

Hospital	Event Number: 45630
Rep Org: QHG OF INDIANA Licensee: QHG OF INDIANA Region: 3 City: FORT WAYNE State: IN County: License #: 13-01535-01 Agreement: N Docket: NRC Notified By: THOMAS M. KUMPURIS HQ OPS Officer: JOE O'HARA	Notification Date: 01/14/2010 Notification Time: 16:00 [ET] Event Date: 01/14/2010 Event Time: 14:00 [EST] Last Update Date: 01/14/2010
Emergency Class: NON EMERGENCY 10 CFR Section: 35.3045(a)(1) - DOSE <> PRESCRIBED DOSAGE	Person (Organization): CHRISTINE LIPA (R3DO) ROBERT LEWIS (FSME)

Event Text

INCORRECT DOSE ADMINISTERED TO PATIENT

Two patients were to receive hyper thyroid therapy on 1/14/10, and the hospital prepared written directives for each patient. One patient was prescribed 25 milliCurie of I-131. The second patient was prescribed 30 milliCurie of I-131. The first patient arrived and the technician assayed and administered the 30 milliCurie dose for the patient who was to receive 25 milliCurie. The tech administered 31.4 milliCurie to the patient. This is a 25.6% difference than prescribed in the written directive for the patient. The patient and prescribing physician have not been informed. The hospital does not believe there is any long term medical consequence to the patient. The hospital management team is reviewing protocols to prevent recurrence of this event.

A Medical Event may indicate potential problems in a medical facility's use of radioactive materials. It does not necessarily result in harm to the patient.