414

William S. Middleton Memorial Veterans' Hospital

2500 Overlook Terrace
Madison, WI 53705

Vacherlon

Veterans Administration

48-01183-81

30-3418

September 18, 1981

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

SUBJ: Report of Diagnostic Misadministration

1. On August 21, 1981, Dr. [ ] referred a patient to the Nuclear Medicine Service for a gated blood pool study. The patient received an intravenous injection of 5 milliCuries of ^{99m}Tc-sulfur colloid instead of the 20 milliCuries ^{99m}Tc-pyrophosphate required for the requested study.

2. Dr. R. E. Polcyn, Chief, Nuclear Medicine Service, determined there was no clear indication for not informing the patient of the error. He informed the patient, and the patient consented to having the liver/spleen examination for which the dose of radiocolloid is routinely administered. The requested cardiac study was subsequently performed three days later.

3. In retrospect, this misadministration was the direct result of inadequate correlation between patient information present on the label affixed to the syringe containing the radiopharmaceutical and the patient identification band worn by the patient.

4. The misadministration has been discussed with all members of the Nuclear Medicine Service with particular emphasis on the importance of verifying that patient identification on the radiopharmaceutical, the consultation form, and wristband is identical. Written performance standards for the technologists underscore the seriousness of such misadministrations by stating that an individual can potentially be removed from his/her position as a Nuclear Medicine Technologist as a direct result of misadministrations.

Judith L. Sullivan
JUDITH L. SULLIVAN
Radiation Safety Officer

T. J. STRANOVA
Hospital Director

(607/115)

8303240207 830218
PDR FOIA
STOEFFLE83-64 PDR