

AHM

Rich

Licensee: Bayhealth Medical Center

License No.: 07-14850-01

Docket No.: 03007565

Inspector No.: 2005001

Bayhealth Medical Center
Kent General Hospital
Radiation Safety Committee Meeting
September 15, 2005

Attendees: Dr. Rachel Taylor, RSO, Donna Lang, Krueger-Gilbert Health Physics, Mary Brown, R.N/O.R., Deborah Watson, Administration, Raji Subramanyan, Cancer Center, John Shevock, Cancer Center, Donald Tilton, D.O., Heather Jones, Nuclear Medicine, Cindy Talerico, Cath Lab, Sheila Snyder, Diagnostic Imaging, Carol Geiger, R.N/Cysto-OR, John Desiderio, Diagnostic Imaging, Vicki Nabb, Diagnostic Imaging

Excused: Debbie Betts, Diagnostic Imaging, John Lahaniatis, Cancer Center

Location: P.D.R #1

Start time: 1:00 pm

Topic	Discussion/s	Actions
Minutes	Minutes from previous meeting (June 2005) were distributed for review	Minutes were approved
ALARA	<p><u>Monthly Badges : April – June</u> Participants over 125 mRem for the quarter – 7 (INT & CAR) Participant exceeding level II – 3 (INT series)</p> <p><u>Bi-monthly Badges: Jan & Feb</u> Participants over 83 mRem – 3 (OR series)</p> <p><u>Absent Badges</u> Why is the entire Anesthesia series not turned in? OR - handful Bi-monthly - 11 Monthly - 22 (mixed series)</p> <p><u>Fetal Badges</u> 4 individuals – highest is 10 mRem</p>	<p>Donna gave Dr. Taylor the ALARA Questionnaires to give to each individual to fill out and report at the next Radiation Safety Meeting</p> <p>Vicki explained the person who handled the badges for that series left – someone has recently taken over and will see to it the badges are handled properly(Greg Wilson)</p> <p>It was suggested that a letter be sent the directors of each series about the badge issue (John Desiderio will take care of)</p>

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<p>Nuclear Medicine Incident Reports</p>	<p>Discussion on the 92 year old patient who needed a therapy dose - Family member felt she should be medicated. Liquid I131 was ordered due to her inability to swallow pills. Upon many attempts with no success it was decided that capsule form would be tried. The capsule was put on a spoon, patient spit out, the capsule was attempted by spoon again & family member took her thumb and pushed capsule into her mouth. Health Physicist & Radiation Safety Officer were notified and the family member thumb was scrubbed and the tips of rubber gloves were cut & placed on her thumb.</p> <p>She was re-evaluated a week later and was found to be a background.</p>	<p>The liquid iodine was never used</p> <p>Dr John has all the paperwork - Donna has asked for a copy be forwarded to her</p>
<p>Missing Cesium Source</p>	<p>On the morning of August 12th upon performing morning quality control on the dose calibrator the Nuclear Technologist discovered the cesium source was missing from the drawer from which it was stored.</p> <p>The lead person was contacted and all persons who had been in the Nuclear Medicine department the Friday before were contacted.</p> <p>The Diagnostic Imaging Manager was contacted and arrived in.</p> <p>The Health Physicist and the Radiation Safety Officer were contacted (both were on vacation).</p>	

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	<p>The head of Security was contacted as well as the NRC who requested the Dover Police be contacted who in turn contacted the FBI.</p> <p>Dover Police followed up with Security, the FBI did not come in.</p> <p>The NRC has been given all the information necessary.</p> <p>Since the incident cameras have been installed in the Nuclear Medicine hallway.</p> <p>Badge key access has been requested to be installed on the Hot lab doors for both the Kent and Milford facilities.</p> <p>Dr Raji asked if the Cancer Center would need to take the same precautions as the Nuclear Medicine department.</p>	<p>Raji was instructed to call Dave Freeman and request the same precautions be used as in Nuclear Medicine over at the Cancer Center</p>
<p>QMP Report</p>	<p><u>Radiopharmaceutical Administrations:</u> 12 administrations subject to the quality management program for Nuclear Medicine</p> <p>No recordable events or misadministrations.</p>	<p>Donna will look at the rest of the paperwork for the high dose release at the Cancer Center tomorrow</p>
<p>Health Physics Audit</p>	<p>Overall records for Nuclear Medicine look good</p> <p>Just a few personal monitoring daily surveys were not done</p>	

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In-Services	An in-service has been set for 3:00 today with the Environmental Services department.	
Executive Summary Conducted for Kent General	Delaware licensing renewal has been received	
Meeting Adjournment	Meeting adjourned at approximately 2:00 pm	Next scheduled meeting is set for December 15 th in PDR #3

Respectfully Submitted,

Rachel Taylor, MD
Radiation Safety Officer

NUCLEAR MED

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