DEC 31 1990

License: 35-13157-02
Docket: 30-11571/90-02
EA No.: 90-212

Muskogee Regional Medical Center
ATTN: William Kennedy, CEO
300 Rockefeller Drive
Muskogee, Oklahoma 74401

Gentlemen:

This refers to the enforcement conference held at the request of NRC on December 13, 1990. This meeting related to the activities authorized by NRC Byproduct Material License 35-13157-02 and to the findings of our recent inspection conducted in response to NRC's being informed of a therapeutic misadministration identified by Muskogee Regional Medical Center (MRMC) in September 1990. The subjects discussed during the meeting are described in the enclosed Enforcement Conference Summary.

In accordance with Section 2.790 of NRC's "Rules of Practice," Part 2, Title 10, Code of Federal Regulations, a copy of this letter will be placed in NRC's Public Document Room.

Should you have any questions concerning this matter, we will be pleased to discuss them with you.

Sincerely,
Original Signed By:
A. B. BEACH

A. Bill Beach, Director
Division of Radiation Safety
and Safeguards

cc:
Oklahoma Radiation Control Program Director

bcc:
DMB - Original (IE-07)
ABBeach
MRodriguez, OC/LFDCB (4503)
CLCain
NMSIS
RIV Files (2)
GFSanborn
RDMartin
LAYandell
WLFisher
LLKasner
MIS System
RSTS Operator
JLieberman

RIV:NMSIS	C:NMSIS	*EO	D:DRSS
LLKasner	CLCain	GFSanborn	ABBeach
12/28/90	12/28/90	/ /90	12/30/90

*Previously concurred

IE-07
1/1

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REG4 LIC30
35-13157-02 PDR

APPENDIX

ENFORCEMENT CONFERENCE SUMMARY

Licensee: Muskogee Regional Medical Center
License: 35-13157-01
Docket/Report: 30-11571/90-02

On December 14, 1990, the licensee's radiation safety officer (RSO), radiation oncologist (oncologist), and hospital administrator (administrator) met with NRC staff members in the Region IV office to discuss the apparent violations identified during an inspection conducted at the licensee's facility in Muskogee, Oklahoma.

The NRC presentation focused on the failure of a number of the licensee's staff members to observe licensee procedures regarding treatment simulations and treatment chart reviews, inadequate oversight of licensed activities by the RSO, and the licensee's delayed reporting of a therapeutic misadministration. The staff discussed the significance of these oversights in that they were common to other treatment cases and had contributed to a significant unintended dosage. The licensee was requested to review the violations and describe corrective actions which had either been proposed or implemented.

The licensee representatives responded, noting that they believed the violations to have occurred as described in NRC Inspection Report 30-11571/90-02. The RSO and oncologist acknowledged the significance of the error that led to a therapeutic misadministration and candidly discussed the contributing factors and root cause for each of the violations. The RSO described the corrective actions which had been implemented prior to the conference and those which were planned.

The RSO had conducted an extensive investigation subsequent to the inspection and had determined, during his discussions with the staff, that staff morale was low due to an excessive workload. Specifically, the staff expressed frustration that their large caseload had resulted in a number of simultaneous activities demanding their attention leaving them little time to attend to treatment chart review and documentation, or other activities not directly associated with patient care. The RSO noted that as observed during the inspection, the staff was dissatisfied that time was not devoted to weekly chart reviews with members of the technical staff and oncologist present.

The licensee had addressed this problem by approving another full time technical position and expanding a part-time position to full-time. Additionally, scheduling changes had been made to distribute the workload more evenly, and certain limitations were placed on the number of patients which could be simulated or treated during any given period. The licensee had also implemented additional weekly and monthly chart reviews which will include members of the technical and medical staffs.

Although the licensee's procedures for treatment simulation and chart review had been adequate, the RSO and oncologist acknowledged that they had not always checked to ensure that each requirement was observed. The licensee recently implemented the use of a patient care form which requires that each individual involved in treatment simulation, dose calculations, and treatment chart review initial the form verifying that they have completed the task as described in the corresponding licensee procedure. This process also requires that the oncologist verify the treatment chart parameters prior to treatment. To support a more thorough treatment set-up and review, the licensee had discontinued the practice of simulating treatment and administering the first treatment fraction on the same day. They believe that this will serve to ensure that each therapy plan is given adequate review prior to starting treatment.

Both the RSO and radiation safety committee had reviewed all department procedures, recommending minor changes as they believed appropriate. Additional procedures and policies had been developed, adopted, and placed in department procedure manuals. These include instruction for contacting the RSO for his approval prior to implementing new procedures or changing existing procedures, a detailed description of errors or circumstances which may constitute a misadministration, and instructions for contacting the proper individuals if any such error is observed. The licensee had also revised simulation radiograph and photograph labeling, requiring that adequate anatomic marking be employed so that the area proposed for treatment could be clearly identified.

The RSO acknowledged that, in the past, he had largely delegated his responsibility for auditing program activities to the oncologist. In response to the inspection, training in NRC requirements had been conducted with both the oncologist and the technical staff. The RSO had reviewed the program in detail, and had reestablished communication with the technologists and therapy dosimetrist. While the oncologist, RSO, and administrator stated that they believed that the RSO's responsibilities had been met subsequent to the inspection, they acknowledged that in their opinion, a dedicated, full-time RSO position would better serve the program. The administrator acknowledged his support of appointing another individual to serve as RSO, and stated that he had taken the initial steps to locate an individual to serve in this capacity.

The staff provided closing comments, acknowledging the licensee's candid discussion. The NRC Enforcement Policy was reviewed and the licensee was notified that a decision regarding enforcement action would be forthcoming.

Linda Kasner

Linda Kasner
Senior Radiation Specialist
Nuclear Materials and Safeguards
Inspection Section

ATTACHMENT

Enforcement Conference Attendance List

Muskogee Regional Medical Center

Muskogee Regional Medical Center

William Kennedy, President
Dr. G. Ladd, Radiation Safety Officer
Dr. L. Cibula, Radiation Oncologist

Nuclear Regulatory Commission (Region IV Office)

A. B. Beach, Director, Division of Radiation Safety and Safeguards
C. L. Cain, Chief, Nuclear Materials and Safeguards Inspection Section
G. F. Sanborn, Enforcement Officer
L. L. Kasner, Nuclear Materials and Safeguards Inspection Section
S. Rajendran, Nuclear Materials Licensing Section

Nuclear Regulatory Commission (NRC Headquarters)

J. M. Johansen, Office of Enforcement
J. R. Schlueter, Nuclear Material Safety and Safeguards