U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 030-01435/92001(DRSS)

Docket No. 030-01435

License No. 12-02642-06 Category G1 Priority 1

Licensee: Veterans Administration
Lakeside Medical Center
333 East Huron Street
Chicago, IL 60611

Inspection Conducted: August 7 through November 3, 1992

Purpose of Inspection: The August 7, 1992 onsite visit was carried out to perform a routine, unannounced inspection of the licensee's radiation safety program. The November 3, 1992 onsite visit was carried out to review a concern pertaining to the radiation safety program.

Inspector: Carolyn R Maton for 11-25-92
Colleen C. Casey Date
Radiation Specialist

Inspector: Michael F. Weber 11/24/92
Michael F. Weber Date
Radiation Specialist

Reviewed By: Carolyn R Maton for 11-25-92
Gary L. Shear, Chief Date
Nuclear Materials Inspection
Section 2

Approved By: [signature] 11-27-92
John A. Grobe, Chief Date
Nuclear Materials Safety
Branch

Inspection Summary

Inspection on August 7, 1992 through November 3, 1992.
(Report No. 030-01435/92001(DRSS))
Areas Inspected: This inspection began as a routine, unannounced inspection of the licensee's activities to evaluate compliance with Commission rules, regulations, and license conditions. Later, the inspection was expanded to include a review of a concern pertaining to the radiation protection program.
Results: Of the areas inspected, one apparent violation was identified, namely the failure of a licensee employee to wear a laboratory coat or other protective clothing in areas where radioactive materials were used, 10 CFR 35.21(a), License Condition No. 28.B (Section 5).

DETAILS

1. Personnel Contacted

*Joseph Moore, Director of Medical Center
Dr. Raymond Zeiss, Acting Chief of Staff
***Dr. Ken Khuans, Acting Chief of Staff
Dr. John Imarisio, Director of Nuclear Medicine
*David Beery, Assistant Chief of Staff
Juanita Williams, Nuclear Medicine Technologist
Don Swatosh, Nuclear Medicine Technologist
**Eli Port, Radiation Safety Officer
John Gough, Assistant Radiation Safety Officer

*Attended telephone exit meeting conducted August 10, 1992.
**Attended telephone exit meeting conducted August 11, 1992.
***Attended exit meeting conducted November 3, 1992.

2. Licensed Program

V. A. Lakeside Medical Center (licensee) is authorized by NRC License No. 12-02642-06 to use byproduct material for medical diagnosis, therapy, and research in humans and animal studies.

3. Inspection History

The licensee was last inspected on December 2 through 10, 1991. Seven apparent violations of NRC regulatory requirements were identified, as follows.

1. Failure to follow emergency procedures.
2. Failure to test a reusable xenon collection system and measure ventilation rates in areas of use of radioactive gas.
3. Failure to make a timely report of a diagnostic misadministration.
4. Failure to use a dedicated check source.
5. Failure to complete evaluations of surveys.
6. Failure to maintain records of materials decayed in storage.
7. Failure to post spill gas clearance times.

Each of these previous apparent violations was closed during this inspection.

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Inspector: Colleen C. Casey — Date: 11-25-92
Radiation Specialist

Inspector: Michael F. Weber — Date: 11/24/92
Radiation Specialist

Reviewed By: Gary L. Shear, Chief — Date: 11-25-92
Nuclear Materials Inspection
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Approved By: John A. Grobe, Chief — Date: 11-27-92
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4. Radiation Protection Program Concerns

Concern: At 10:00 a.m. on May 26, 1992, exposure rate results for the survey to be performed at the end of that day in the nuclear medicine department had already been entered on the survey forms.

On November 3, 1992, the inspectors examined records which show that byproduct material was administered to patients in the nuclear medicine department on May 26, 1992, at 8:40 a.m., 11:55 a.m., 1:09 p.m., and 1:13 p.m. The inspectors also noted that the completed survey form for May 26, 1992 did not list the time the survey was taken. The inspectors were not able to question the technologist who filled in the survey form since she was no longer working at the V. A. Lakeside Medical Center, and her location was unknown.

The concern was not substantiated and no violations of NRC requirements were identified.

5. Radiological Protection Procedures

10 CFR 35.21(a) requires that the licensee, through the Radiation Safety Officer, ensure that radiation safety activities are being performed in accordance with approved procedures. The licensee's procedures for nuclear medicine use are described in a letter dated December 10, 1991, and were approved by License Condition No. 28.B.

The letter dated December 10, 1991 states in Item No. 2.b. that the licensee shall use procedures equivalent to those outlined in Regulatory Guide 10.8, Revision 2, for nuclear medicine use.

Item 1 of Appendix 1 to Regulatory Guide 10.8, Revision 2, states that laboratory coats or other protective clothing will be worn at all times where radioactive materials are used.

During the inspection on August 7, 1992, the inspectors observed that the nuclear medicine technologist was not wearing her laboratory coat. The technologist indicated that due to the "stuffy" work environment, she had removed her laboratory coat in the late morning, and continued to inject patients, make up kits, etc., without replacing her laboratory coat. She also indicated that she was unaware of the requirement to wear protective clothing at all times in areas where radioactive materials are used.

The safety significance is minor since the technologist indicated that she had not spilled any radioactive material

on herself since she began working at the V. A. Lakeside Medical Center, and her end of day surveys of her person have been negative.

The technologist agreed to wear her lab coat as required, and management agreed to look into the "stuffiness" problem in the nuclear medicine department.

The failure of the nuclear medicine technologist to wear her laboratory coat or other protective clothing at all times in areas where radioactive materials were used constitutes an apparent violation of 10 CFR 35.21(a), License Condition No. 28.B.

One apparent violation of NRC requirements was identified.

6. Other Areas Inspected

The inspectors also conducted a review of other routine inspection elements, including organization, scope of program, internal audits or inspections, training and instructions to workers, facilities and equipment, materials, receipt and transfer of radioactive material, area surveys, internal and external personnel radiation protection, radioactive effluent and waste disposal, notification and reports, misadministrations, posting and labeling, transportation, recordkeeping for decommissioning, and bulletins and information notices.

No violations of NRC requirements were identified.

7. Exit Meetings

On August 10, 1992, the inspectors conducted a telephone exit meeting with the Director of the Medical Center and the Assistant Chief of Staff. The next day the inspectors conducted a telephone exit meeting with the Radiation Safety Officer. At each meeting, the inspectors summarized the inspection and the apparent violation, and discussed the licensee's proposed corrective actions. On November 3, 1992, the inspectors held an exit meeting at the V. A. Lakeside Medical Center with the Acting Chief of Staff. At this meeting, the inspectors briefly summarized the inspection.

No information contained in this report was considered proprietary by the licensee.