MILWAUKEE, WISCONSIN 53215 AND REPORT OF INCIDENT

[X] Designated Original

133

misadministration

Misadministration report for St Luke's Hosp., Lic #1 # 48-01338-01

△88

► CALL SECURITY SAFETY MANAGER AS SOON AS ACCIDENT

EMPLOYEES & VISITORS ONLY

NAME

FOR EMPLOYEES ONLY

JOB TITLE

DATE OF HIRE

INDICATE FULL TIME OR

SOCIAL SECURITY NO.

STREET ADDRESS - CITY, STATE & ZIP CODE (FILL IN FOR PATIENT)

SEX | DATE OF BIRTH | MARITAL STATUS: 1) MARRIED 2) SINGLE 3) DIVORCED 4) WIDOWED

THE INCIDENT

DATE OF INCIDENT | MILITARY TIME | LOCATION OF INCIDENT | EMPLOYEE'S, PATIENT'S, VISITOR'S CONDITION BEFORE INCIDENT: 1) NORMAL 2) SENILE 3) SEDATED 4) OTHER (EXPLAIN)

6-23-81 | 1030 | NUC MEDICINE

DESCRIBE EXACTLY WHAT HAPPENED, WHAT CAUSED THE INCIDENT. DESCRIBE PROPERTY OR EQUIPMENT DAMAGE.

MIS-ADMINISTRATION OF RRX NOTICED BY RADIOPHARMACEY. PATIENT WAS ADMINISTERED WRONG RRX BY [ ] PATIENT RECEIVED RRX #29608 A TC-MDP DOSE INSTEAD OF RRX #29607 A TC-PYP. THIS WILL DELAY IMAGING OF PYROPHOSPHATE SCAN FOR A DAY. PATIENT HAS BEEN RE-SCHEDULED FOR NEXT DAY. RADIATION SAFETY OFFICER NOTIFIED AT 1211; 23-JUN-81.

INSTRUCTIONS TO THE SUPERVISOR: ALL INCIDENTS SHOULD BE INVESTIGATED TO IDENTIFY CAUSE. RECORD YOUR FINDINGS IN THIS SECTION.

CAUSES — UNSAFE CONDITIONS: PLACE (X) IN APPROPRIATE BOX

- [ ] DEFECTIVE FLOORS, STAIRS, RUGS, ETC.
- [ ] IMPROPER EQUIPMENT
- [ ] IMPROPER ILLUMINATION
- [ ] MAINT. DEPT. (HAS) (HAS NOT) BEEN NOTIFIED
- [ ] LACK OF PROPER GUARDS
- [ ] UNSAFE EQUIPMENT
- [ ] POOR HOUSEKEEPING
- [ ] UNSAFE DESIGN OR PROCESS
- [ ] OTHER (LIST BELOW)

WHEN NOTIFIED:

UNSAFE ACTS

- [ ] PHYSICAL DEFECTS
- [ ] FAILURE TO FOLLOW INSTRUCTIONS
- [ ] FAILURE TO OBSERVE SAFETY RULES
- [ ] FAILURE TO USE GOOD JUDGEMENT
- [ ] FAILURE TO USE SAFETY EQUIP. (BED RAILS, SAFETY GLASSES, ETC.)
- [ ] LACK OF EXPERIENCE OR TRAINING
- [ ] IMPROPER PROCEDURE
- [ ] INATTENTION OR NEGLIGENCE
- [ ] OTHER (LIST BELOW)

PREVENTIVE ACTION: WHAT ACTION IS BEING TAKEN TO PREVENT IMMEDIATE RECURRENCE?

XA Copy Has Been Sent to PDR

IE30 S 1/0

RECOMMENDATIONS OF SUPERVISOR ON PREVENTION OF THIS TYPE OF ACCIDENT.

(11)

JUL 8 1981

XA
8108210338 810623
NMS LIC30
98-01338-01

SUPERVISOR'S SIGNATURE | DATE | SIGNATURE [signature] | DATE 6-23-81

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

8108210431 810701
NMS LIC30
48-16749-01 CF

A member of the American Osteopathic Hospital Association and the Wisconsin Hospital Association
5310 West Capitol Drive, Milwaukee, Wisconsin 53216 414-447-6543

JUL 6 1981

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.[ ]. 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 ~s 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.