

Docket File Information
SAFETY INSPECTION REPORT AND COMPLIANCE INSPECTION

1. LICENSEE Elkhart General Hospital REPORT NUMBER(S) 2010-001		2. NRC/REGIONAL OFFICE U.S. Nuclear Regulatory Commission, Region III 2443 Warrenville Road, Suite 210 Lisle, Illinois 60532	
3. DOCKET NUMBER(S) 030-17305	4. LICENSE NUMBER(S) 13-18879-01	5. DATE(S) OF INSPECTION 10/27/2010	
6. INSPECTION PROCEDURES 87130, 87131, 87132		7. INSPECTION FOCUS AREAS 03.01 through 03.07	

SUPPLEMENTAL INSPECTION INFORMATION

1. PROGRAM 2230	2. PRIORITY 2	3. LICENSEE CONTACT Dr. Sun-Shing Steven Leung – RSO	4. TELEPHONE NUMBER 574-423-7857
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Main Office Inspection Next Inspection Date: 10/2012
 Field Office Inspection Temporary Job Site Inspection

PROGRAM SCOPE

This licensee was a community hospital permitted to use radioactive material pursuant to 10 CFR 35.100, 35.200, 35.300, 35.400, 35.500 and 35.600. The licensee performed approximately 200-400 diagnostic procedures monthly and possessed 4 nuclear medicine technicians. The licensee's therapy program consisted of approximately 2-3 temporary Cs-137 implants per year, 10-15 I-131 non-cancer treatments per year, 1-2 I-131 cancer treatments per year, 20-30 HDR patients per year. The licensee possessed one HDR unit. The licensee possessed numerous authorized users and two medical physicists on the licensee but only 3-4 authorized users routinely administered licensed material.

Observations and Findings

The inspector observed the licensee administer licensed material and the technician had all radiation safety equipment available and implemented proper radiation safety practices. The inspector interviewed licensee staff and determined that they were aware of radiation safety practices and were implementing the radiation safety program adequately. The inspector reviewed selected documents which included: dosimetry records, radiation safety committee meeting minutes, dose administration records, dose calibrator records and radiological surveys; no abnormal issues were identified. The inspector performed independent radiological surveys and did not identify an abnormal radiation or contamination levels.

10 CFR 35.63(d) states, in part, that a licensee may not use a dosage if the dosage differs from the prescribed dosage by more than 20 percent. Contrary to the above on 11/17/08, an authorized user cancelled an injection of Tc-99m for a cardiac study for a patient (prescribing dosage of 0.0 millicuries) and the patient received approximately 10.8 millicuries of Tc-99m. As part of the corrective actions, the licensee restructured orders by authorized users to cancel a procedure, retrained the individual involved in the error, and retrained all other individuals that could be involved in the administration of licensed material to patients. The radiation safety committee reviewed the case on 11/21/08 and approved the corrective actions. No other incidents were identified during the inspection.

During the last inspection on April 2-3, 2008, the NRC identified one violation concerning eating and/or drinking in areas where licensed materials were used and/or stored. The inspector did not identify any similar violations during this inspection and noted that all individuals who work in areas where licensed material was used and/or stored were aware that such activities were prohibited. This violation is considered closed.