

# **Ionising Radiation (Medical Exposure) Regulations Inspection (Announced)**

Radiology Department,  
Healthcare Management Trust  
(HMT), Sancta Maria Hospital

Inspection date: 15 and 16  
February 2022

Publication date: 17 May 2022

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**Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales**

## **Our purpose**

**To check that people in Wales receive good quality healthcare**

## **Our values**

**We place patients at the heart of what we do. We are:**

- Independent
- Objective
- Caring
- Collaborative
- Authoritative

## **Our priorities**

**Through our work we aim to:**

**Provide assurance:**

**Provide an independent view on the quality of care**

**Promote improvement:**

**Encourage improvement through reporting and sharing of good practice**

**Influence policy and standards:**

**Use what we find to influence policy, standards and practice**

# 1. What we did

Healthcare Inspectorate Wales (HIW) completed an announced Ionising Radiation (Medical Exposure) Regulations inspection of the Radiology Department based at Healthcare Management Trust (HMT), Sancta Maria Hospital on 15th and 16th February 2022.

Our team for the inspection comprised of two HIW inspectors and a Senior Clinical Diagnostic Officer from the Medical Exposures Group (MEG) of UK Health Security Agency (UKHSA), who acted in an advisory capacity.

HIW explored how the service:

- Complied with the Ionising Radiation (Medical Exposure) Regulations 2017
- Met the National Minimum Standards for Independent Health Care Services in Wales 2011.

Further details about how we conduct Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspections can be found in Section 5 and on our website.

## 2. Summary of our inspection

Evidence provided throughout the inspection demonstrated that there was good compliance with IR(ME)R 2017.

There was positive feedback provided by patients about their experiences when attending the department. We saw arrangements in place to promote privacy and dignity of patients and found that staff treated patients in a kind, sensitive and professional manner.

Generally, staff were happy with the level of support provided by their immediate line manager and senior managers within the service.

Discussions with staff throughout our inspection provided assurance that arrangements were in place to ensure that examinations were being undertaken safely.

Some areas for improvement were identified.

This is what we found the service did well:

- The SAF was completed to a high standard, demonstrating an understanding of the regulations and their implementation into clinical practice
- Information provided indicated that there were good arrangements in place to help staff meet the communication needs of patients attending the department
- Clear evidence to demonstrate that there was good interaction and engagement between Medical Physics Experts (MPEs)<sup>1</sup> and the department

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<sup>1</sup> An MPE is a person having knowledge, training and experience to act or give advice on matters relating to radiation physics applied to medical exposure in diagnostic radiology, nuclear medicine and radiotherapy, whose competence in this respect is recognised by a competent authority. All

- Clear evidence of optimisation including local Diagnostic Reference Levels (DRLs)<sup>2</sup> in place for commonly performed examinations and ongoing work to set further local DRLs
- Clear evidence of a positive incident reporting culture
- Duty holder training, competency and entitlement records reviewed were clear and comprehensive
- Appropriate arrangements implemented to allow for effective infection prevention within the department.

This is what we recommend the service could improve:

- Ensure information about actions taken as a result of feedback is being shared with patients
- A number of areas were highlighted where additional detail was required in written documentation to ensure the information accurately reflects actual practice.

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employers who carry out medical exposures are required in IR(ME)R to appoint a suitable medical physics expert.

<sup>2</sup> Diagnostic reference levels (DRLs) are a practical tool to promote optimisation. DRLs are used to identify issues related to equipment or practice by highlighting unusually high radiation doses.

### 3. What we found

#### **Background of the service**

The Healthcare Management Trust (HMT) is a registered charity delivering not for profit health and social care within England and Wales. The charity operates a number of independent planned surgical care hospitals as well as care of the older person homes in addition to supporting other charities within the social care sector who together operate a further 340 social care beds.

HMT Sancta Maria Hospital (the hospital) is one of the two hospitals in HMT and they moved to their current premises in February 2021. The hospital aims to provide medical and surgical diagnosis and treatment of patients:

The Radiology Department at the hospital consists of equipment including:

- A DR X-ray unit
- A mobile DR X-ray unit
- A mobile C-arm.

The department employs a supervisor radiographer, a radiographer and Consultant Radiologists.

