December 2021 through September 2022 **Therapeutic and Diagnostic Machine Medical Reportable Events (MRE)**	
December 2022 RPAC meeting	
Therapeutic	
1.	A patient was prescribed one treatment per day but was treated BID for the first two days of her treatment, receiving 4 fractions in those two days. This occurred due to an error in generating the patient's treatment schedule. No corrective action needed; the total dose and number of fractions delivered matches the prescription but will be delivered over two fewer days overall. Corrective actions include, prior to the patient's first day of treatment, the treating therapists will compare the patient's schedule to the radiation prescription to ensure they match. Also, each site's Therapy Supervisor (or designee) will perform an independent verification of the patient's schedule within the first three days of treatment. 12/27/2021
2.	A patient was prescribed treatment to Lumbar spine and the Sacrum. The Lumbar plan was incorrectly delivered to the sacrum. This was discovered during treatment. The RSO determined that the dose delivered did not pose any additional danger to the patient. Corrective actions include, the facility has generated a new external beam time out standard operating procedure that expands on current patient and technique verifications. 3/2022
3.	A patient was scheduled for 16 fractions of the right breast with 2 Tangential fields. On the 16th fraction, the superior shift was made but the lateral shift was missed by the therapist. It was determined that the patient's right breast did not receive >50% of the prescribed dose for this single fraction. It was concluded that 5-10% of the target volume received the prescribed dose for that fraction. The treating therapist acquired the actual couch parameters which removed the interlock, without any imaging to verify the patient's set up. One additional fraction was added to the course of treatment to bring the target volume up to the original intended dose. 1.A thorough review and re-education of the utilization of the “override” and “acquire” functions on the linear accelerator control console. The “acquire” feature should be used on the first treatment day and should never be utilized without proper imaging. 2. Initiated a move towards a breast setup that aligns with the other sites within the network. This includes evaluating the field light from both the medial and lateral tangent angle and a check of the field fall parameter. 3/2022
4.	A patient was scheduled to receive 15, twice a day fractions separated by 6 hours. On the 9th the linac lost connection to Mosaiq during the morning therapy and that administration was not correctly manually entered into Mosaiq. Therefore, on June 16th after the morning fraction, Mosaiq had 29 recorded fractions with one more still due. The afternoon fraction was delivered on the 16th before it was discovered that the manual entry for the 9th was not ever recorded. The linac used is being removed on 7/2 and replaced with a new linac. A new policy was developed for manual recording of therapy fractions delivered. Two staff members are required during manual recording. Therapists will update treatment schedule promptly when changes occur. 6/2022