مستشفى الملك فيصل التخصصي ومركز الأبحاث
King Faisal Specialist Hospital & Research Centre

QUALITY & SAFETY COMMITTEE MEETING #19

Wednesday, 14 December 2022 (3:30 - 5:30 pm)

3.0

Patient Safety Story - Wrong Treatment

A 41-year-old female patient known to have Metastatic Nasopharyngeal Carcinoma, had multiple failed chemotherapy lines and she is on immunotherapy and palliative radiation therapy. She was admitted due to rib pain despite. She was planned to receive another Palliative radiotherapy to the right lower posterior chest wall mass aiming to control the pain.

On the day of event, she mistakenly received radiation to the wrong site/ area (which was intended for another patient plan). Patient was seen by the radiation oncology team and the error was disclosed. The team assured the patient and her husband that likely there will be no serious direct harm as the dose is within acceptable dose tolerance, the patient agreed to proceed with radiotherapy to her right site which was given few days after this event.

Lessons Learned:

- Failure to follow the proper patient identification policy before procedure by the primary therapist,
- Failure to follow the proper patient identification policy during the handover process between therapist - the primary nurse,
- Lack of proper time out process (Safety Measure: Time-out Procedure -RTS-01-01-02),
- Lack of proper patient engagement in their treatment and procedures,

Action Plan:

- Establish a specific time out procedure form related to radiation therapy practice,
- Explore with HITA possible application for patient identification through barcoding technology,
- Just culture was implemented for the involved staff.

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Patient Safety Story - Cont.