



Nuclear Medicine Laboratory *FRIEDA SILVA DE ROLDAN, M.D.*
Hato Rey Community Hospital *Medical Director*

January 30, 1995

United States Nuclear Regulatory Commission
Region 11
Atlanta, Georgia

Lic No. 52-17704-01
Docket No. 030-13199

Mr. Douglas M. Collins, Chief
Nuclear materials Safety Branch
Division of Radiation Safety
and Safeguards

Subject: Response to Violation, NRC inspection report number
52-17704-01/94-01

Dear Mr. Collins:

Included is the response to the notice of violation dated
January 4, 1994 for the Hato Rey Community Nuclear Medicine NRC
license 52-17704-01.

Sincerely

Elba Orduna-Acum, MD
Radiation Safety Officer
Nuclear Medicine Laboratory

Frieda Silva-Roldan, MD
Director
Nuclear Medicine Laboratory

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January 30, 1995

RESPONSE TO THE NOTICE OF VIOLATION
HATO KEY COMMUNITY HOSPITAL

LICENSE NO 52-17704-01
DOCKET NO 030-13199

This is the response to the notice of Violation submitted to us after NRC inspection of the nuclear medicine laboratory at Hato Rey Community Hospital on December 5-6, 1994.

A. Violation accepted.

Reason for violation: The nuclear medicine technologist received a written directive to administer a therapeutic dose of ^{131}I , oral solution, to a patient as treatment for hyperthyroidism. The laboratory usually purchase unit doses to Mallinckrodt company and the dose is usually administer to the patient the day the calculated dose is near the desired dose.

The dose was measured in a dose calibrator, as required, and administered to the patient.

After the administration of the dose, the technologist measured the empty vial. She found that the vial still had 1.6 mCi, for that reason she stated an administered dose of 8.6 mCi to the patient.

After administration of the total oral solution in the vial, the technologist failed to add water to wash the solution usually attach to the vial.

Corrective Action: The technologist was instructed to wash several times the vial with tap water after administering the therapeutic dose in order to avoid differences in the doses. She was also told to confirm the written directive with the measured dose. If there is any deviation, notify immediately the authorized user.

In addition the physician will prepare a written report of all the therapeutic doses administered after verifying the prescribed dose and the administered dose.

Date of full compliance: Immediately

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B. Violation accepted.

Reason for violation: The nuclear medicine technologist failed to monitor the external surface of the packages labeled with radioactive contamination. She had follow the instruction in the 10 CFR (prior to January 1994) to survey packages only if they appear to be broken or moisten.

Corrective Action: The technologist was immediately instructed to survey all incoming packages label with Radioactive Materials.

Date of full compliance: Immediately

C. Violation accepted.

Reason for violation: The nuclear medicine technologist that usually covers the period of vacations are actively working in other laboratories and have their body and ring film badges. In this occasion, we hire a nuclear medicine technologist that was unemployed, and an involuntary omission regarding the ring thermoluminescent film badge occurred.

Corrective Actions: The nuclear medicine technologist supervisor of the laboratory will be in charge of verifying the possession of film badges prior to the expected working period. If the employee do not have one, she/he will order a visitor film badge for the person.

Date of full compliance: February 1, 1995