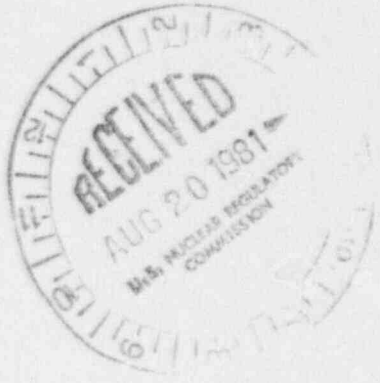
DCS
misadministration
(CF Available)
30-11581

Northwest General Hospital



July 1, 1981

U.S. Nuclear Regulatory Commission
Region III
799 Roosevelt Road
Glen Ellyn, Illinois 60137

Gentlemen:

Enclosed herewith is a diagnostic misadministration report, as required per 10CFR 35.43, and the corrective action we have taken to prevent a reoccurrence.

Should you require additional information, please let me know.

Sincerely,

NORTHWEST GENERAL HOSPITAL

CHARLES E. BUTRICK
ADMINISTRATOR

CEB:clj

Enclosure

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Licensee Name: NORTHWEST GENERAL HOSPITAL

NRC License No.: 48-16749-01

Regarding: Diagnostic Misadministration Report per 10CFR 35.43

Date: July 1, 1981

Description of Event:

On May 26, 1981 a diagnostic misadministration of a radiopharmaceutical occurred as defined in 10CFR 35.41(b). The referring physician was Dr. Tisinai. Upon completion of a bone scan for the patient, the patient was waiting to be returned to their room. During this waiting period, the patient was injected with a diagnostic scanning agent, Tc-99m - pyrophosphate, intended for a different patient.

There were two errors that led to this misadministration: (1) When the dose was received from Nuclear Pharmacy, Inc., the wrong name was on the label resulting, apparently, from an error in the ordering procedure; and (2) the patient's requisition and chart were not checked to verify the order prior to injection. There was no requisition nor written order for the patient receiving the misadministered radiopharmaceutical. The referring physician was immediately notified and felt that a cardiac scan would be of benefit to the patient, therefore he ordered it and it was carried out. There was no effect on the patient since the test would very likely have been ordered within the next few days.

Action Taken to Prevent Recurrence:

1) Extra care will be exercised in the ordering procedure to insure that the dose ordered for each patient is identified.

2) The hospital policy of checking the requisition and chart for the order was reviewed and the Medical Isotope Committee recommended that two people should view the written order prior to an administration.

3) The person who carried out the misadministration has since resigned. This person had been working at Northwest General Hospital for one month and was not thoroughly familiar with all of the hospital procedures.