

VERIFICATION AND DOCUMENTATION OF SITE AND SIDE PRIOR TO RADIATION THERAPY



Prepared on behalf of National Medical Professional RRG, Inc.

INTRODUCTION

Consider the case where a patient was referred for treatment of carcinoma of the right lung. Routine CT Imaging was used by the radiation oncologist to develop an appropriate treatment plan for the right lung.

Unfortunately, at some point during the planning and simulation process, the images became inverted as the patient was assumed to be in the supine position when actually the simulation was performed with the patient prone. The error was not noted until the completion of the treatment course.

In another instance, a woman received treatment to the wrong breast because the radiation oncologist prescribed the treatment to the wrong site. This was caused by conflicting pathology and imaging reports. While the doctor checked the patient clinically, he wrote the prescription based on the wrong report.

While errors in the delivery of radiation oncology are thought to be rare and usually result in little or no injury to a patient, errors do in fact occur, and practitioners must work to implement practices that mitigate the causes of error. In a study published by the Pennsylvania Patient Safety Authority¹ wrong location and wrong side events accounted for 24% of reported events for the period 2004-2009 (Fig 1).

RECOMMENDATIONS:

Due to the complexities of treatment, every member of your team must understand the correct laterality of the target, as oftentimes the delivery angles do not provide enough guidance. All targeted organs, as well as organs at risk, must be accurately identified in all sections of the patient's record with consistent, codified terms. The use of "breast" or "lung" to describe the target in the patient chart or during treatment planning is insufficient. All bilateral organ targets should be identified with either "right" or "left". To ensure everyone on your team abides by this practice, make sure there is a place to specify "left" and "right" on all treatment related documents.

We also recommend that the appropriate protocols and systems be in place prior to any of the patients' treatments. Current regulations require the implementation of a Quality Management Program (QMP) that is to be reviewed at least on a yearly-basis. The QMP implementation involves the design of specific steps to assure correct radiation delivery. Every member in your radiation therapy department must understand these steps to ensure the Program's success.

A thorough QMP is not only essential for high quality care, it also ensures you have the documented evidence needed to successfully defend your case in court. Your comprehensive documentation of patients' records is concrete evidence that supersedes any testimony. Conversely, a lack of documentation will leave you exposed to subjectivities.

Figure 1. Radiation Oncology Event Types Reported to the Pennsylvania Patient Safety Authority, June 2004 through January 2009

TYPE OF ERROR	NUMBER OF REPORTS	% OF TOTAL
Wrong Dose	10	40%
Wrong Patient	4	16%
Wrong Location	3	12%
Wrong Side	3	12%
Wrong Setup	2	8%
Wrong Treatment	1	4%
Wrong Treatment Device	1	4%
Equipment Other	1	4%
TOTAL	25	100%

If you would like to know more about the development of a QMP for your practice, or if you have other questions about misadministration prevention, contact our risk management department at 888.804.9556 or claims@nmpinsurance.com.

¹Errors in Radiation Therapy. ¹Patient Safety Authority 2009 Sep;6 (3):87-92.