Berlin Memorial Hospital

COMMUNITY HEALTH NETWORK

Weber

December 3, 1992

U.S. NUCLEAR REGULATORY COMMISSION
Region III
799 Roosevelt Road
Glen Ellyn, Illinois 60137

ATTN: Gary L. Shear, Chief
Nuclear Materials Inspection - Section 2

RE: REPLY TO A NOTICE OF VIOLATION



Thank you for conducting the safety inspection at our facility November 6, 1992. We welcome the opportunity to improve our procedures and practices. We have taken corrective measures to address the identified violations as outlined below:

A. On November 6, 1992, in the Nuclear Medicine hot lab, (1) personal effects such as lipstick were found, and (2) drink was found stored in a refrigerator designated for radioactive materials.

1.

Without proper office space to conduct business or administer paperwork, strict adherence to regulation as pertains to "personal effects" has become lax over the years. As this violation had not been pointed out in previous inspections or noted by our nuclear consultants, this practice unfortunately became routine.

We were unable to reach a consensus on what is and what is not a "personal effect". A call was made to Michael F. Weber (one of our inspectors) to obtain a precise definition. Mr. Weber gave what he stated was his interpretation of the regulation. He also informed us that any precise definition would have to be obtained from Washington.

We have acted upon Mr. Weber's interpretation that any personal belonging that is brought in and taken out of the work area daily constitutes a personal effect and is not to be stored in the hot lab or imaging area. All personal effects have been removed from the nuclear area.

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Berlin, Wisconsin 54923
414-361-1313

Acquiring office space for nuclear medicine is currently being studied. This will avoid future violations of this nature. Temporary office arrangements can be made by February 1, 1993. At that time, we will consider ourselves in full compliance.

2.

The employee on duty had a temporary medical condition requiring her to consume liquids throughout the day. Without thinking, she placed a container of fruit juice in the hot lab refrigerator. This resulted in a repeat violation.

The need for a refrigerator in the hot lab was reviewed by the Nuclear Medicine Coordinator and the Director of Diagnostic Imaging. As it is used exclusively for storage of M.A.A., other alternatives were explored. It was decided that one kit per dose could be used since lung scans are a low volume procedure at this facility.

Nuclear Medicine removed the refrigerator from the hot lab. Full compliance was achieved November 9, 1992.

B. On November 6, 1992, a licensed employee did not wear personnel monitoring devices while in areas where radioactive materials were used or stored, specifically the Nuclear Medicine hot lab and imaging room. Furthermore, the employee did not wear finger exposure monitors during the preparation, assay, and injection of radiopharmaceuticals; and when holding patients during procedures.

The employee in question had misplaced her monitoring devices and was unable to locate them. As there were no other qualified personnel to perform the above mentioned duties, she proceeded without her monitoring devices.

On the next regularly scheduled working day, procedures were performed by an alternate nuclear technologist. This continued until the arrival of replacement monitoring devices. Nuclear Medicine now has an extra film badge and finger exposure monitor labeled "spare" to be utilized in these situations. Full compliance was achieved November 10, 1992.

C. On May 26, 1992, the licensee's Radiation Safety Committee met and conducted business and the

Radiation Safety Officer was not present.

On the date in question, the Radiation Safety Officer was unable to attend the scheduled meeting due to an urgent case in the Diagnostic Imaging Department. As he was the only radiologist on duty, his priority was patient care. The committee continued its meeting as the agenda contained only routine report information, all within standards and no items requiring debate or decision making. The RSO was aware of all information presented, and was briefed again after the meeting.

As the above is not acceptable according to regulation, the Berlin Memorial Hospital Radiation Safety Committee will meet only when the required members and specifically the RSO are able to attend. Full compliance was achieved November 24, 1992.

Sincerely,

Diantha Van Eimeren

Diantha Van Eimeren, R.N.,M.S.N.
Vice President & Chief Operating Officer

DVE/gfc

c: Craig W. C. Schmidt, President & C.E.O.
Laurie O'Bara, Director Diagnostic Imaging