10 CFR 35.33

DIAGNOSTIC MISADMINISTRATION REPORT

3150-0170
Expires 5/31/91

(N1) LICENSEE NAME: Brigham and Women's Hospital

(N2) LICENSE NUMBER: 20-17131-13

(N3) CITY: Boston

(N4) STATE: MA

(N5) EVENT DATE: MONTH 12 DAY 16 YEAR 88

(N6) REPORT DATE: MONTH 12 DAY 16 YEAR 88

(N7) TYPE OF MISADMINISTRATION
- [X] (101) WRONG RADIOPHARMACEUTICAL
- [ ] (102) DOSAGE DIFFERING FROM PRESCRIBED BY 50%
- [ ] (103) WRONG PATIENT
- [ ] (104) WRONG ROUTE

(N8) DID THE MISADMINISTRATION INVOLVE AN ISOTOPE OF IODINE?
- [ ] (999) YES
- [X] (111) NO

(N9) NUMBER OF PATIENTS WHO RECEIVED A MISADMINISTRATION UNDER THIS REPORT: one(1)

(N10) INTENDED

- [ ] (105) NO CLINICAL PROCEDURE
- [X] (106) NUCLEAR MEDICINE STUDY (Complete (N10A) INTENDED and (N11) GIVEN)
- [ ] (107) X RAY STUDY
- [ ] (108) ULTRASOUND STUDY
- [ ] (109) CT STUDY
- [ ] (110) NMO STUDY
- [ ] (111) OTHER

(N10A) INTENDED MILLICURIES	ISOTOPE	CHEMICAL FORM	STUDY	(N11) GIVEN MILLICURIES	ISOTOPE	CHEMICAL FORM	STUDY
25 mCi	Tc-99m	MDP	bone	25 mCi	Tc-99m	TcO_4^-	N/A

(N12) PRECIPITATOR
- [ ] (71) REFERRING PHYSICIAN
- [ ] (72) WARD NURSE
- [ ] (73) WARD CLERK
- [ ] (74) NUCLEAR PHARMACY
  - NAME OF NUCLEAR PHARMACY | CITY | STATE
- [X] (75) AUTHORIZED USER
- [ ] (76) HOT LAB TECHNOLOGIST
- [X] (77) IMAGING TECHNOLOGIST
- [ ] (78) CLINIC RECEPTIONIST
- [ ] (79) SCHEDULING TECHNOLOGIST
- [ ] (80) PATIENT
- [ ] (81) OTHER

(N13) ERROR

HOT LAB
- [ ] (11) MISLABELED A SYRINGE
- [ ] (12) MISLABELED A VIAL OR VIAL SHIELD
- [ ] (13) RECONSTITUTED WRONG REAGENT KIT
- [ ] (14) PLACED RECONSTITUTED VIAL IN WRONG SHIELD
- [X] (15) SELECTED WRONG VIAL WHEN DRAWING DOSAGE
- [ ] (16) SET DOSE CALIBRATOR IMPROPERLY
- [ ] (17) MISREAD DOSE CALIBRATOR
- [ ] (18) MISUNDERSTOOD RADIOPHARMACEUTICAL OR DOSAGE ORDER

REFERRAL
- [ ] (20) MISUNDERSTOOD REFERRING PHYSICIAN'S REQUEST
- [ ] (21) REQUESTED WRONG STUDY
- [ ] (22) REQUESTED STUDY FOR WRONG PATIENT

ADMINISTRATION
- [ ] (30) SELECTED WRONG PATIENT
- [ ] (31) ANSWERED WAITING ROOM PAGE INTENDED FOR OTHER PATIENT
- [ ] (32) BROUGHT WRONG PATIENT TO CLINIC
- [ ] (33) SELECTED WRONG SYRINGE FROM DOSAGE CART

OTHER
- [ ] (40) Specify

(N14) CONTRIBUTING FACTORS
- [X] (80) STUDENT TECHNOLOGIST
- [ ] (81) NEW EMPLOYEE
- [ ] (82) FOREIGN LANGUAGE
- [ ] (83) PATIENT INCOHERENT OR UNCONSCIOUS
- [ ] (84) ID BRACELET NOT CHECKED
- [ ] (85) REQUISITION NOT CHECKED
- [ ] (86) PATIENT CHART NOT CHECKED
- [ ] (87) NEW PROCEDURE
- [X] (88) HEAVY WORKLOAD
- [ ] (89) OTHER

(N15) ACTION TAKEN TO PREVENT RECURRENCE

IMPLEMENT NEW PROCEDURES FOR
- [ ] (C1) VERIFICATION OF REQUEST
- [X] (C2) RADIOPHARMACEUTICAL ~~HANDLING AND~~ HANDLING
- [ ] (C3) VERIFICATION OF PATIENT IDENTIFICATION
- [X] (C4) REINSTRUCT PERSONNEL
- [X] (C5) REPRIMAND PERSONNEL
- [X] (C6) IMPROVE SUPERVISION OF PERSONNEL
- [ ] (C7) NO ACTION
- [ ] (C8) OTHER

(N16) EFFECT ON PATIENTS
- [X] NONE APPARENT
- [ ] SEE ABSTRACT

(N17) ABSTRACT (If more space is required attach additional sheets.)

A 40 year old woman with back pain was referred for a bone scan to obtain clarification after two sets of spine radiographs were inconclusive. The nuclear medicine technologist withdrew and administered 25 mCi from a multidose vial labeled "TcO_4^-" instead of "MDP".

License No. 20-17131-03

Docket No. 030-15070

~~MLER~~ 9-002

RADIATION OFFICER (Printed Name)	SIGNATURE	TELEPHONE	DATE
David E. Drum, M.D.	David E. Drum	(617) 732-6056	12/29/88

NUCLEAR REGULATORY COMMISSION USE

(N18)	(N19) AS	(N20) REGIONAL LOG NUMBER	(N21) ACCESSION NUMBER	(N22) INITIALS
[ ] (999) YES [ ] (111) NO				

Return Original to Region I

NRC FORM 472 (5-88)

1 X 30

REGION I
NMSS LICENSEE EVENT REPORT

License No. 20-17131-03

Docket No. 030-15070

MLER-RI-89-002

I. ACTION CONTROL DATA

Licensee BRIGHAM AND WOMEN'S HOSPITAL

Event Description diagnostic misadministration

Event Date 12/16/88 Report Date 12/16/88

II. REPORTING REQUIREMENT

[ ] 10 CFR 20.402 - theft or loss

[ ] 10 CFR 20.403(a)(b) overexposure/release

[ ] 10 CFR 20.405 - 30 day report

[ ] Other

[ ] 10 CFR 35.33 Therapeutic Misadministration

[X] 10 CFR 35.33 Diagnostic Misadministration

[ ] License Condition

III. REGION I RESPONSE

[ ] Immediate Site Inspection Inspector Date

[ ] Special Inspection Inspector Date

[ ] Telephone Inquiry Inspector Date

Licensee Representative and Title

[ ] PN [ ] Daily Report

[X] Information entered - Region I log and Outstanding Items List

[X] Review at next routine inspection

IV. REPORT EVALUATION

[X] Description of Event

[X] Levels of R/M involved

[X] Cause of Event

[X] Corrective Actions

[ ] Calculation Adequate

[ ] Letter to Licensee requesting additional information

Completed by: E Ullrich Date 3/1/89

Reviewed by: [signature] Date 3/9/89

V. SPECIAL INSTRUCTIONS OR COMMENTS

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