PASCACK VALLEY HOSPITAL
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QUALITY MANAGEMENT PROGRAM

November 13, 1996

This Quality Management Program is in effect to provide high confidence that radiation delivered with our Cobalt 60 Teletherapy Unit will be administered as directed by the authorized user.

Following is a list of policies and procedures that are followed to meet this objective.

I. Prior to administration, a prescription* will be completed in the following manner:

A) A Radiation Therapist will write the treatment site, overall treatment period stated as number of fractions or weeks as described by the authorized user.

B) The authorized user will complete the Total Dose, Dose per Fraction and prescription point, volume or isodose line. This prescription will be dated and signed by an authorized user prior to administration of treatment*. The written prescription will be part of the individual patients chart **which includes the patients name**.

II. Prior to administration of a teletherapy dose the patients identity is verified first by asking for the patient by name and secondly by at least one of the following by comparison with the corresponding information in the patient's record: birth date, address, social security number, signature, the name on the patient's ID bracelet or hospital ID card, the name on the patient's medical insurance card , or the photograph of the patient's face.

III. All Computer generated Isodose Plans and irregular field plans will be approved by an authorized user and reviewed by the radiation therapist prior to administration of treatment. All calculations will be reviewed to make sure they are in accordance with the written prescription. All computer generated Rx times will be verified by performing a "manual" calculation to the Rx point, or other point of interest.

IV. Prior to each administration of treatment the written prescription will be reviewed by the radiation therapist to make sure that the administration is in accordance with the written prescription. In particular, the treatment site and dose per fraction will be confirmed to verify agreement with the written prescription. Should there be any question concerning the prescription or how to carry out the prescription, the radiation therapist shall seek guidance from another technician, dosimetrist, physicist, or authorized user before any administration of treatment.

V. **Under no circumstances will any parameters not accounted for in the full calibration be used for treatments until such parameter has been properly verified out by the Teletherapy Physicist and appended to the full calibration.**

VI. Any unintended deviation from the written prescription will immediately be brought to the attention of the authorized user, physicist, and technicians. All deviations will be evaluated as to whether a misadministration has occurred as defined by part 35.2 NRC Rules and Regulations and appropriate action will be taken. Should the deviation be deemed minor and not a misadministration the authorized user shall determine if any adjustments are necessary and amend the written prescription.

VII. This Quality Management Program will be reviewed with all related personnel upon implementation and thereafter at intervals not to exceed 12 months. During this review the effectiveness of the Quality Management Program will be re-evaluated and modified should it be found necessary. A representative sample of patient charts (5% of New Patients or 30 patients, whichever is greater) will be reviewed to see that all administrations were given in accordance with the prescription. All recordable events and misadministrations will be evaluated to verify compliance with all aspects of the quality management program. Records will be made of the review and kept for a period of at least 3 years. Should the Quality Management Program require modification to increase the program's efficiency the NRC Regional Office will be sent the modifications within 30 days after the modifications have been made.

*If, because of the patient's condition, a delay in order to provide a written revision to an existing written prescription would jeopardize the patient's health, an oral revision to an existing written prescription will be acceptable, provided that the oral revision is documented immediately in the patient's record and a revised written prescription is signed by the authorized user within 48 hours of the oral revision.

Also, a written revision to an existing written prescription may be made for any therapeutic procedure provided that the revision is dated and signed by an authorized user prior to the administration of the teletherapy dose, or next teletherapy fractional dose.

If, because of the emergent nature of the patient's condition, a delay in order to provide a written directive would jeopardize the patient's health, an oral directive will be acceptable, provided that the information contained in the oral directive is documented immediately in the patients record and a written directive is prepared within 24 hours of the oral directive.