The department also had advice and support from Medical Physics Experts (MPE), provided through a Service Level Agreement (SLA) between the hospital and the Swansea Bay University Health Board.



## Quality of patient experience

*We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.*

Overall, there was very positive feedback provided by patients about their experiences when attending the department.

We saw arrangements in place to promote privacy and dignity of patients and found that staff treated patients in a kind, sensitive and professional manner.

Information provided indicated that there were good arrangements in place to help staff meet the communication needs of patients attending the department.

Whilst the service routinely collects patient feedback, they need to make sure that arrangements are in place to share the results and inform patients about actions taken as a result of their feedback.

As part of the inspection process HIW issued both online and paper surveys to obtain patient views on the services provided by the department. In total, there were 17 responses received. Not all respondents answered all of the questions. The vast majority of responses to the questions asked indicated a positive patient experience by users of this service.

Patients were asked in the questionnaire to rate their overall experience of the service. Sixteen of the 17 who answered the question rated the service as 'very good', and one rated it as 'good'. Patient's told us:

*"...Service is excellent"*

*"Outstanding"*

HIW also issued an online survey to obtain staff views on the diagnostic imaging department at the hospital. In total, we received 11 responses from staff at the hospital. These responses included radiographers, consultants and "other" staff. Again, not all respondents answered all of the questions.

The majority of responses indicated a positive staff experience, with 73 percent recommending this organisation as a place to work. The staff view on the patient experience was also positive with all being satisfied with the quality of care they give to the patients, and all indicating that they would be happy with the standard of care provided by this organisation for themselves or their family.

## **Staying healthy**

There were a number of information posters displayed in the radiology waiting areas. These included details around the benefits and risks of medical exposures being carried out. Additionally, posters were displayed throughout the department advising patients of the importance of letting staff know if there was a likelihood they may be pregnant. This is important to prevent potential harm to an unborn child and is required under IR(ME)R to make pregnancy enquiries, where relevant.

The welcome to the department sign included details of the importance of checking patient identity details, checking clinical information and patients' pregnancy status prior to any procedure. Other information included one sign around ensuring patients were free from discrimination. Information on how the patient could obtain their results and details outlining how the patient could provide feedback on their experiences was also displayed.

We did not notice many leaflets with regards to general health care advice and support on display. However, we were told that as part of the pre-assessment process, patients were provided with information about healthy lifestyles, smoking cessation, exercise, drinking and diet. The hospital also had links with a weight loss organisation who could support patients and provide information to patients on alcohol, drug and mental health support. The hospital did not treat patients with a body mass index (BMI)<sup>3</sup> above 40.

## **Dignified care**

During our time within the department we observed staff engaging with patients in a polite, sensitive and professional manner. We did not overhear any sensitive conversations taking place during the inspection. We observed patients being taken into available treatment rooms for private conversations when required. The X-Ray room door was closed when the examinations were taking place. The

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<sup>3</sup> BMI uses height and weight to work out if a person has a healthy weight, underweight or overweight. The result is not the perfect measure of overall health.

X-Ray room door automatically locked when closed; access was only then possible using a key card for entry and a button to exit. 15 of the 16 patients who answered the question said they were able to speak to staff about their examination without being overheard by other people.

There was a changing room available within the department, situated within the waiting area. The room had two doors, which allowed the patient to go straight into the examination room, once they had changed clothing. There were also posters in the changing room relating to the importance of informing staff of any issues relating to pregnancy and the treatment carried out. Whilst we did not directly observe patients having their examinations, we saw staff greeting patients in a friendly manner. All patients who responded to the survey said that they had been treated with dignity and respect by the staff at the hospital and they were able to maintain their own privacy and dignity during their appointments.

All staff who answered the question in the survey, said patients' privacy and dignity was always maintained.

14 of the 15 patients who answered the question said they felt they could access the right healthcare at the right time (regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation).

None of the 15 patients who answered the question indicated they had faced discrimination when accessing or using the health service.

### **Patient information and consent**

As previously detailed, we saw posters displayed within the department, which included information regarding the benefits and risks of the exposure to ionising radiation for the examinations being undertaken.

