

Division of Nuclear Medicine Procedure / Protocol University Hospital & TAC Nuclear Medicine AFCH PET/CT

ADMINISTRATION OF RADIOPHARMACEUTICALS
UPDATED: SEPTEMBER 2017

CPT CODE: N/A

Prior to administration of the radiopharmaceutical these tasks must be performed:

1. Order and/or prepare the dose if not already prepared by radiopharmacy staff.
2. Using the Nuclear Medicine / Radiopharmacy Information System
 - a. Select the correct patient from the list of patients
 - b. Validate and correct the patient's weight
 - c. Select the correct dose from the list of available doses
 - d. Confirm prescription label is correct for patient and exam to be performed
 - Specifically verify the patient name, time of calibration, dosage and radiopharmaceutical.
 - e. Confirm the selected dose agrees with the prescription and enter the dose from the dose calibrator
 - i. The system is set to flag at +/- 10% per USP dispensing standards, however,
 1. For diagnostic administration the allowable variation from prescribed is +/- 20% or within the specific protocol/weight dose range. Per NRC and TJC standards.
 2. For therapeutic administration the allowable variation from prescribed is +/- 10%.
 - ii. The technologist verifies the dose is within the allowed variance. If the limit is exceeded the technologist takes corrective actions which include, but not limited to,
 1. Having the nuclear pharmacy draw up a new dose.
 2. Getting a verbal (diagnostic) or written (therapeutic) variance from the Nuclear Medicine Faculty.
3. Identify the patient according to UWHC procedure (2 forms of ID: wristband verification or name and birth date or MR#).
4. Ask female patients whether they are pregnant or nursing. If so, inform Nuclear Medicine physician immediately so an informed medical decision can be made concerning risks and benefits of the procedure. A discussion with the patient, sometimes referring physician and possible modifications of the procedure or even cancellation.
5. Explain the procedure to patient.
6. Review the order in HealthLink (or current hospital information system) to verify this test and dose are suitable for the patient and patient history as supplied. This review includes that the dose is appropriate for the patient's weight. Any questions raised will be discussed with nuclear medicine physician staff or residents prior to administration of the dose.
7. Administer the dose.
8. Enter the order and complete the electronic MAR in HealthLink (or current hospital information system) which includes the dose, radiopharmaceutical, time, site and route of injection.
9. Discard needles, gloves, trash, etc in the proper waste receptacles. Clean the syringe shield with a Cavi-wipe (or other approved wipe) prior to returning it to the Nuclear Pharmacy.
10. Direct the patient on what to do next (e.g. have a seat, return at a later time, eat/don't eat).
11. Remove/deface the radioactive symbol from all labels associated with the syringe or holder not directly adhered to the syringe. The label directly adhered to the syringe will be considered destroyed since it is disposed of through a sharps container/infectious waste which is incinerated.)
12. This procedure assumes points 2 through 7 are completed without any separation of the technologist from the dose and the patient. If there is any separation, the technologist MUST re-identify the patient, procedure and radiopharmaceutical as required in points 3 and 6.
13. Administration errors.
 - An error is defined as the wrong patient, the wrong radiopharmaceutical (or pharmaceutical), the wrong dosage (differing by more than the +/- percent allowed by the individual protocol or outside of the range), or the wrong route of administration.
 - When an administration error occurs the technologist will notify the following:
 - The assigned Nuclear Medicine Faculty for the day.
 - If the assigned Nuclear Medicine Faculty is not available, then notify any of the Nuclear Medicine faculty.
 - The Nuclear Medicine Manager (or designate).
 - The UWHC Radiation Health Physicist.
 - The Nuclear Medicine faculty will,

- Determine
 - If the exam can proceed and, if so, give any special instructions to the technologist as needed or,
 - The exam needs to be rescheduled.
- Talk to the patient and the ordering clinician, as appropriate.
- The technologist will also complete a PSN (or current patient incident report) and prepare a written account of what happened to be given to the Nuclear Medicine Manager and the Radiation Health Physicist.
- The technologist will also correct the following, so all reflects what was actually administered:
 - The NMIS entries
 - Medication Administration Record(s)
 - If the exam was already completed work with a Senior Technologist to credit exams or radiopharmaceuticals, as needed

Individuals authorized to administer and/or dispense radiopharmaceuticals and/or pharmaceuticals include:

Technologists

BRUNK, Danielle
 DONAR, Megan
 DENU, Rhonda
 FIERS, Douglas
 FUERBRINGER, Derek
 GOETSCH, Christopher
 GROW, Kerry
 HOVEY-ANDERSEN, Rosalie
 JANSMA, Heather
 KITT, Bryan
 KOPACZ, Kelley

PETERSON, Laura
 PETTIS, Kristine
 SECRIST, Elizabeth
 WORDEN, Emily

MD / Resident / Fellow

CHO, Steve (AU)
 HALL, Lance (AU)
 IBRAHIM, Nevein (AU)
 JAIN, Aditya (AU)
 JOHNSON, Heather (AU)
 KAJI, Eugene (AU)

KIELER, Minnie
 RITTER, Henry (AU)
 STONE, Charles (AU)
 THENKONDAR, Anu (AU)
 ZASADIL, Mary (AU)

Pharmacy

BORTZ, Nicole
 KNISHKA, Scott (ANP)
 KUBLY, Angel (ANP)
 LAWRENCE, Jennifer

And

All Radiology Residents
 All Cardiology Fellows

All Assigned Pharmacy personnel and students
 All Nuclear Medicine Technologist students

Reviewed By:

 Scott B. Perlman, MD, MS
 Chief, Nuclear Medicine

 Charles Stone
 Director, Nuclear Cardiology

 John Vetter, PhD, DABR
 Medical Physicist

 Derek Fuerbringer, CNMT
 Manager, Nuclear Medicine
 University Hospital

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 Manager, Nuclear Medicine
 The American Center

 Scott Knishka, RPh, BCNP
 Radiopharmacist