

Full Report

03/30/2011

Item Number: TN06123 **Last Updated:** 01/30/2008

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

Event Cause: WRONG PATIENT SELECTED

Event Date: 07/18/2006 **Report Date:** 09/29/2006

Licensee/Reporting Party Information:

Name: MIDDLE TENN MEDICAL CENTER **License Number:** R-75099
City: MURFREESBORO **State:** TN **Zip Code:** 37133

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 patient presented to the nuclear medicine department. Technologist checked the arm band and the patient had the correct first and last name. The patient was injected with 20 millicuries of Tc99m MDP. The tech looked at the chart for additional information and discovered the wrong patient had been injected. The patient that had been scheduled and the patient that presented had the same first and last names. The technologist contacted the operations manager and the nurse but did not notify the RSO. The RSO learned of the event two months after it happened. Root cause: The tech did not follow procedures regarding two methods of identifying patients. Radiation Safety Committee developed procedures to make sure the RSO is notified. Patient did not receive excessive dose and no health effects.

Corrective Actions:

Action Number: Corrective Action:
1 PERSONNEL RECEIVE IMPROVED SUPERVISION

Patient Information:

Patient Number: 1
Patient Informed: Y
Date Informed: 07/18/2006
Diagnostic Study: BONE SCAN
Radiopharmaceutical: MDP/MEDRONATE/OSTEOLITE

% 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