As part of the inspection process we requested the hospital to complete a self-assessment form (SAF). The SAF stated that patient information posters summarising benefits and risks from the available modalities were displayed prominently in radiology patient waiting areas. The operator carrying out the X-ray exposure, would be available to provide further information to the patient or their representative on request. A consultant radiologist would provide more detailed information should it be required. However, from the information supplied, we believe that consideration needs to be given to the information theatre patients are receiving on the benefits and risks of the radiation exposure and this should be formally agreed and written down to ensure a consistent approach.

The employer had a written procedure in place in relation to provision of adequate information to individuals to be exposed relating to benefits and risks. The purpose of this was to ensure that whenever practicable, and prior to an exposure taking place, the individual to be exposed or their representative was provided with adequate information relating to the benefits and risks associated with the radiation dose from the exposure.

All patients who answered the question said they felt involved as much as they wanted to be in any decisions made about their treatment and that they had received clear information to understand the risks and benefits of their treatment options. Additionally, all patients told us they had been given information on how to care for themselves following their procedure or treatment. All patients, bar two, who answered the question said they had been given written information on who to contact for advice about any after effects from any treatments they had received.

#### Improvement needed

The employer must ensure that the information theatre patients are receiving on the benefits and risks of the radiation exposure is formally agreed and made available to enable staff to give a consistent approach in their explanation.

#### Communicating effectively

All patients who responded to the question on our survey confirmed that they were listened to by staff during their appointment. Staff we spoke with confirmed that they had access to communication support services, if required, to assist any patients attending the department who are unable to communicate verbally in English. We were also informed that there were staff working on the department able to converse in other languages, including Welsh. However, no badges were seen to identify staff able to converse in Welsh.

On the first day of our inspection it was highlighted that there were few notices displayed within the department advising patients that they could speak to staff in Welsh, if they wished to do so. There were also very few posters in Welsh. The hospital should consider displaying more bilingual posters. All patients who responded to our survey confirmed that they were able to speak to staff in the language of their choice.

All patients who answered the question said their preferred language was English. Again, all bar one patient who answered the question said healthcare information was available in their preferred language and one answered 'not applicable'.

There were hearing loops available within the reception area for the department and in the outpatient department, where the X-rays were carried out. These hearing loops assist people wearing hearing aids to communicate with staff.

## **Timely care**

All patients who completed the survey told us it was 'very easy' to find their way to the department and that it was 'very easy' or 'fairly easy' to arrange an appointment for their procedure.

Appointments in the department were made in advance and the hospital were able to meet the demands of patients. Staff confirmed that patients initially wait in the main hospital reception area on their arrival. They were then called through to the department waiting area when staff were ready for them. Appointments would be arranged based on availability of staff and equipment. Staff confirmed that should there be any unexpected delays whilst patients are already in the department, they would be informed immediately. During our time on the department we did not observe any patients waiting significant lengths of time before being taken into the X-ray room.

Nine of the ten staff who answered the question on the survey said they always or usually had adequate materials, supplies and equipment to do their work, and one said they sometimes do. Six of the ten who expressed an opinion said they were always or usually able to make suggestions to improve the work of their team/department and four said they sometimes could. Five of the ten who expressed an opinion said they were always or usually involved in deciding on changes introduced that affect their work area / team / department and five said they sometimes were. All ten staff said they were always or usually satisfied with the quality of care they give to patients. Seven of the ten who expressed an opinion said patients were always or usually involved in decisions about their care and three felt this was not applicable to them.

## **Individual Care**

### **Citizen engagement and feedback**

Patient feedback forms were available on tables in the department's waiting area. There was also a paragraph included on the department sign in the waiting area asking patients to complete the patient feedback form in the waiting area or on the hospital social media pages. The feedback form only asked one question 'how do you rate the service' and included a comments box. The service should consider expanding the feedback form to collate additional useful feedback.

Staff and senior managers of staff we spoke with described the process in place to ensure that regular feedback was taken from patients and the arrangements to feed back the results to staff. The results were updated on DATIX<sup>4</sup>. We were also told that if a patient gave their contact details as part of any feedback, they were contacted directly. Arrangements were in place to respond to any verbal concerns raised by patients. We were informed that attempts were made, where possible, to try to resolve the issues with the patient quickly and efficiently. Where this was not possible, patients were signposted to the hospital complaints process.

