

RADIATION ONCOLOGY CENTER
FUNDACION HOSPITAL METROPOLITANO

ADDENDUM TO MISADMINISTRATION REPORT

Docket No. 030-11155
License No. 52-16033-01

Nuclear Regulatory Commission
ATTN: Mr. Héctor Bermúdez
Region II
101 Marietta Street, NW
Suite 2900
Atlanta, Georgia 30323-0198

CAUSE OF THE EVENT

Our investigation concluded that a direct intervention of the patient was the most likely cause for the premature removal of the implant. Several things point to that conclusion:

- (1) The vagina was very tight which made very improbable an expontaneous expulsion of the cylinder;
- (2) two sutures in the introitus were still in place after the sources were outside the body;
- (3) the patient was very anxious prior and through the procedure and had stated several times that she wanted to go home on Saturday (on the day the event occurred);
- (4) the previous day (Friday) she was told by the Radiotherapist that the implant was likely to be removed late Saturday afternoon and that she would probably go home Sunday morning;
- (5) Saturday morning, when the Radiotherapist was checking on her and before saying that the sources were out, the patient asked again if "she could go home if that thing that was placed inside my body was out".

Due to the personality of the patient and all the contradictory statements made by her on the event, we have to conclude that she removed the cylinder.

[Handwritten Signature]
Victor Marrero, M.D.

Date of addendum: January 11, 1994

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PDR available per Charles Hasey.

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PDR ADOCK 03011155
C PDR

IE07

Fundacion Hospital Metropolitano, Inc.

DES

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EDUCATIONAL AND RETRAINING PROGRAM FUNDACION HOSPITAL METROPOLITANO

I. Subject

A. *Nuclear and Radiological Safety*

Topics

1. *Review of radiological emergency response procedures.*
2. *How to recognize radiological emergencies involving patients undergoing sealed source or radiopharmaceutical therapy.*
3. *Proper procedures to follow in response to the radiological emergencies.*
4. *Notification requirements internal and external.*
5. *Types of emergencies that can result in misadministration.*

II. Objectives

1. *To retrain all members of the nursing staff and other hospital employees who may be involved in the handling of patients hospitalized while undergoing therapy with NRC licensed materials.*
2. *To emphasize in the emergency procedures and response in case of radiological emergencies.*

III. Attendants

1. *Nursing Staff (RN;LPN)*
2. *Escorts*
3. *Ward Clerks*

DEO 7

4. *Housekeeping*
5. *Radiological Technician*
6. *Linen Dept.*
7. *Operating Room Staff*

IV. Resources

- A. *Mrs. Marta Acevedo*
Director of Educational Program
Radiotherapy Department
- B. *Mr. Santiago Gómez*
Consultant Physics
- C. *José Díaz, M.D.*
President
Radiological Safety Committee
- D. *Mrs. Rosalia Roque, R.N.; M.S.N.*
Director of Staff Development Program
Nursing Department
- E. *Mrs. Luz H. Kentish, R.N.*
Nursing Quality Assessment and Improvement Coordinator

V. Methodology

- A. *Conferences*
- B. *Workshops*

VI. Evaluation

- A. *Pre and post test*
- B. *Session of Questions and answers*

VII. Dates

- 1st session: January 11-14*
- 2nd session: January 17-21*
- 3rd session: January 24-28*
- 4th session: January 31 to February 4*
- 5th session: February 7-11*
- 6th session: February 14-18*
- 7th session: February 21-25*