Full Report

03/30/2011

Item Number: **TN06069** **Last Updated:** 07/07/2006

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

Event Cause: RADIOPHARMACEUTICAL IMPROPERLY LABELED

Event Date: 05/09/2006 **Report Date:** 06/02/2006

Licensee/Reporting Party Information:

Name: CARDINAL HEALTH License Number: R-47080

City: KNOXVILLE State: TN Zip Code: 37921

Other Information:

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

Narrative:

A technician at Fort Sanders Parkwest Hospital reported an unexpected result from a patient scan. The drug ordered was Tc-99m medronate for bone imaging but the patient showed myocardial uptake. An investigation revealed that the dose was mistakenly dispensed as Tc-99m sestamibi, a cardiac imaging agent. The root cause of the event was a failure by the pharmacist to select the correct drug for the prescription. The order was taken correctly from the customer but was not filled with the correct product. Additionally, both the pharmacist and the dispensing technician failed to verify that the drug vial matched the prescription label prior to dispensing the dose. An in service training session was held for all pharmacists and techs at the nuclear pharmacy to remind them of the proper procedures for sorting prescriptions and drawing doses.

Corrective Actions:

Action Number:	Corrective Action:
1	PERSONNEL RECEIVED ADDITIONAL TRAINING