~~326~~ 516 396

TO: Referring Physician Dr. [ ]

NRC Regional Office
Office of Inspection and Enforcement

Also send copy to:
U.S. Nuclear Regulatory Commission
c/o Document Management Branch
Washington, D.C. 20555

REPORT OF DIAGNOSTIC MISADMINISTRATION

Date of report 11/10/81 Date of Incident 10/5/81

Licensee St. Anthony Hospital Number 48-13834-01 03005495

Address 1004 N. 10th St.

City, State Milwaukee, Wisconsin 53233

Referring Physician Dr. [ ]

Signature

Description of event A nuclear medicine bone scan request was sent by the third floor nursing unit to nuclear medicine. It was discovered later that the request had been improperly filled out and the bone scan had been administered to the incorrect patient.

Effect on patient No adverse effect.

Preventive action Nursing supervisors were notified. Ward clerks were told that increased attentiveness is needed when using patient addressograph plates.

This report is to be sent within ten (10) days after the end of calendar quarter in which the incident occurred.

The Medical Isotope Committee and the licensee (administration) has been informed of this incident.

Submitted by:

, Radiation Safety Officer

IE30

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ST. ANTHONY HOSPITAL · INCIDENT REPORT · No. 2099

IDENTIFICATION	INCIDENT DATE	BED ADJUSTMENT	CONDITION BEFORE	NAME AND ADDRESS OF PERSON INVOLVED. USE ADDRESSOGRAPH IF AVAILABLE.
☒ 1 - Patient ☐ 2 - Employee ☐ 3 - Visitor	10/5/81	(Patients only) ☐ 1 - Not adjustable ☐ 2 - Up ☐ 3 - Down	☒ 1 - Normal ☐ 2 - Senile ☐ 3 - Disoriented ☐ 4 - Sedated ☐ 5 - Unconscious ☐ 6 - Other	[redacted]
SEX ☐ 1 - Female ☐ 2 - Male	INCIDENT TIME ☒ AM ☐ PM 11:00	REPORT DATE 10/5/81	RESTRAINTS ☐ YES ☐ NO	
AGE	LOCATION OF INCIDENT	SIDE RAILS UP ☐ DOWN ☐		

IF PATIENT give cause for Hospitalization. Give BRIEF DESCRIPTION of Incident. Clarify any necessary items, state cause, part of Body Injured.
Pre-operative evaluation of left foot. A nuclear radicine scan (bone) request was sent to nuclear radicine by the 3rd floor nursing unit. The request was initialed by [redacted] It was discovered later, after the scan had been started, that the request was improperly filled out. Incorrect patient.

IF VISITOR give reason for presence

Home Phone

Visitor Signature

STATEMENT OF ATTENDING PHYSICIAN

SIGNATURE OF ATTENDING PHYSICIAN

STATEMENT OF PHYSICIAN GIVING INITIAL TREATMENT

SIGNATURE OF PHYSICIAN DATE

IF EMPLOYEE give BRIEF DESCRIPTION of Incident. Clarify any necessary items, state cause, part of body injured, part inv.

Dept. Job Title

EMPLOYEE SIGNATURE DATE

WAS MEDICAL ATTENTION PROVIDED? YES ☐ NO ☐ IF YES, BY WHOM AND WHAT TYPE.

OCT 5 RECEIVED PERSONNEL

IF MEDICATION PATIENT MEDICINE ☐ FLOOR STOCK MEDICINE ☐

PERSONNEL DATA:
DISPENSING ERROR NO
PERSON(S) RESPONSIBLE —
ADMINISTRATION ERROR
PERSON(S) RESPONSIBLE

DRUG DATA:
NAME OF DRUG TC MDP
DOSAGE FORM OF DRUG INJECTION
STRENGTH OF DRUG 17 mCi
DOSES OF DRUG RECEIVED ONE
CONDITION OF PATIENT AFTER DRUG ADMINISTRATION NORMAL

INCIDENT CAUSE

☐ Dosage	☐ Transcription
☐ Route	☐ Wrong Medication
☒ Unordered	☐ Labeling
☐ Duplication	☐ Time Given
☐ Omission	☐ Other

DATE ERROR DISCOVERED 10/5/81
TIME ERROR DISCOVERED 11:30 AM
BY WHOM [redacted]

DESCRIBE IN DETAIL

IF EQUIPMENT
IDENTIFY EQUIPMENT
WAS EQUIPMENT DEFECTIVE?
WERE SAFETY DEVICES IN USE?
WAS PERSON TRAINED IN USE OF THIS EQUIPMENT?
WAS PERSON AUTHORIZED TO USE THIS EQUIPMENT?
HISTORY OF PREVENTIVE MAINTENANCE ON EQUIPMENT.

ADDITIONAL COMMENTS:

VITAL SIGNS: B P P R (Do not write below this line)

Name and Title of person preparing report

Supv. Signature

STATE CORRECTIVE ACTION TAKEN. INDICATE IF FURTHER INVESTIGATION IS NECESSARY.

NOV 23 1981

TIME LOST (Employee only) ☐ 1. Yes ☐ 2. No DAYS MO

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WHITE AND YELLOW COPIES TO NURSING SERVICE AFTER COMPLETION