

Docket File Information
SAFETY INSPECTION REPORT AND COMPLIANCE INSPECTION

1. LICENSEE/LOCATION INSPECTED: Missouri Baptist Medical Center 3015 North Ballas Road St. Louis, Missouri 63131 REPORT NUMBER(S) 2013-01	2. NRC/REGIONAL OFFICE Region III U. S. Nuclear Regulatory Commission 2443 Warrenville Road, Suite 210 Lisle, IL 60532-4352
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3. DOCKET NUMBER(S) 030-08325	4. LICENSE NUMBER(S) 24-11128-02	5. DATE(S) OF INSPECTION 04/18/2013
6. INSPECTION PROCEDURES USED 87130, 87131, 87132	7. INSPECTION FOCUS AREAS 3.01-3.07	

SUPPLEMENTAL INSPECTION INFORMATION

1. PROGRAM CODE(S) 02230	2. PRIORITY 2	3. LICENSEE CONTACT Thomas J. Moenster	4. TELEPHONE NUMBER (314) 996-5397
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Main Office Inspection Next Inspection Date: October, 2014

Field Office Inspection _____

Temporary Job Site Inspection _____

PROGRAM SCOPE

EA-12-242

This was a follow-up inspection in response to a Notice of Violation dated January 29, 2013, transmitting a Severity Level III violation to the licensee for failure to have procedures that provide high confidence that administrations are in accordance with the written directives. The licensee had two instances that were identified by the inspector in which the prescribed dose was either entered wrong or had failed to be entered for the prescribed dose within the written directive.

Performance Observations

The inspector reviewed the licensee's written directives that were performed from December, 2012 to April, 2013. The inspector randomly selected 16 written directives ranging from yttrium-90 procedures, iodine-131 procedures, prostate seed implants, procedures involving samarium-153, and high dose remote afterloader procedures. For the applicable written directives, the inspector verified that a pre-treatment checklist for radiopharmaceutical procedures had been developed, 100 percent audit of all procedures with results reported quarterly to the radiation safety office and to the Radiation Safety Committee, revising the Radiopharmaceutical Therapy Record to add a block to compare the prescribed activity to the assayed activity, and train applicable hospital personnel on how to review written directives. The inspector also verified that the licensee's procedure for reviewing written directives had been updated. The inspector performed an in office review of the licensee's documentations for one of the selected prostate seed implant written directive. The inspector held a final telephone exit meeting with the licensee on May 2, 2013.

All aspect of the licensee's corrective actions were implemented, and the previous violation was closed.

No additional violations of NRC regulatory requirements were identified.