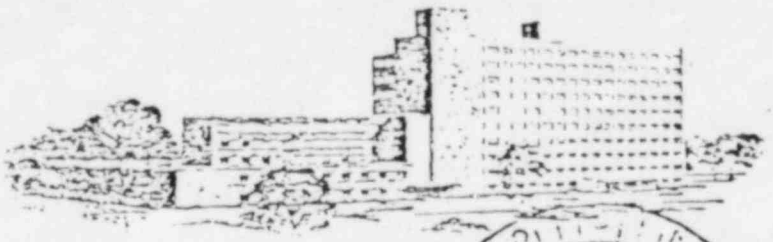
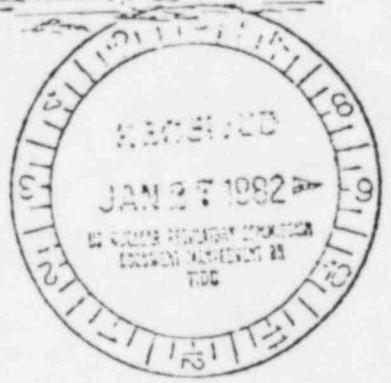
410 Misadministration

ST. VINCENT HOSPITAL

P O BOX 1221
GREEN BAY, WISCONSIN - 54305
(414) 432-8621



January 18, 1982



Region III
Office of Inspection and Enforcement
U. S. Nuclear Regulatory Commision
799 Roosevelt Road
Glen Ellyn, IL 60137

Gentlemen:

In compliance with Title 10, Code of Federal Regulations, Part 35.43. "Reports of Diagnostic Misadministration", St. Vincent Hospital, U.S.N.R.C. License #48-03220-03 reports the following misadministration during the period October 1 - December 31, 1981.

Referring Physician: [ ] M.D.

Description of Events: The patient was to have a brain scan using 20 millicuries of technetium labeled glucoheptonate. The technologists picked up a syringe containing 65 millicuries of unlabeled technetium, which was to have been labeled with sulpher colloid, and injected the patient.

Effects on Patient: There will probably be no short or long term ill effects. The brain scan was performed and the test did not have to be repeated.

Action Taken to Prevent Reoccurence: The following statements have been added to the Department of Radiology procedure manual:

"In an effort to avoid, or lessen, the chance misadministration of a radioactive substance to our patients, the following procedure must be followed.

Medication (radiopharmaceutical) shall be drawn, in the required amount, immediately preceding injection and only after the patient's name and exam have been verified by the administering person.

Failure to follow this procedure will result in disciplinary action."

Sincerely,

Sr. M. Paulette Collings

Sr. M. Paulette Collings
Executive Vice President

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XA Copy Has Been Sent to PDR

cc: Radiation Safety Officer

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