BENJAMIN J. CAYETANO
GOVERNOR OF HAWAII

LAWERENCE MIIKE
DIRECTOR OF HEALTH

MAUI MEMORIAL HOSPITAL
221 MAHALANI STREET
WAILUKU, MAUI, HAWAII 96793

Feb. 5, 1997
Maui Memorial Hospital
License No. 53-13519-01

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, D.C. 20555

Dear Director:

Please find enclosed, Maui Memorial Hospital's "Reply to a Notice of Violation" and our "Response to An Apparent Violation in Inspection Report No.030-03561/ 96-01".

We are making every effort to rectify all of the problems with our radiation safety program that were found during your last inspection of our facility. If you have any further questions, please contact our radiation safety officer, Thomas Sullivan, M.S., at 808-242-2600.

Thank you for your assistance in this matter. The administration of Maui Memorial Hospital is committed to conducting our Radiation Safety Program to the highest standards possible. Any further suggestions or recommendations would be greatly appreciated.

Sincerely,

Alan G. Lee
Administrator

cc: USNRC, Regional Administrator, Region IV
USNRC, Region IV Walnut Creek Field Office

Reply to a Notice of Violation

Date: 2-5-97

Maui Memorial Hospital
Wailuku, Hawaii

Docket No. 030-03561
License No. 53-13519-01

A. Inadequate survey of I-131 Patient's room following radiopharmaceutical therapy

The handle of the door to the patient's bathroom was probably re-contaminated by the technologist who was trying to decontaminate the room. The cleaning of I-131 patient's rooms can be very trying to the technologist because repeated cleanings of some contaminated surfaces with multiple cleansers can still leave significant removable contamination. Also, during high census times, there is an urgency by the nursing staff to release the room for a new patient.

We do feel that our procedures for decontamination are adequate. We do preventively cover many items and surfaces with absorbable paper or plastic wrap. We do survey all areas with a low-level GM survey meter. We clean all hot areas and then wipe test them for removable activity. We repeat cleaning and wipe testing areas with removable activity until the levels are below 200 dpm per 100cm^2. We then repeat our GM survey of the entire room before releasing the room for the next patient.

In order to correct this problem, we have changed our policy for releasing I-131 patient rooms. We are now requiring that two people separately do the final GM survey of the room before the room can be released for general use. The first person will be the technologist who cleans and wipe tests the room. The second person will be either the RSO or another nuclear medicine technologist who has not decontaminated the room. This should assure that the final GM survey is not hastily done and that any remaining contamination will be found. We are requiring that both people sign-off on the room before it can be released.

The Nursing staff have been told in the past that the I-131 patient's rooms may be out of commission for weeks at a time if they cannot be quickly decontaminated. This will be emphasized again at future inservices.

B. Failure to Instruct the Nursing Personnel to notify RSO in case of Patient's death

We have annual inservices for all nursing staff who care for patients who have radioactive implants or who receive therapeutic doses of radionuclides.

We have corrected this problem by changing our instruction sheet to read: "If the patient dies, or has any emergency, immediately notify the Radiation Safety Officer." A memo emphasizing this instruction has been sent by the RSO to the Nursing staff. This will also be a routine part of the instructions given during all future inservices.

Reply to a Notice of Violation (continued)

C. Failure to establish a quorum (RSO and management absent from Radiation Safety Committee Meetings)

The Radiation Safety Committee shall not hold a meeting unless our RSO and management representative and at least one-half of the committee's membership is present.

As of 7-25-96, we have had a new RSO, who has been attending all of the meetings for the last two and a half years. During the last quarterly meeting, a new management representative has been appointed. This problem should be easily corrected.

D. Failure to Keep a Decommissioning File

Information pertinent to the safe and effective decommissioning of our facility has now been gathered into a "Decommissioning File" and copies of it can be found in the Nuclear Medicine Department, the RSO's files, and the Administration's files.

We have made every effort to improve our radiation safety program and should be in full compliance as of 2-5-97.

Response to An Apparent Violation in Inspection Report No. 030-03561/96-01

Date: 2-5-97

Maui Memorial Hospital
Wailuku, Hawaii

Docket No. 030-03561
License No. 53-13519-01

Security of Stored Material

"An apparent violation was identified involving a failure to secure from unauthorized access or removal licensed material located in a controlled area. Specifically, an imaging room and the nuclear medicine hot lab were left unsecured and without constant surveillance by licensee personnel on November 22 and 25, 1996."

A number of mistakes, by the technologists involved, compounded to make the first part of the apparent violation. 1) It was late after cleaning an I-131 patient's room, and the technologist, wanting to save some time, temporarily stored the contaminated waste in the imaging room (a controlled area), instead of taking it to the designated waste storage area. The waste was secured here overnight, but obviously, was not kept under constant surveillance. 2) The next day, due to the surprise inspection by the NRC, the technologist focussed on the inspection, and didn't move the contaminated waste to the appropriate restricted storage area. 3) The Siemens gamma camera technician does calibrations and repairs often enough that he is considered to be an integral part of the staff. He has received radiation safety training from his employer. He is not considered a security threat for removal of licensed materials. But, as the report pointed out, he is not an employee of the licensee and should not have had access to licensed materials. These three mistakes led up to the first part of the apparent violation.

The second part of the apparent violation was due to the particular layout of the nuclear medicine department. We have a separate room with cardiology stress equipment located outside the main imaging room. The technologists frequently have to go from the hot lab and imaging room, across a small hallway, into this other room. They are seldom gone from the imaging room more than a minute or two. But, they do leave the hot lab from constant surveillance.

A number of corrective actions have already been taken. 1) The technologists have been instructed to store any and all licensed material only in the designated restricted areas (hot lab or brachytherapy source storage room).

Response to Apparent Violation
Corrective Actions (continued)

2) We installed an automatic door closure and a keypad type lock on the nuclear medicine hot lab door. The technologists have been instructed to keep this door closed at all times to prevent any breach of security.

The new door closure and lock seems to be working well and to have helped solve some of the problems concerning our security of stored materials.

We should now be in full compliance as of 2-5-97. The adminstration of Maui Memorial Hospital, the RSO, and the radiation safety committee are committed to conducting our Radiation Safety Program to the highest standard of compliance.

M E M O R A N D U M

DATE: January 29, 1997

TO: Leona & Nursing Staff- Maui East

FROM: Thomas Sullivan, M.S.,
Radiation Safety Officer

RE: Notification of RSO

This memo is to update all nursing staff caring for patients who have radioactive implants or who receive therapeutic doses of radionuclides.

WHAT DO YOU DO IF THE PATIENT DIES DURING ONE OF THESE PROCEDURES?

If the patient dies, or has any emergency, immediately notify the Radiation Safety Officer. He will provide additional instruction concerning the safe handling of such a patient.

Also notify the admitting physician.

WHAT DO YOU DO IF THE PATIENT CODES DURING ONE OF THESE PROCEDURES?

First, use Code Blue procedures and save the patient's life! Any exposure to you will be minimal. Then, notify the RSO and physician.

Please Post this Memo & Discuss at the next Staff Meeting