UNITED STATES
NUCLEAR REGULATORY COMMISSION

In the Matter of	)	
	)	
WASHINGTON HOSPITAL CENTER Washington, DC 20010	)	Docket No. 30-09588 License No. 08-03604-04 EA 86-43

CONFIRMATORY ORDER MODIFYING LICENSE

I

Washington Hospital Center, Washington, D.C. (licensee or hospital) is the holder of specific byproduct material License No. 08-03604-04 issued by the Nuclear Regulatory Commission (the Commission or the NRC) pursuant to 10 CFR Parts 30 and 35. The teletherapy license, which authorizes the use of cobalt-60 sources in a teletherapy unit for the treatment of humans, was originally issued on July 17, 1973, was most recently renewed on February 27, 1984, and is due to expire on February 28, 1989.

II

On February 10-11, 1986, an NRC inspection of License No. 08-03604-04 was conducted at the hospital to review the circumstances associated with a misadministration which occurred at the hospital on February 7, 1986. The misadministration, which was identified by the licensee and reported to the NRC, involved the administering of a cobalt-60 teletherapy treatment of 150 rads to a patient who was not the patient referred by the attending physician to receive such treatment.

The circumstances surrounding the medical misadminstration incident are as follows. On February 6, 1986, a radiation therapy treatment was ordered for a patient in the Renal Transplant Unit of the hospital by the patient's attending

physician. After the physician signed the order in the patient's chart requesting the treatment, the chart was transferred to the clerk for that hospital unit so that the order could be entered into the computer used to both schedule treatments and notify the treating departments of the scheduled treatment. The clerk, by use of a light pen on the screen, erroneously entered the order for the radiation therapy into the computer file for a patient whose name was listed adjacent to the name of the intended patient.

On the morning of February 7, 1986, the Radiation Therapy Department, after reviewing the computer printout listing those patients scheduled for radiation therapy, contacted the respective units in the hospital so that the patients could be brought to the department for treatment. Subsequently, the incorrect patient was brought from the Renal Transplant Unit to the Radiation Therapy Department where she was examined by a radiation therapy physician authorized by the license to use licensed materials for such treatment. In accordance with hospital procedures, the patient's chart accompanied her. Although the radiation therapy physician noted that the chart did not contain an order for radiation treatment, he decided to approve administration of the treatment to the patient based on the computer printout without first consulting with either the patient's attending physician or the nursing staff on the patient's unit, contrary to hospital policy. As a consequence, this patient received an unnecessary and unplanned administration of 150 rads of radiation.

III

These events demonstrate that serious errors can occur in the absence of 1) adequate controls over administration of radiation treatments and 2) the proper consultation by the NRC authorized user with a patient's attending physician prior to the use of licensed material for treatment of the patient. On February 11, 1986 Region I issued a Confirmatory Action Letter documenting commitments made by the licensee to make improvements in its program to prevent such misadministrations in the future. These commitments were also discussed at an enforcement conference on February 21, 1986. Because of the importance of these commitments to the safe and appropriate use of licensed material, I have determined that the commitments set forth in the Confirmatory Action Letter should be incorporated into the hospital license as required by this Order.

IV

Accordingly, pursuant to Sections 81 and 161b of the Atomic Energy Act of 1954, as amended, and the Commission's regulations in 10 CFR 2.204 and Part 30, IT IS HEREBY ORDERED THAT THE LICENSEE SHALL:

A. Assure that an authorized physician user listed in Condition 12 of License Number 08-03604-04 reviews every patient chart prior to the

initiation of cobalt-60 teletherapy treatment and confirms that the treatment has been requested and is appropriate.

B. Require consultation regarding the planned treatment between an authorized user and the referring physician or the Chief Resident prior to the initial treatment of each teletherapy patient.

V

The licensee or any other person adversely aifected by this Order may request a hearing within 30 days after issuance of this Order. Any request for hearing shall be submitted to the Director, Office of Inspection and Enforcement, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, within 30 days of the date of this Order. Copies shall also be sent to the Executive Legal Director at the same address and to the Regional Administrator, U.S. Nuclear Regulatory Commission, Region I, 631 Park Avenue, King of Prussia, Pennsylvania 19406. If a hearing is requested, the Commission will issue an order designating the time and place of any hearing. If a hearing is held, the issue to be considered at such hearing shall be whether this Order shall be sustained.

This Order shall become effective upon expiration of the time during which a hearing may be requested or, in the event a hearing is requested, on the date specified in the Order issued following further proceedings on this Order.

FOR THE NUCLEAR REGULATORY COMMISSION

James M. Taylor, Director
Office of Inspection and Enforcement

Dated at Bethesda, Maryland,
this 29th day of May 1986.