

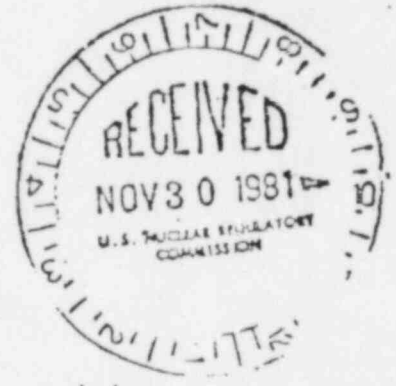
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TO: Referring Physician Dr. []

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 0505493

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:

[Signature], Radiation Safety Officer

IX 30

XA Copy Has Been Sent to PDR

NOV 23 1981

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IE LIC30
48-13834-01

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IDENTIFICATION	INCIDENT DATE	BED ADJUSTMENT	CONDITION BEFORE	NAME AND ADDRESS OF PERSON INVOLVED. USE ADDRESSOGRAPH IF AVAILABLE.
<input checked="" type="checkbox"/> 1. Patient <input type="checkbox"/> 2. Employee <input type="checkbox"/> 3. Visitor SEX <input type="checkbox"/> 1. Female <input type="checkbox"/> 2. Male AGE	10/5/81 INCIDENT TIME <input checked="" type="checkbox"/> AM <input type="checkbox"/> PM 11:00 LOCATION OF INCIDENT	(Patients only) <input type="checkbox"/> 1. Not adjustable <input type="checkbox"/> 2. Up <input type="checkbox"/> 3. Down REPORT DATE 10/5/81 SIDE RAILS UP <input type="checkbox"/> DOWN <input type="checkbox"/>	<input checked="" type="checkbox"/> 1. Normal <input type="checkbox"/> 2. Sane <input type="checkbox"/> 3. Disoriented <input type="checkbox"/> 4. Sedated <input type="checkbox"/> 5. Unconscious <input type="checkbox"/> 6. Other RESTRAINTS <input type="checkbox"/> YES <input type="checkbox"/> NO	

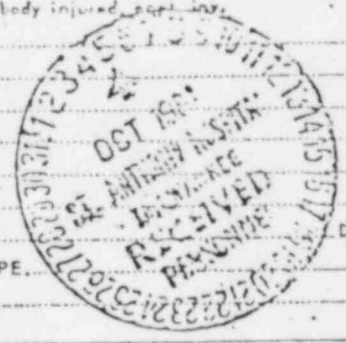
IF PATIENT give cause for Hospitalization. Give BRIEF DESCRIPTION of Incident. Clarify any necessary items, state cause, part of Body Injured.
 post-operative swelling of left foot. A nuclear radioactive scan (bone) request

IF VISITOR give reason for presence. was initiated by [] It was discovered later, after the exam had been started, that the request was improperly filled out. Incorrect patient.

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 involved.
 Dept. Job Title

EMPLOYEE SIGNATURE DATE
 WAS MEDICAL ATTENTION PROVIDED? YES NO IF YES, BY WHOM AND WHAT TYPE.



IF MEDICATION	PATIENT MEDICINE <input type="checkbox"/>	FLOOR STOCK MEDICINE <input type="checkbox"/>	INCIDENT CAUSE
PERSONNEL DATA DISPENSING ERROR: NO PERSON(S) RESPONSIBLE: ADMINISTRATION ERROR: PERSON(S) RESPONSIBLE: DRUG DATA: NAME OF DRUG: <u>TC MOP</u> DOSAGE FORM OF DRUG: <u>INJECTION</u> STRENGTH OF DRUG: <u>1% cc</u> DOSES OF DRUG RECEIVED: <u>ONE</u> CONDITION OF PATIENT AFTER DRUG ADMINISTRATION: <u>NORMAL</u>			<input type="checkbox"/> Dosage <input type="checkbox"/> Route <input checked="" type="checkbox"/> Unordered <input type="checkbox"/> Duplication <input type="checkbox"/> Omission <input type="checkbox"/> Transcription <input type="checkbox"/> Wrong Medication <input type="checkbox"/> Labeling <input type="checkbox"/> Time Given <input type="checkbox"/> Other DATE ERROR DISCOVERED: <u>10/5/81</u> TIME ERROR DISCOVERED: <u>11:30 AM</u> BY WHOM: []

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.
 (Employee only) TIME LOST DAYS MO
 1. Yes 2. No
 NOV 23 1981
 PINK AND GOLD COPIES TO NURSING SERVICE IMMEDIATELY
 WHITE AND YELLOW COPIES TO NURSING SERVICE AFTER COMPLETION