

Docket File Information

SAFETY INSPECTION REPORT AND COMPLIANCE INSPECTION

1. LICENSEE Oakwood Hospital and Medical Center		2. NRC/REGIONAL OFFICE Region III 2443 Warrenville Road Lisle, IL 60532	
REPORT NUMBER(S) 2006-001			
3. DOCKET NUMBER(S) 030-02051	4. LICENSE NUMBER(S) 21-04515-01	5. DATE(S) OF INSPECTION Nov. 2 and 13, 2006	
6. INSPECTION PROCEDURES USED 87131 and 87132		7. INSPECTION FOCUS AREAS 03.01, 03.02, 03.03, 03.04, 03.05, 03.06, 03.07, and 03.08	

SUPPLEMENTAL INSPECTION INFORMATION

1. PROGRAM CODE(S) 02240	2. PRIORITY G 2	3. LICENSEE CONTACT Jerry Drake, M.D., RSO	4. TELEPHONE NUMBER 313.593.7000
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Main Office Inspection Next Inspection Date: November 2008

Field

Temporary Job Site

PROGRAM SCOPE

This large hospital was authorized to use materials permitted in Sections 35.100, 35.200, 35.300, 35.400, 31.11, I-125 for the GlinSite system, and iridium-192 in an HDR unit. In addition, the hospital possessed a CIS-US (SN 95-492) self-shielded irradiator unit containing a cesium-137 source; the licensee's blood lab staff used the irradiator on a daily basis.

The nuclear medicine department was staffed with 9 technologists who performed approximately 1,200 diagnostic nuclear medicine procedures per month which included a full spectrum of diagnostic imaging studies. The licensee received unit doses from a licensed nuclear pharmacy and used Mo-99/Tc-99m generator for kit preparation. Typically in a year, the hospital treated 100 cases of hyperthyroidism, 20 cases of thyroid carcinoma, and 50 whole body CA follow up studies. Radioiodine was obtained from a licensed nuclear pharmacy in capsule form. The department also administered an average of 1-2 beta-emitting radiopharmaceutical dosages annually.

The radiation therapy department was staffed with 2 medical physicists and 3 dosimetrists. The hospital had not used its Cs-137 sources for temporary implants since the previous inspection. Although authorized to use I-125 within the GlinSite Radiotherapy System, the licensee had not used this material to date. The department used I-125 and Pd-103 for permanent prostate implants to treat approximately 30-40 cases per year. The department possessed an HDR unit and administered approximately 120 patient treatments per year; the majority of these treatments were for bronchial, breast, and gynecological cancers. All HDR patient treatments were administered by the attending radiation oncologist and the medical physicist (therapy technologists did not operate the controls to the HDR unit). Source exchange, maintenance, and repairs on the HDR unit were performed by the manufacturer.

This inspection consisted of interviews with licensee personnel, a review of select records, tours of the blood bank, nuclear medicine, and radiation oncology departments, and independent measurements. The inspector observed the administration of several diagnostic nuclear medicine procedures. The inspection included observations of HDR safety checks, dose calibrator QA checks, security of byproduct material (not subjected to the Order for the Increased Controls), use of personnel monitoring, and package receipts and surveys. The inspector observed one HDR brachytherapy treatment. The inspector reviewed the written directive for the procedure; observed the licensee performing daily QA checks and treatment planning; and observed the patient treatment and patient surveys at the conclusion of the treatment. The inspector also interviewed the physician authorized user and nurse who attended the patient.

The inspection included a review of the licensee's actions in response to the Order for Increased Controls (EA-05-090), dated Nov. 14, 2005. The results of the IC inspection were documented in IR 030-02051/2006002.

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