

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

ADMINISTRATION OF RADIOPHARMACEUTICALS  
UPDATED: DECEMBER 2020

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 per Nuclear Medicine operational SOPs for aseptic radiopharmaceutical preparation.
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 Health Link (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 Health Link (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 and carrier 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.

Commented [FDE1]: Do we want to update this to cisgender or birth gender female?

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 Lead Technologist to credit exams or radiopharmaceuticals, as needed

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

<u>Technologists</u>		<u>MD</u>
BEAMAN, Katelin	PETERSON, Laura	CHO, Steve (AU)
DONAR, Megan	PETTIS, Kristine	IBRAHIM, Nevein (AU)
DENU, Rhonda	SECRIST, Elizabeth	KAJI, Eugene (AU)
FUERBRINGER, Derek	WORDEN, Emily	KUSMIREK, Joanna (AU)
GOETSCH, Christopher		PERLMAN, Scott (AU)
GROW, Kerry	<u>Pharmacy</u>	PIRASTEH, Ali (AU)
JANSMA, Heather	BORTZ, Nicole	STONE, Charles (AU)
KITT, Bryan	KNISHKA, Scott (ANP)	ZASADIL, Mary (AU)
KOPACZ, Kelley	KUBLY, Angel (ANP)	
MINER, Robbin	LAWRENCE, Jennifer	

*And*

All Nuclear Medicine Residents and Fellows	All Radiology Residents
All Assigned Pharmacy personnel and students	All Cardiology Fellows
All Nuclear Medicine Technologist students	

Reviewed By:

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 Manager  
 Nuclear Pharmacy Services