03-03604-04

DCS NO. 03009588021690
Date: February 20, 1990

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE--PNO-I-90-12

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by the Region I staff on this date.

Facility:
Washington Hospital Center
110 Irving Street, N.W.
Washington, D.C. 20010
DC 030-09588

Licensee Emergency Classification:
____ Notification of Unusual Event
____ Alert
____ Site Area Emergency
____ General Emergency
__X__ Not Applicable

Subject: THERAPEUTIC MISADMINISTRATION INVOLVING A COBALT-60 TELETHERAPY UNIT

On February 16, 1990 at 3:15 p.m., the licensee informed Region I of a therapeutic misadministration that occurred earlier the same day. The misadministration occurred when the wrong patient was administered 45 rads to the lung. The radiation therapy technician called the right patient's name. The wrong patient responded. The technician did not confirm the patient's identity with the patient's wrist band or the name on the patient's chart. The technician questioned the patient when she could not find the lung treatment positioning marks on the patient's chest. The patient responded that the marks had been washed off. This same technician also commented to the patient that he looked different from the chart picture. The patient responded that his appearance had changed since he lost his hair. The technician positioned the patient and, together with a second technician, proceeded with the treatment. When the technicians noticed that the chart for the patient under treatment did not have the intended patient's name, the treatment was immediately terminated. The patient treated was identified as a patient who was undergoing therapy to the brain.

The licensee has advised the NRC that no adverse effects are anticipated as a result of the misadministration.

The licensee's corrective actions include counseling of the technician, re-instruction of all the therapy technicians on the proper method for patient identification and discussion of the incident at a department staff meeting for additional emphasis on patient identification techniques.

NRC Region I staff will continue to review the circumstances of the misadministration.

The Government of the District of Columbia has been notified.

CONTACT: J. Piccone 215-337-5169
M. Shanbaky 215-337-5209

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E-30

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