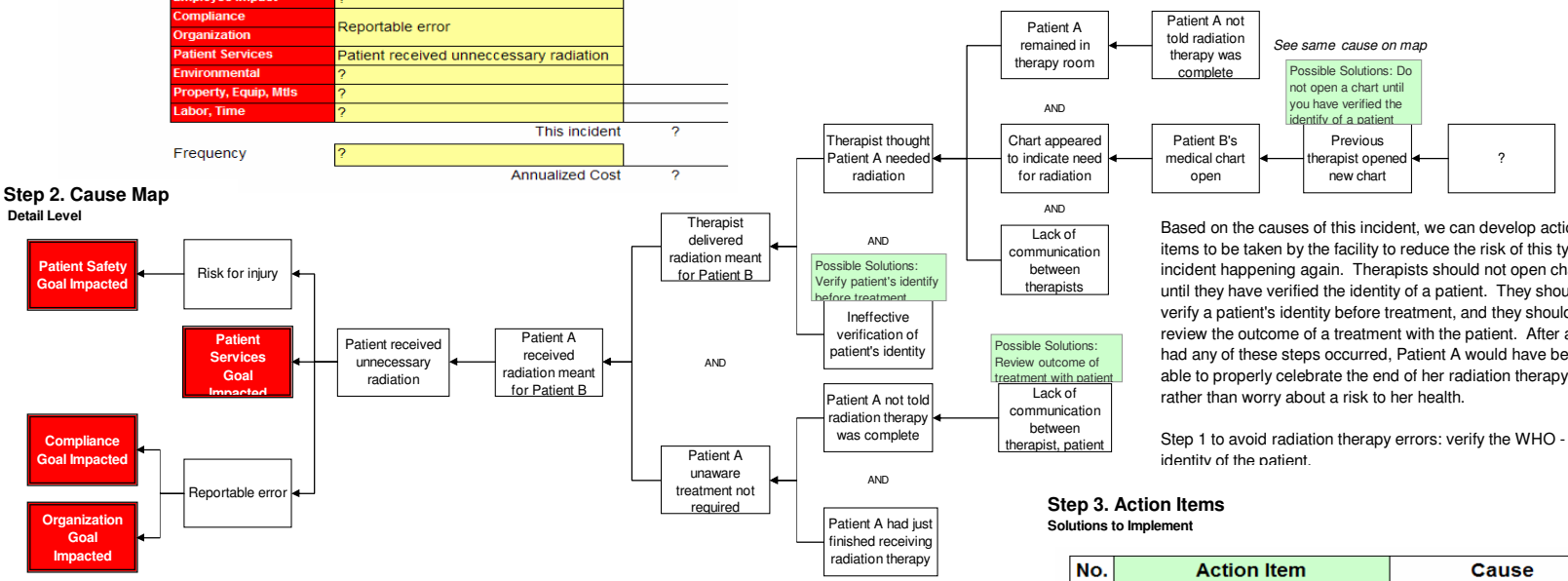
In March 2006 a patient (who we'll call Patient A) reached an exciting milestone. She had just completed radiation treatment for a brain tumor. However, she was not told that her radiation therapy was complete. Instead, the therapist opened the medical chart of another patient (Patient B) and left. Another therapist came in, saw the chart for Patient B, and noticed that Patient B required radiation treatment for breast cancer. The therapist then delivered that radiation to Patient A.

This incident impacted the facility's patient safety goal, because of the risk of injury to Patient A. Additionally, it impacted the patient service goal, because Patient A received unnecessary radiation. The organization and compliance goals were also impacted because of this reportable error.

How did this happen? Patient A was at risk for injury because of the delivery of unnecessary radiation. She was given radiation meant for another patient because the therapist delivered the radiation and Patient A, not knowing that her own treatment was complete, didn't know to stop it. The therapist did not effectively verify the identity of Patient A, instead going off the chart that had been opened by the previous therapist, for unknown reasons. Had the first therapist told Patient A that her therapy was complete, or had the first therapist not opened another patient's chart, or had the second therapist verified the identity of Patient

Step 2. Cause Map

Detail Level



Based on the causes of this incident, we can develop action items to be taken by the facility to reduce the risk of this type of incident happening again. Therapists should not open charts until they have verified the identity of a patient. They should verify a patient's identity before treatment, and they should review the outcome of a treatment with the patient. After all, had any of these steps occurred, Patient A would have been able to properly celebrate the end of her radiation therapy, rather than worry about a risk to her health.

Step 1 to avoid radiation therapy errors: verify the WHO - the identity of the patient.

Step 3. Action Items

Solutions to Implement

No.	Action Item	Cause
1	Do not open a chart until you have verified the identify of a patient	Previous therapist opened new chart
2	Verify patient's identify before treatment	Ineffective verification of patient's identity
3	Review outcome of treatment with patient	Lack of communication between therapist, patient

ThinkReliability
Investigate Problems. Prevent Problems.
Houston, Texas 281-412-7766 ThinkReliability.com

Why?

Effect ← Cause

NOTE: Read the Cause Map from left to right with the phrase "Was Caused By" in place of each arrow.