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

Michael F. Easley, Governor
William G. Ross, Jr., Secretary

Linda Sewall, Division Director
Beverly O. Hall, Section Chief

November 12, 2002

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 diagnostic radiopharmaceutical misadministration. This was classified as a misadministration pursuant to 15A NCAC 11 .0104(70)(a)(ii)(B), for sodium iodide I-125 or I-131, administered dosage differs from the prescribed dosage by more than 20 percent and the difference is greater than 30 microcuries.

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

Sincerely,

J. Marion Eaddy III, Health Physicist
Radioactive Materials Branch

enclosures

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

Michael F. Easley, Governor
William G. Ross, Jr., Secretary

Linda Sewall, Division Direct
Beverly O. Hall, Section Chi

November 12, 2002

David Rushing, R.S.O.
Pitt County Memorial Hospital
2100 Stantonsburg Road
Greenville, NC 27834

Dear Mr. Rushing:

I have received the "Report of Misadministration" dated November 05, 2002. The information supplied appe to be sufficient to address the misadministration which occurred on November 04, 2002. A copy of the rep 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, licensee, maintain a record of each misadministration for at least five (5) years.

Sincerely,

J. Marion Eaddy III, Health Physicist
Radioactive Materials Branch

jme

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

NCDENR

RADIATION PROTECTION SECTION
RADIOACTIVE MATERIAL BRANCH

MISADMINISTRATION REPORTING FORM

(RPS USE ONL

INSTRUCTIONS: Completion and submittal of this form is required by 15A NCAC 11 .0350. This form **MUST** be submitted within **15 days** of the discov of the misadministration. This report **SHALL NOT** contain the patient's name or any other information that could lead to the identification of the patient. Records c misadministration must be maintained for five (5) years. This form may be transmitted via facsimile to (919) 571-4148. Original forms must be mailed to: ***Radioact Materials Branch, Radiation Protection Section, 1645 Mail Service Center, Raleigh, N.C., 27699-1645.***

1a. Licensee Name: Pitt Co. Memorial Hospital 1b. License No. 074 246-3

2. Physical Address: 2100 Stantonsburg Rd, Greenville NC 27834

3. Mailing Address:

4. Date of Event: 11/4/02 5. Date Reported to RPS: 11/5/02

6. Name of Authorized user who issued the written directive: Dr Jalram Vainright

TYPE OF MISADMINISTRATION

A. ☐ Diagnostic Radiopharmaceutical other than ^{125}I or ^{131}I

A dose to the patient that **EXCEEDS** 5 REMS effective dose equivalent **OR** 50 REMS dose equivalent to a individual organ; **AND**,

- ☐ Wrong patient
- ☐ Wrong radiopharmaceutical
- ☐ Wrong route of administration, or
- ☐ Administered dose differs significantly from prescribed dose; **OR**

☒ Diagnostic Radiopharmaceutical involving ^{125}I or ^{131}I

- ☐ Wrong patient
- ☐ Wrong radiopharmaceutical
- ☒ Administered dose exceeds prescribed dose by 20% **and** difference exceeds 30 microcuries

RECEIVED
NOV 7 2002
RADIOACTIVE MATERIALS

B. ☐ Therapeutic Radiopharmaceutical other than ^{125}I or ^{131}I

- ☐ Wrong patient
- ☐ Wrong radiopharmaceutical
- ☐ Wrong route of administration, or
- ☐ Administered dose differs from prescribed dose by 20%

☐ Therapeutic Radiopharmaceutical involving ^{125}I or ^{131}I

- ☐ Administered dose differs from prescribed dose by 20%

C. ☐ Accelerator or Teletherapy

- ☐ Any radiation dose involving:
  - ☐ Wrong patient
  - ☐ Wrong mode of treatment
  - ☐ Wrong treatment site
- ☐ Treatments involving three (3) or fewer fractions; **AND**,
  - ☐ Calculated total administered dose differs from total prescribed dose by 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%

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 not removed upon completion of procedure
- ☐ Calculated administered dose differs from the prescribed dose by more than 20%

NCDENR
NORTH CAROLINA DEPARTMENT OF ENVIRONMENT AND NATURAL RESOURCES

RADIATION PROTECTION SECTION
RADIOACTIVE MATERIAL BRANCH

MISADMINISTRATION REPORTING FORM

(RPS USE ONLY)

INSTRUCTIONS: Completion and submittal of this form is required by 15A NCAC 11 .0350. This form **MUST** be submitted within **15 days** of the discover of the misadministration. This report **SHALL NOT** contain the patient's name or any other information that could lead to the identification of the patient. Records of misadministration must be maintained for five (5) years. This form may be transmitted via facsimile to (919) 571-4148. Original forms must be mailed to: ***Radioactiv Materials Branch, Radiation Protection Section, 1645 Mail Service Center, Raleigh, N.C., 27699-1645.***

1a. Licensee Name PCMH 1b. License No. 296-3

2. Physical Address 2100 Stantonsburg Rd Greenville NC

3. Mailing Address

4. Date of Event 11/4/02 5. Date Reported to RPS 11/5/02

6. Name of Authorized user who issued the written directive Dr Julian Vanderslice

TYPE OF MISADMINISTRATION (continued):

E. ☐ Gamma Stereotactic Radiosurgery

- ☐ Any radiation dose involving:
  - ☐ Wrong patient
  - ☐ Wrong treatment site
- ☐ Calculated total administered dose differs from total prescribed dose by more than 10%

Was the patient notified of their misadministration? ☒ Yes ☐ No

If No, explain. If yes, what information was provided

Provide a written account of the event to include, at a minimum, the following (attach additional sheets as necessary):

1. Brief description of the event;
2. Licensee's evaluation of why the event occurred;
3. Any anticipated short or long term effects to the patient; none
4. Licensee's evaluation of improvements needed to prevent recurrence;
5. Documentation of the actions taken by the licensee to prevent recurrence.

NOTE: DO NOT include patient name or any information that could lead to the identification of the patient.

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

Reviewed by: _____ Date reviewed: _____ Misadministration Log No. _____

Revised Sep. 2002

Patient was administered an I-131 dose for a TBI (Total Body Iodine) Scan on 11-4-02 by Nuclear Medicine Technologist, Rebecca P. Barbre. The NMT Tech picked up the wrong I-131 lead Container by mistake. This Container had a label for I-131 (2.0mCi dose assayed for 10-7-02 with an expiration of 10-17-02). The Capsule was ~~not~~ counted/assayed in the dose calibrat and read by the technologist as 1.8 mCi I-131. The tech is certain without a doubt that the dose calibrator was set on the I-131 dial during the assay.

The capsule was administered to the patient and patient received instructions about returning for her 24-h and 48-hour scans.

Approximately 1/2-1 hour after patient was dosed, the supervisor, Cassandra Carpenter, noticed the other I-131 vial was sitting behind the lead shield with the I-131 lead pig seals still intact (un-opened). ~~Pts~~

The Capsule Administered was calculated to contain 182 mCi of I-131.

The exposure for the patient are minimal. This will result in her treatment being delayed for 1 day.

The Technologist has been informed of the delay in the patient's treatment. She will receive additional instruction in bed side procedures.

11/5/07