NCDENR
North Carolina Department of Environment and Natural Resources
Division of Radiation Protection

Michael F. Easley, Governor

William G. Ross Jr., Secretary
Richard M. Fry, Director

November 27, 2001

R. L. Woodruff
USNRC Region II
Atlanta Federal Center
Suite 23T85
61 Forsyth Avenue
Atlanta, GA 30303

RE: MISADMINISTRATION AT PITT COUNTY MEMORIAL HOSPITAL

Dear Mr. Woodruff:

Enclosed is a copy of all correspondence between the agency and Pitt County Memorial Hospital regarding the therapeutic radiopharmaceutical misadministration. This was classified as a misadministration pursuant to 15A NCAC 11 .0104(70)(b)(ii), administered dose differs from prescribed dose by more than 20 percent.

Should you have any questions, please feel free to contact me.

Sincerely,

J. Marion Eaddy III, Health Physicist
Radioactive Materials Section

Enclosures

1645 Mail Service Center Raleigh, North Carolina 27699-1645
Phone: (919) 571-4141 FAX: (919) 571-4148 Internet: www.drp.enr.state.nc.us

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27 November 2001

David Rushing, R.S.O.
East Carolina University Medical Center
Pitt County Memorial Hospital
2100 Stantonsburg Road
Greenville, NC 27834

Dear Mr. Rushing:

I have received the "Report of Misadministration" received 26 November 2001. The information supplied appears to be sufficient to address the misadministration which occurred on 12 November 2001. A copy of the report will be maintained in your file and the incident may be reviewed during the next inspection of your facility.

The North Carolina Regulations for Protection Against Radiation (15A NCAC 11 .0350(c)) require that you, the licensee, maintain a record of each misadministration for at least five (5) years.

Sincerely,

J. Marion Eaddy III, Health Physicist
Radioactive Materials Section

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NORTH CAROLINA DEPARTMENT OF ENVIRONMENT, HEALTH, & NATURAL RESOURCES
DIVISION OF RADIATION PROTECTION
RADIOACTIVE MATERIALS SECTION

Recd 26 Nov 01

REPORT OF MISADMINISTRATION

Completion and submittal of this form is required by 15A NCAC 11 .0350.

(1) Licensee Name	(2) Licensee #	(3) Address of Licensee	(4) City
Pitt County Mem. Hospital	074-0296-3	2100 Stantonsburg Rd	Greenville

(5) State	(6) Zip Code	(7) Phone Number	(8) Date of Event	(9) Date Reported to DRP
NC	27834	252-816-2933	11/12/01	11/13/01

(10) Name of authorized user that issued the written directive
Dr. Eric Finical

TYPE OF MISADMINISTRATION

A. ☐ Diagnostic Radiopharmaceutical Other than I-125 or I-131
A dose to the patient that exceeds 5 rems effective dose equivalent or 50 rems dose equivalent to any individual organ; and
- ☐ wrong patient
- ☐ wrong radiopharmaceutical
- ☐ wrong route of administration
- ☐ administered dose differs significantly from prescribed dose

☐ Diagnostic Radiopharmaceutical Involving I-125 or I-131
- ☐ wrong patient
- ☐ wrong radiopharmaceutical
- ☐ administered dose exceeds prescribed dose by 20% and difference exceeds 30 microcuries

B. ☐ Therapeutic Radiopharmaceutical Other than I-125 or I-131
- ☐ wrong patient
- ☐ wrong radiopharmaceutical
- ☐ wrong route of administration
- ☐ administered dose differs from prescribed dose by more than 20%

☑ Therapeutic Radiopharmaceutical Involving Sodium Iodide I-125 or I-131
- ☑ administered dose differs from prescribed dose by more than 20%

C. ☐ Accelerator or Teletheraphy
- ☐ Any radiation dose involving
  - ☐ wrong patient
  - ☐ wrong mode of treatment
  - ☐ wrong treatment site
- ☐ Treatments of 3 or fewer fractions; and
  - ☐ calculated total administered dose differs from total prescribed dose more than 10%
- ☐ Calculated weekly administered dose is 30% greater than weekly prescribed dose
- ☐ Calculated total administered dose differs from total prescribed dose by more than 20%

TYPE OF MISADMINISTRATION

D. ☐ Brachytherapy
- ☐ Any radiation dose involving
  - ☐ wrong patient
  - ☐ wrong radioisotope
  - ☐ wrong treatment site
- ☐ Any radiation dose involving a sealed source that is leaking
- ☐ One or more temporary implants was not removed upon completion of the procedure
- ☐ Calculated administered dose differs from the prescribed dose by more than 20%

E. ☐ Gamma Stereotactic Radiosurgery
- ☐ Any radiation dose involving
  - ☐ wrong patient
  - ☐ wrong treatment site
- ☐ Calculated total administered dose differs from total prescribed dose more than 10%

Was patient notified of their misadministration?	☑ Yes ☐ No
If no, explain. If yes, what information was provided. Patient was notified and told that no effects are anticipated.	

Description of event to include:
a. Brief description of event;
b. Licensee's evaluation of why event occurred;
c. Any anticipated short and long term effects on the patient;
d. Licensee's evaluation of improvements needed to prevent recurrence; and
e. Documentation of the actions taken by the licensee to prevent recurrence.

Do not include patient name or any information that could lead to identification of patient!
(If more space is needed, please attach additional sheets)

DO NOT WRITE IN THIS SPACE (FOR OFFICE USE ONLY)

Reviewed By	Date Reviewed	Misadministration File Number
JMME 3	27 Nov 01	01-07

Rushing, David

From: Carpenter, Cassandra
Sent: Tuesday, November 13, 2001 4:14 PM
To: Rushing, David
Subject: Misadministration I131


TEXT.htm

Incident:
The patient was scheduled thru the doctor's office. They scheduled a Total
Body Iodine Scan with therapy. The patient was cleared for pregnancy issues
and dosed with 2 mCi of I131. When the patient returned for her scan, the
order was reviewed by the technologist doing the scanning and it was realized
that the patient was actually for a hyperthyroid ablation dose. The
radiologist was notified and the supervisor was instructed to order 28 mCi of
I131 to administer to the patient for her therapy dose. Total dose to patient
was 29.9mCi.

Action Taken: The technologist that initially dosed the patient was counciled
about properly checking the orders and verifying if there are any questions
about a procedure.

Future Procedure:
The orders will be checked by the Nuclear Supervisor along with the
Radiologist to ensure that the proper procedure is being performed.