All staff who expressed an opinion said that patient / service user experience feedback was collected within their directorate/department. Nine of the 11 who expressed an opinion said they received regular updates on patient / service user experience feedback in their department and two answered “don’t know”. Additionally, nine of the 11 who expressed an opinion said feedback from patients / service users was used to make informed decisions within their department, one said it is not and one answered “don’t know”.

However, we did not notice information on how the organisation had learned and improved based on feedback received. The service must ensure that a board similar to a “you said, we did”<sup>5</sup> board is displayed to inform patients of the actions taken as a result of feedback.

#### Improvement needed

The hospital must ensure that arrangements are in place to provide patients with regular updates on the patient experience feedback received by the service, as well as any subsequent actions taken.

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<sup>4</sup> DATIX in addition to including an incident reporting module, also includes a safety alerts module, patient feedback module, risk and risk assessments.

<sup>5</sup> It is the way of showing how the views and ideas of people using the services are being listened to and used to improve services and patient experiences.

## Delivery of safe and effective care

*We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.*

Evidence provided and discussions with staff demonstrated that overall compliance with IR(ME)R 2017 was very good. Staff had a good awareness of their duty holder roles and responsibilities.

Information provided indicated that appropriate arrangements had been implemented by the service to allow for effective infection prevention and decontamination within the department.

Discussions with staff throughout our inspection provided assurance that arrangements were in place to ensure that examinations were being undertaken safely.

## Compliance with Ionising Radiation (Medical Exposure) Regulations

### Duties of employer

#### *Patient identification*

There was an up to date written employer's procedure for staff to correctly identify patients prior to their exposure. This aimed to correctly identify the individual to be exposed to ionising radiation, in accordance with the requirements of IR(ME)R 2017. The procedure set out the questions that staff were required to ask to confirm the patient's full name, date of birth and home address. This approach was in keeping with current professional body guidance<sup>6</sup> on IR(ME)R.

Included in the information detailed within the procedure were steps staff should take if they encountered different types of scenarios including patients lacking capacity, unconscious patients and patients unable to communicate in English.

During the inspection, we reviewed a sample of current and retrospective patient records. All records reviewed evidenced that patient identification checks had

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<sup>6</sup> [https://www.rcr.ac.uk/system/files/publication/field\\_publication\\_files/irmer-implications-for-clinical-practice-in-diagnostic-imaging-interventional-radiology-and-nuclear-medicine.pdf](https://www.rcr.ac.uk/system/files/publication/field_publication_files/irmer-implications-for-clinical-practice-in-diagnostic-imaging-interventional-radiology-and-nuclear-medicine.pdf)

been carried out by staff, in accordance with the written procedure. Every patient who answered the question on our survey confirmed that they had been asked to confirm their personal details prior to their procedure being undertaken.

#### *Individuals of childbearing potential (pregnancy enquiries)*

There was a written employer's procedure in place in relation to the process for identifying whether an individual of childbearing potential is or maybe pregnant, prior to undergoing any exposures. This aimed to prevent the accidental radiation exposure of a foetus during a radiological examination by ensuring that enquiries regarding pregnancy were made in an appropriate and consistent manner.

Depending on the individual's response, the procedure set out the process staff must follow. The details included the age range of individuals who should be asked about pregnancy, which was between the ages of 12 and 55 years and where the primary beam may irradiate the abdominal and pelvic regions. This was important to minimise the potential harm to an unborn child from an exposure of ionising radiation. Posters were displayed throughout the department advising patients of the importance of letting staff know if there was a likelihood that they may be pregnant. These posters correctly referred to individuals of child bearing potential. However, the procedure, the referral form and the policy, all referred to female patients. These documents need to be changed to consider the gender diversity of the patients and include information as seen in the relevant poster on display.

Staff we spoke with were able to describe their responsibilities in regards to the pregnancy enquiries, which included the need to consider individuals of childbearing potential.

#### **Improvement needed**

The employer must ensure that the employer's procedure is updated to refer to individuals of child bearing potential rather than females.

#### *Non-medical imaging exposures*

There was an up to date employer's procedure in place which detailed the non-medical imaging exposures. These are exposures that do not give a direct health benefit to the individual undergoing the exposure. They include exposures for insurance or litigation purposes carried out by the radiology department. Staff we spoke with were able to describe the types of non-medical imaging that took place and the procedure that was followed, including the necessary justification and authorisation. Referrals for such exposures would only be accepted from



registered healthcare professionals, with referral rights. Where the request was from a solicitor, the consultant radiologist who received the request would be the referrer for the exposure. A consultant radiologist would also act as practitioner for all such exposures.

