



**Docket File Information**

**SAFETY INSPECTION REPORT AND COMPLIANCE INSPECTION**

<p>1. LICENSEE/LOCATION INSPECTED:</p> <p>St. Mary Medical Center - Hobart 1500 S Lake Park Ave., Hobart, IN and 300 W 61st. Ave., Hobart, IN</p> <p>REPORT NUMBER(S) 2018001</p>	<p>2. NRC/REGIONAL OFFICE</p> <p>Region III U. S. Nuclear Regulatory Commission 2443 Warrenville Road, Suite 210 Lisle, IL 60532-4352</p>
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<p>3. DOCKET NUMBER(S)</p> <p>030-31379</p>	<p>4. LICENSE NUMBER(S)</p> <p>13-03459-03</p>	<p>5. DATE(S) OF INSPECTION</p> <p>11/29/18</p>
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<p>6. INSPECTION PROCEDURES USED</p> <p>87132</p>	<p>7. INSPECTION FOCUS AREAS</p> <p>02.01, 02.02, 02.04, 02.05, 02.06, 02.07, 02.09</p>
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**SUPPLEMENTAL INSPECTION INFORMATION**

<p>1. PROGRAM CODE(S)</p> <p>02240</p>	<p>2. PRIORITY</p> <p>2</p>	<p>3. LICENSEE CONTACT</p> <p>Santosh K. Kar, M.S., RSO</p>	<p>4. TELEPHONE NUMBER</p> <p>(815) 370-6538</p>
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Main Office Inspection      Next Inspection Date: 11/29/2020

Field Office Inspection    300 W 61st. Ave., Hobart, IN

Temporary Job Site Inspection \_\_\_\_\_

**PROGRAM SCOPE**

This was an unannounced, routine inspection. At the time of the inspection, seven full-time nuclear medicine technologists performed approximately 10 to 12 diagnostic administrations per day, and approximately two therapeutic administrations of I-131 capsules per month. The licensee retained the services of a medical physics consultant to review the content and implementation of the program quarterly, and maintained a Radiation Safety Committee, which also met quarterly.

**Performance Observations**

The inspector: (1) observed that licensed material was secured as required; (2) observed a nuclear medicine technologist (NMT) properly administer iodine-123 to a patient for a thyroid uptake test and a thyroid scan; (3) observed an NMT wearing whole body and extremity dosimeter badges while handling licensed material; (4) noted that there were no Y-90 SIR-Spheres administrations during the inspection; (5) noted that the licensee used technetium-99m macroaggregated albumin to conduct a liver to lung shunting test prior to administering Y-90 SIR-Spheres; (6) reviewed applicable records and interviewed applicable staff regarding Y-90 SIR-Spheres administrations; (7) noted that the licensee conducted ambient exposure rate surveys of patients post Y-90 SIR-Spheres administration; (8) noted that the licensee conducted proper ambient exposure rate surveys of applicable materials to determine the amount of Y-90 SIR-Spheres that was administered to the patient; (9) noted that there was no 10 CFR 35.300 use during the inspection but the inspector reviewed applicable records of 35.300 use; (10) followed up on the licensee's contact with the NRC Region III Office on August 18, 2016, concerning a potential medical event at the hospital involving a patient getting 35 mCi Tc-99m MDP instead of the intended non-nuclear bone densitometry test and the inspector noted that the patient actually received 25.5 mCi Tc-99m MDP and the inspector used the proper Tc-99m-MDP package insert to determine that there was no medical event because the patient did not receive 5 rem to the whole body nor 50 rem to an organ or tissue; (11) noted that the licensee conducted a root cause analysis for preventing the aforementioned 25.5 mCi Tc-99m MDP incident, and implemented actions to prevent similar occurrences; and (12) reviewed dosimeter badge records for 2015-2018 to date, and the annual highest whole body and extremities doses were 321 millirem, and 2690 mrem, respectively.

No violations of NRC requirements were identified as a result of this inspection.