

3/13/00 cc: INEEL
P. Larkins
D. Soltenberg, ASD
INEEL

Event Reporting Handbook

EVENT REPORT COVER PAGE

AGREEMENT STATE

EVENT REPORT NO. RI - 00 - 101

DATE: 3/10/00

TO: Pat Larkins
Deputy Director
Office of State Programs

SUBJECT: Misadministration Report

STATE: Rhode Island

Signature and Title: Charles V. DiMarzio

Supervising Radiation Control Specialist

NRC FORM 566 (4-84)		U. S. NUCLEAR REGULATORY COMMISSION		APPROVED BY OMB: NO. 3150-0178 EXPIRES: 04/30/97	
MEDICAL MISADMINISTRATION					
LICENSEE Rhode Island Hospital			CITY AND STATE Providence, RI		ORIGINAL ITEM NUMBER RI-00-101
TYPE OF LICENSE (e.g., Broad Scope, Private Practice Medical, etc.) Broad Scope Medical			LICENSE NUMBER 7D-051-01		THIS ITEM NUMBER
ABNORMAL OCCURRENCE		FOLLOW-UP REPORT		THE PATIENT WAS NOTIFIED	
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
				DATE OF EVENT 2/14/00	
				DATE OF THIS REPORT 3/10/00	
SODIUM IODINE, I-125 OR I-131, > 50 MICROCURIES					
<input type="checkbox"/> WRONG PATIENT					
<input type="checkbox"/> WRONG RADIOPHARMACEUTICAL					
<input checked="" type="checkbox"/> ADMINISTERED DOSE DIFFERS FROM PRESCRIBED DOSE BY > 20% AND DIFFERENCE EXCEEDS 30 MICROCURIES					
THERAPEUTIC RADIOPHARMACEUTICAL DOSE, OTHER THAN I-125 OR I-131					
<input type="checkbox"/> WRONG PATIENT					
<input type="checkbox"/> WRONG RADIOPHARMACEUTICAL					
<input type="checkbox"/> WRONG ROUTE OF ADMINISTRATION					
<input type="checkbox"/> ADMINISTERED DOSE DIFFERS FROM PRESCRIBED DOSE BY > 20%					
STEREOTACTIC RADIOSURGERY (GAMMAKNIFE)					
<input type="checkbox"/> WRONG PATIENT					
<input type="checkbox"/> WRONG TREATMENT SITE					
<input type="checkbox"/> ADMINISTERED DOSE DIFFERS FROM PRESCRIBED DOSE BY MORE THAN 10%					
TELETHERAPY					
<input type="checkbox"/> WRONG PATIENT					
<input type="checkbox"/> WRONG MODE OF TREATMENT					
<input type="checkbox"/> WRONG TREATMENT SITE					
<input type="checkbox"/> ADMINISTERED DOSE DIFFERS FROM PRESCRIBED DOSE BY MORE THAN 10% IF THERE ARE 3 OR FEWER FRACTIONS PRESCRIBED; OR WHEN WEEKLY CALCULATED ADMINISTERED DOSE EXCEEDS PRESCRIBED DOSE BY > 30%; OR WHEN CALCULATED TOTAL ADMINISTERED DOSE DIFFERS FROM PRESCRIBED DOSE BY > 20%.					
BRACHYTHERAPY					
<input type="checkbox"/> WRONG PATIENT					
<input type="checkbox"/> WRONG RADIOISOTOPE					
<input type="checkbox"/> WRONG TREATMENT SITE					
<input type="checkbox"/> LEAKING SOURCE					
<input type="checkbox"/> ONE OR MORE SOURCES NOT REMOVED AT END OF TREATMENT					
<input type="checkbox"/> CALCULATED ADMINISTERED DOSE DIFFERS FROM PRESCRIBED DOSE BY > 20%					
DIAGNOSTIC RADIOPHARMACEUTICAL DOSE, OTHER THAN QUANTITIES THAT EXCEED 30 MICROCURIES OF I-125 OR I-131, OR BOTH, WHEN THE PATIENT DOSE EXCEEDS 5 REM EFFECTIVE DOSE EQUIVALENT OR 50 REM ORGAN DOSE AND INVOLVES:					
<input type="checkbox"/> WRONG PATIENT					
<input type="checkbox"/> WRONG RADIOPHARMACEUTICAL					
<input type="checkbox"/> WRONG ROUTE OF ADMINISTRATION					
<input type="checkbox"/> ADMINISTERED DOSE DIFFERS FROM PRESCRIBED DOSAGE					
ABSTRACT (Include the cause of the misadministration, contributing factors, and licensee corrective action. May be continued on the reverse side.)					

Two patients, for whom therapeutic doses of 75 and 100 millicuries of Iodine 131 had been prescribed, were interchanged, each receiving the other's intended dose. Both patients were present in the department at the same time, along with their prescribing physicians, and the medical physicist who prepared the doses. The order in which the doses were to be administered to the patients was apparently determined among the persons involved, then reversed at the last minute. This reversal was apparently not clearly communicated to the physicist, a contributing cause of the incident. However, the ultimate cause of the misadministrations was failure to strictly follow established procedures, i.e., checking the prescriptions, the doses, and the patient identifications.

No effects are expected to result from the misadministrations, and both patients were notified. The licensee has provided retraining to emphasize the need for strict adherence to procedure.