Full Report

03/30/2011

Item Number: LA060003 **Last Updated:** 07/10/2006

Event Type: MD2 - MISADMINISTRATION **Total Persons Affected:**

Event Cause: PROCEDURE NOT FOLLOWED

Event Date: 03/05/2006 **Report Date:** 03/07/2006

Licensee/Reporting Party Information:

Name: CARDINAL HEALTH License Number: LA-5119-L01
City: WEST MONROE State: LA Zip Code: 71292

Other Information:

Reportable Event:	Y	Reciprocity:	NONE
Atomic Energy Act Material:	Y	Abnormal Occurrence:	Y
Investigation:	N	Send this Report to NRC:	Y
Consultant Hired:	N	Event Closed by State:	Y

Narrative:

On March 5, 2006, a technician at St. Francis North Hospital contacted the Cardinal Health pharmacy to inform them that a scan on a patient had shown lung imaging instead of the expected cardiac imaging after administering a dose labeled Myoview. An investigation by the pharmacy revealed that the customer's Tc-99m Myoview dose (acardiac imaging agent) had mistakenly been dispensed as a Tc-99m MAA dose (apulmonary imaging agent). The cause of this event was a failure by the dispensing pharmacist to follow proper Cardinal Health compounding procedures. The pharmacist pulled the wrong kit from the refrigerator and placed it in a Myoview vial shield. The pharmacist failed to double-check the label on the vial prior to compounding, as well as after removing the vial from the shield. Additionally, the dispensing pharmacist performed a QC test on the dose, but failed to label the starting point on the QC chromatography strip. This led to a misinterpretation of the failing test as a passing test. In order to prevent a recurrence of this event, the pharmacy is going to begin requirring all employees performing QC tests to label the starting point of all QC strips. Formerly, the practice was to perform the QC test and enter the data into the computer immedialtely, so some employees were relying on their memory and not properly labeling the QC strips. Adfditionally, the pharmacy is planning to switch brands of MAA, since the Drax MAA vial and the Myoview vials are identical in appearance. This should help reduce the incidence of this type of error.

Corrective Actions:

Action Number:	Corrective Action:
1	NEW PROCEDURE WRITTEN

Patient Information:

Patient Number: 1
Patient Informed: Y
Date Informed: 03/05/2006
Diagnostic Study: LUNG
Radiopharmaceutical: MAA (MACROAGGREGATED ALBUMIN)

% Dose Exceeds Prescribed:
% Dose is Less Than Prescribed:
Effect on Patient: NONE
Adminstered By: TECHNICIAN

Dose to Family:	rem	Sv
Dose to Newborn:	rem	Sv
Dose to Fetus	rem	Sv

Source of Radiation:

Source Number: 1
Form of Radioactive Material: UNSEALED SOURCE Radionuclide or Voltage (kVp/MeV): TC-99M
Source Use: RADIOPHARMACEUTICAL Activity: Ci GBq
Manufacturer:
Model Number:
Serial Number: