NORTHWEST COMMUNITY HOSPITAL

DEPARTMENT OF RADIOLOGY
OFFICE OF RADIATION SAFETY & MEDICAL PHYSICS
J M PAUL, Ph D DABR, CHIEF PHYSICIST
AND RADIATION PROTECTION SUPERVISOR
RICHARD F KOCH, M S, DABR
P C PHILIP, M S

Northwest Community Hospital
800 West Central Road - Arlington Heights, IL 60005
Report Form of Diagnostic Misadministration

Mail the report to: NRC Region III
799 Roosevelt Road
Glen Ellyn, IL 60137

1. Re: NRC License No. 12-13027-02

2. a) Patient Name: [redacted] Pt. ID# [redacted] /So. Sec. No# Not Avail

b) Was the procedure intended on the same patient? [redacted] / No

3. Name of the radiologist: C. Soter, M.D.
4. Name of the involved technologist: Sam Mulay
5. Name of the referring physician: Dr. Warrier

6. a) Procedure intended: Brain Scan
b) Pharmaceutical intended: Glucepatate Tc^{99m}
c) Amount intended: 20 mCi

7. a) Procedure done: Bone Scan
b) Pharmaceutical given: Osteolite Tc^{99m}
c) Amount given: 20mCi

8. Description of event (what happened):

Please see Insert Sheet

9. The effect on patient (describe): None

10. Action taken to prevent any recurrence:

Hopefully the Physician will write legibly

Send a copy to the referring physician.

Karen Franz R.T.
Karen Franz
Supervisor, Nuclear Medicine

J. M. Paul
J. M. Paul, Ph.D.
Radiation Protection Supervisor

NORTHWEST COMMUNITY HOSPITAL

☒ PATIENT
☐ VISITOR

OCCURRENCE REPORT

1
DATE June 26, 1984 TIME 12:00 ☐ am ☒ pm

NOTE: CONFIDENTIAL REPORT /NOT PART OF MEDICAL RECORD

PRIVILEGED AND CONFIDENTIAL

All information provided on this form, including any appended materials, is furnished as a report to the Quality Assurance Committee and is PRIVILEGED and CONFIDENTIAL, to be used solely in the course of internal quality control and for the purposes of reducing morbidity and mortality and improving the quality of patient care, as provided in Illinois Revised Statutes Chapter 51, Section 101, *et seq.*

2
Name [redacted] Date of birth [redacted] Marital status MAR

Address [redacted] ARLINGTON HTS ILL. Phone No. [redacted]

Date admitted 6/25/84 Hosp. ID No. [redacted] Room No. [redacted]

Attending physician KRISHNAN WALLIUM MD Charge nurse

Reason for being in hospital (i.e., admitting diagnosis, surgical procedure, presenting complaint, business purpose)
DIABETIC + CVA

If business-related: Occupation Employer

3
Describe occurrence [redacted] AT APPROXIMATELY 12:00 pm, JUNE 24, 1984 WAS INJECTED FOR A BONE SCAN BY SAM MULAY R.T. NUCLEAR MEDICINE DEPARTMENT. THE PATIENTS CHART WAS EXAMINED PRIOR TO INJECTION AND WHAT APPEARED TO BE "RADIONUCLIDE BONE SCAN" WAS OBSERVED. BOTH THE FLOOR AND MR. MULAY READ THE ORDER AS "BONE SCAN". LATER HOWEVER — WAS DISCOVERED THAT THE ATTENDING PHYSICIAN WANTED A BRAIN SCAN. THIS ERROR WAS DUE TO ILLEGIBLE WRITING OF PHYSICIAN (SEE PHOTOSTAT).

Describe patient/visitor and/or family response to occurrence (if any)

Witness(es) (include roommates)

Name Address Phone No

Name Address Phone No

Name Address Phone No

4a 4b 4c

Type of occurrence
- ☐ Diagnosis-related
- ☐ Surgery-related
- ☐ Treatment/procedure-related
- ☐ Blood-related
- ☐ IV-related
- ☐ Medication-related
- ☐ Fall
- ☐ Other

Location of occurrence
- ☒ Patient room
- ☐ Operating room
- ☐ Recovery room
- ☐ Emergency department
- ☐ Blood bank
- ☐ Critical care unit (specify)
- ☐ Labor and delivery room
- ☐ Nursery
- ☐ Radiology
- ☐ Physical therapy
- ☐ Laboratory
- ☐ Other

Initial estimate of injury
- ☐ None
- ☐ Minimal
- ☐ Moderate
- ☐ Serious
- ☐ Unknown

SUBMIT COMPLETED REPORTS AS SOON AS POSSIBLE.
FOR SERIOUS OCCURRENCES, CALL DIRECTLY TO ADMINISTRATION, EXT. 337

THIS FORM MAY NOT BE DUPLICATED

COMPLETE FOR ALL OCCURRENCES

5
Medication within past twelve hours (include name & dosage)

6
X-ray ordered following occurrence?
☐ Yes
☐ No
☒ Not applicable
Results

COMPLETE THE FOLLOW FOR FALLS ONLY

7a
Activity orders
☐ Up without assistance
☐ Up with assistance
☐ Bed rest with BR privileges
☐ Bed rest with bedside commode
☐ Bed rest only
☐ Restraints (specify type)

7b
Bed rails
☐ Up
☐ Down
☐ None

7c
Bed position
☐ High
☐ Low
☐ Not adjustable

7d
Signal light Working?
☐ Yes
☐ No

Cord in reach?
☐ Yes
☐ No

On?
☐ Yes
☐ No

8
Attending physician called? ☒ Yes ☐ No
If yes Name DR. WARLICK Date 6/26/84 Time _____ By whom FLOOR
Results CANCER BONE SCAN, NUCLEAR BRAIN SCAN ORDERED

9
Examined by physician? ☐ Yes ☐ No If yes Date _____ Time _____ Where _____
Findings (must also be recorded in chart)

Treatment initiation following occurrence (if any)

Name of examining physician _____ Signature _____ Date _____

10
Name of person reporting occurrence SAMUEL J. MULAY
Title NUCLEAR MEDICINE TECHNOLOGIST
Name of person preparing report (if different from above) _____
Title _____ Signature _____ Date _____
Name of supervisor KAREN FRANZ
Title SUPERVISOR Signature _____ Date _____

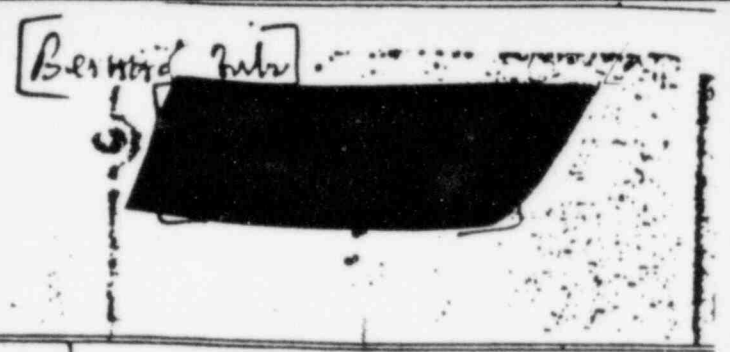
COMMITTEE INFORMATION ONLY

Date received _____

NORTHWEST COMMUNITY HOSPITAL
ARLINGTON HEIGHTS, ILLINOIS

PHYSICIAN'S ORDERS AND PROGRESS NOTES

PLEASE GIVE US YOUR NUMBER



Date – Time	PROGRESS NOTES
	S) Numbness Rt hand x 3 days Weakness Rt side x 1 day #1DM PE: HEENT unremarkable BP 152/90 Resp 18 pulse 76 regular Neck - negative Heart sounds normal Lungs clear - chest - abd CN cranial weakness Rt side of face hand and leg Babinski's Rt side Rt hemiparesis Rt hemiplegia Dip: CVA. K. Rao MD

Date – Time	DOCTOR'S ORDERS
6-25-84	#08 1) Radionuclide Bone Scan 2) Persantin 75 mg t.i.d 3) A.S.A - gr 5 q.d. D 4) Blood sugar daily - AM 5) N.P.H - insulin 45 int. Start and daily AM 6) Urine chemtest t.i.d 7) C.B.C 003 SMA 007 Hg12, HB and Lytes 005 8) E.K.G. 006 9) B.P. q hrly 10) V.S. q.i.d 11) 1500 Cal A.D. A diet. #10 c low cholesterol 12) PT. evaluation #08 w/m Intermittent

PHYSICIAN'S ORDERS

CHART COPY

License # 13-12914-c

Our Lady of Mercy Hospital
U.S. Highway 30 Dyer, Indiana 46311-1799 (219) 865-2141

August 23, 1984

U.S. Nuclear Regulatory Commission
799 Roosevelt Road
Glen Ellyn, Illionis 60137

Re: Misadministration - Dr. Tae Park
Licensee: Our Lady of Mercy Hospital

Dear Sir:

In concert with Part 35.43, Reports of Diagnostic Misadministration, the following report is intended to comply with the intent of said section.

On May 29, 1984 a misadministration occurred where 16mCi, Technetium 99m, Pyrophosphate was administered to a patient for whom that radiopharmaceutical was not ordered.

Description of the Events:

On May 29, 1984 at 10:45 a.m. a staff nuclear medicine technologist prepared a 16mCi dose of Technetium 99m, Pyrophosphate to be administered to the current patient in room 3209-2. The technologist proceeded to that patient's room, logged the radiopharmaceutical administration in the correct patient's chart and greeted the patient by stating the patient's name to which the radiopharmaceutical was to be administered. The patient subsequently nodded his head in agreement, the procedure was explained to the patient and subsequently the dose administered. After a period of time the patient in retrospect questioned the circumstances with a unit nurse who indicated that there had been an error. Subsequent investigation revealed that the appropriate dose had been administered to the wrong patient and that the patient who received the dose was not to have received the radiopharmaceutical, but rather that patient's roommate was the proper patient.

The incident was discussed with the patient and the Medical Director of Nuclear Medicine, who immediately contacted the attending physician to inform him of the error.

The Nuclear Medicine Department subsequently contacted Ray W. Dielman of Dielman Consultants, Incorporated, the Nuclear Medicine and Radiation Safety Consultant, who advised the supervisory personnel present on May 30, 1984 that a written report to the NRC was not any longer necessary. Believing that we had satisfied the appropriate requirements, and that no other medical management with this specific incident regarding the patient was required, no further action was taken at that time.

AUG 28 1984

No discernable effect on the patient was noted other than being upset because of the error. Since the dose was at a diagnostic level our perception at this point is that no detrimental effect to the patient is present.

In order to prevent this type of misadministration in the future two actions are being taken: 1-All staff are counseled on necessity to identify patients prior to radiopharmaceutical administration; 2-Formulation of an intra-departmental policy and procedure regarding administration of injectable material..

In late July 1984, a question was raised regarding the misadministration incident which prompted us to investigate further the NRC regulatations. This resulted in a call to the Regional Office where we were informed that a written report was indeed required. This letter is intended to provide that written report as described in Part 35.43.

Should you have any questions or require clarification of this incident, please do not hesitate to contact me.

Sincerely,

Joseph Daniels
Manager, Radiology/Nuclear Medicine

JD:cw

cc: M.L. Hirsch, M.D., Medical Director
L. Coleman, Vice-President
L. Smith, Finance/Risk Management
File