3/13/00 cc: INEEL
Plunkin
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EVENT REPORT COVER PAGE

AGREEMENT STATE

EVENT REPORT NO. RI - 00 - 101

DATE: 3/10/00

TO: Pat Larkins
Deputy Director
Office of State Programs

SUBJECT: Misadministration Report

STATE: Rhode Island

Signature and Title: Charles V. DeMonbrun

Supervising Radiation Control Specialist

NRC FORM 666 (4-94) U. S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB: NO. 3150-0178
EXPIRES: 04/30/97

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 1 HOUR. THIS INFORMATION IS REQUESTED TO ASSESS MISADMINISTRATIONS AND EVALUATE ACTIONS NECESSARY TO PREVENT THEIR RECURRENCE. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0178), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

MEDICAL MISADMINISTRATION

LICENSEE	CITY AND STATE	ORIGINAL ITEM NUMBER
Rhode Island Hospital	Providence, RI	RI-00-101
TYPE OF LICENSE *(e.g., Broad Scope, Private Practice Medical, etc.)*	**LICENSE NUMBER**	**THIS ITEM NUMBER**
Broad Scope Medical	7D-051-01	

ABNORMAL OCCURRENCE	FOLLOW-UP REPORT	THE PATIENT WAS NOTIFIED	DATE OF EVENT
[ ] YES [X] NO	[ ] YES [X] NO	[X] YES [ ] NO	2/14/00
			DATE OF THIS REPORT 3/10/00

[ ] SODIUM IODINE, I-125 OR I-131, > 30 MICROCURIES
- [ ] WRONG PATIENT
- [ ] WRONG RADIOPHARMACEUTICAL
- [X] ADMINISTERED DOSE DIFFERS FROM PRESCRIBED DOSE BY > 20% AND DIFFERENCE EXCEEDS 30 MICROCURIES

[ ] THERAPEUTIC RADIOPHARMACEUTICAL DOSE, OTHER THAN I-125 OR I-131
- [ ] WRONG PATIENT
- [ ] WRONG RADIOPHARMACEUTICAL
- [ ] WRONG ROUTE OF ADMINISTRATION
- [ ] ADMINISTERED DOSE DIFFERS FROM PRESCRIBED DOSE BY > 20%

[ ] STEREOTACTIC RADIOSURGERY (GAMMAKNIFE)
- [ ] WRONG PATIENT
- [ ] WRONG TREATMENT SITE
- [ ] ADMINISTERED DOSE DIFFERS FROM PRESCRIBED DOSE BY MORE THAN 10%

[ ] TELETHERAPY
- [ ] WRONG PATIENT
- [ ] WRONG MODE OF TREATMENT
- [ ] WRONG TREATMENT SITE
- [ ] ADMINISTERED DOSE DIFFERS FROM PRESCRIBED DOSE BY MORE THAN 10% IF THERE ARE 3 OR FEWER FRACTIONS PRESCRIBED; OR WHEN WEEKLY CALCULATED ADMINISTERED DOSE EXCEEDS PRESCRIBED DOSE BY > 30%; OR WHEN CALCULATED TOTAL ADMINISTERED DOSE DIFFERS FROM PRESCRIBED DOSE BY > 20%.

[ ] BRACHYTHERAPY
- [ ] WRONG PATIENT
- [ ] WRONG RADIOISOTOPE
- [ ] WRONG TREATMENT SITE
- [ ] LEAKING SOURCE
- [ ] ONE OR MORE SOURCES NOT REMOVED AT END OF TREATMENT
- [ ] CALCULATED ADMINISTERED DOSE DIFFERS FROM PRESCRIBED DOSE BY > 20%

[ ] DIAGNOSTIC RADIOPHARMACEUTICAL DOSE, OTHER THAN QUANTITIES THAT EXCEED 30 MICROCURIES OF I-125 OR I-131, OR BOTH, WHEN THE PATIENT DOSE EXCEEDS 5 REM EFFECTIVE DOSE EQUIVALENT OR 50 REM ORGAN DOSE AND INVOLVES:
- [ ] WRONG PATIENT
- [ ] WRONG RADIOPHARMACEUTICAL
- [ ] WRONG ROUTE OF ADMINISTRATION
- [ ] ADMINISTERED DOSE DIFFERS FROM PRESCRIBED DOSAGE

ABSTRACT *(Include the cause of the misadministration, contributing factors, and licensee corrective action. May be continued on the reverse side.)*

Two patients, for whom therapeutic doses of 75 and 100 millicuries of Iodine 131 had been prescribed, were interchanged, each receiving the other's intended dose. Both patients were present in the department at the same time, along with their prescribing physicians, and the medical physicist who prepared the doses. The order in which the doses were to be administered to the patients was apparently determined among the persons involved, then reversed at the last minute. This reversal was apparently not clearly communicated to the physicist, a contributing cause of the incident. However, the ultimate cause of the misadministrations was failure to strictly follow established procedures, i.e., checking the prescriptions, the doses, and the patient identifications.

No effects are expected to result from the misadministrations, and both patients were notified. The licensee has provided retraining to emphasize the need for strict adherence to procedure.