Misadministration

DMB COPY

THE CLEVELAND CLINIC FOUNDATION

One Clinic Center 9500 Euclid Avenue Cleveland, Ohio 44195-5191

A National Referral Center An International Health Resource

-01
34-00466-07

Steven J. Aron Jr. PhD
Radiation Safety / Q21
216/444-6645

Darrel Wiedeman, Chief
Nuclear Materials Safety Section No. 1
U.S. NUCLEAR REGULATORY COMMISSION, REGION III
799 Roosevelt Road
Glen Ellyn, Illinois 60137

June 13, 1988

Dear Mr. Wiedeman:

The attached Diagnostic Misadministration Report is sent to you in compliance with the Code of Federal Regulations, 10 CFR 35.33 (c).

Should you require any additional information, please don't hesitate to call me at (216) 444-6645.

Sincerely,

Steven J. Aron Jr.

Steven J. Aron, Jr., Ph.D.
Radiation Safety Officer

cc: Raymundo T. Go, M.D.
James E. Lees

Attachment

IX 30
'11

JUN 14 1988

A/9

9207230063 911104
PDR FOIA
DAVIS91-445 PDR

9207230063

NRC FORM #73
(6-87)
10 CFR 35.33

U.S. NUCLEAR REGULATORY COMMISSION
Approved by OMB
3150-0170
Expires 5-31-88

DIAGNOSTIC MISADMINISTRATION REPORT

(N1) LICENSEE NAME: CLEVELAND CLINIC FOUNDATION

(N2) LICENSE NUMBER: | | |—| | | | | | |—| |

(N3) CITY: CLEVELAND

(N4) STATE: OHIO

(N5) EVENT DATE: CENTURY | DAY | YEAR: 0 5 | 2 4 | 8 8

(N6) REPORT DATE: MONTH | DAY | YEAR: 0 5 | 2 4 | 8 8

(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
- [ ] (106) NO CLINICAL PROCEDURE
- [X] (108) NUCLEAR MEDICINE STUDY (between IN10A) INTENDED and IN11) GIVEN)
- [ ] (107) X-RAY STUDY
- [ ] (109) ULTRASOUND STUDY
- [ ] (110) CT STUDY
- [ ] (112) NMR STUDY
- [ ] (113) OTHER

(N10A) INTENDED	MILLICURIES	ISOTOPE	CHEMICAL FORM	STUDY
	12.0	Tc-99m	DTPA	renal

(N11) GIVEN	MILLICURIES	ISOTOPE	CHEMICAL FORM	STUDY
	0.611	99m Tc O4	TcO4	renal

(N12) PRECIPITATOR
- [ ] (111) REFERRING PHYSICIAN
- [ ] (112) WARD NURSE
- [ ] (113) WARD CLERK
- [ ] (114) NUCLEAR PHARMACY
  NAME OF NUCLEAR PHARMACY | CITY | STATE
- [X] (116) NUCLEAR TECHNOLOGIST — 3A-8 6-15-8
- [ ] (117) IMAGING TECHNOLOGIST
- [ ] (118) CLINIC RECEPTIONIST
- [ ] (119) SCHEDULING TECHNOLOGIST
- [ ] (120) PATIENT
- [ ] (121) OTHER

(N13) ERROR

HOT LAB
- [ ] (111) MISLABELED SYRINGE
- [ ] (112) MISLABELED VIAL OR VIAL SHIELD
- [ ] (113) RECONSTITUTED WRONG REAGENT KIT
- [ ] (114) PLACED RECONSTITUTED VIAL IN WRONG SHIELD
- [ ] (115) SELECTED WRONG VIAL WHEN DRAWING DOSAGE
- [ ] (116) SET DOSE CALIBRATOR IMPROPERLY
- [ ] (117) MISREAD DOSE CALIBRATOR
- [ ] (118) MISUNDERSTOOD RADIOPHARMACEUTICAL OR DOSAGE ORDER

REFERRAL
- [ ] (120) SCI/UNDERSTOOD REFERRING PHYSICIAN'S REQUEST
- [ ] (121) REQUESTED WRONG STUDY
- [ ] (122) REQUESTED STUDY FOR WRONG PATIENT

ADMINISTRATION
- [ ] (130) SELECTED WRONG PATIENT
- [ ] (131) ANSWERED WAITING ROOM PAGE INTENDED FOR OTHER PATIENT
- [ ] (132) BROUGHT WRONG PATIENT TO CLINIC
- [X] (133) SELECTED WRONG SYRINGE FROM DOSAGE CART

OTHER
- [ ] (140) Specify

(N14) CONTRIBUTING FACTORS
- [ ] (180) STUDENT TECHNOLOGIST
- [ ] (181) NEW EMPLOYEE
- [ ] (182) FOREIGN LANGUAGE
- [ ] (183) PATIENT INCOHERENT OR UNCOOPERATIVE
- [ ] (184) ID BRACELET NOT CHECKED
- [ ] (185) REQUISITION NOT CHECKED
- [ ] (186) PATIENT CHART NOT CHECKED
- [ ] (187) NEW PROCEDURE
- [ ] (188) HEAVY WORKLOAD
- [ ] (189) OTHER

(N15) ACTION TAKEN TO PREVENT RECURRENCE
- IMPLEMENT NEW PROCEDURES FOR
  - [ ] (C1) VERIFICATION OF REQUEST
  - [ ] (C2) RADIOPHARMACEUTICAL LABELING AND HANDLING
  - [ ] (C3) VERIFICATION OF PATIENT IDENTIFICATION
- [X] (C4) REINSTRUCT PERSONNEL
- [ ] (C5) REPRIMAND PERSONNEL
- [ ] (C6) IMPROVE SUPERVISION OF PERSONNEL
- [ ] (C7) NO ACTION
- [ ] (C8) OTHER

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

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

Used 0.611 mCi Tc-99m TcO4 peaking source for positioning patient. Experienced difficulty injecting Tc-99m DTPA. Injected positioning source activity in error. Patient reinjected with 11.5 mCi of Tc-99m DTPA after obtaining physician approval. Total Tc-99m activity did not exceed intended Tc-99m activity.

NUCLEAR REGULATORY COMMISSION USE

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

received 6-6-88