### *Referral guidelines*

The referrers' responsibilities were defined in the employer's procedures. The referral guidelines used were based on the Royal College of Radiologist (RCR) iRefer<sup>7</sup> 8<sup>th</sup> edition publication. We were told that access to iRefer is available to all referrers to support compliance. Additionally, a leaflet on referrer responsibilities under IR(ME)R was provided for referrers and includes a link to referral guidelines.

GMC registered medical practitioners are group entitled by the Head of Clinical Services to make a referral. The employer's procedure also referred to all registered medical practitioners (to include General Practitioners) who were entitled to refer for all diagnostic examinations by the Head of Clinical Services. The hospital does not accept referrals from non-medical referrers.

Senior managers confirmed that referral awareness information was provided in the form of a leaflet on referrer responsibilities under IR(ME)R which also included a link to referral guidelines. We were told that referral forms are audited for IR(ME)R compliance. Additionally, non-compliant referral forms were returned to referrers. Where insufficient clinical information was provided by the referrer, the practitioner would arrange for the referral form to be returned, identifying additional information required. In the case of urgent referrals, the practitioner would arrange for the referrer to be contacted, to obtain the relevant information. We were also informed that iRefer was accessible via the health board intranet page and could be accessed using any health board IT system.

There was an employer's written procedure in place setting out the referral process for staff to follow. The purpose of this document was to provide guidance on making a referral for a medical exposure and consequently to reduce the numbers of referrals which were rejected by the practitioner. The referral form must include the following patient details; full name, address, date of birth and hospital number.

Both in the SAF returned by the hospital and from speaking with staff, the process was described for cancelling referrals. We were told that when a referral was

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<sup>7</sup> <https://www.rcr.ac.uk/clinical-radiology/being-consultant/rcr-referral-guidelines/about-irefer>

cancelled, a form was sent back to the referrer that indicated the person responsible for cancelling the referral e.g. patient, referrer or radiographer, or radiologist and a reason was provided for why the cancellation had occurred. Most referrals come from in house consultants and they were also returned using the process described above. If the referral was from a general practitioner, they would telephone to cancel request.

The employer's procedure for entitlement and identification of referrers, practitioners and operators did not include MPEs as operators in the table listed. MPE's need to be entitled as operators and included in the relevant table.

A check of a sample of current and retrospective referrals showed that the documents complied with IR(ME)R requirements and fulfilled all questions on the referral form.

Senior staff we spoke with stated that moving onto the new hospital site also gave the opportunity to establish more robust systems such as requiring referral forms in theatres to be completed correctly.

#### Improvement needed

The employer is to ensure that MPEs are entitled as operators and added to the employer's procedure table for entitlement.

#### Duties of practitioner, operator and referrer

The employer had a system in place to identify the different IR(ME)R roles of the professionals involved in referring, justifying<sup>8</sup>, authorising and performing radiology exposures to patients. The hospitals' Ionising Radiation Safety Policy detailed the specific roles and responsibilities in line with IR(ME)R, which were

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<sup>8</sup> Justification is the process of weighing up the expected benefits of an exposure against the possible detriment of the associated radiation dose.

referrer<sup>9</sup>, practitioner<sup>10</sup> and operator<sup>11</sup> (known as duty holders). The policy included details of the requirements that had to be met before an individual could be formally entitled to become a duty holder, as well as training requirements for newly appointed duty holder roles.

From reviewing the SAF and through speaking with senior staff we were informed about the process for the induction / training programmes in place for all newly appointed duty holders under IR(ME)R. This included the process for both radiographers and radiologists.

We reviewed a sample of duty holder training, competency and entitlement records and found these to be in order. There were also systems in place to monitor training compliance. Staff we spoke with also demonstrated an awareness and understanding of their duty holder roles under IR(ME)R 2017.

Senior managers described the arrangements for notifying staff of any changes to policies and procedures. Following any amendments, the updated document were shared with relevant staff via an email notification and staff briefing. Staff subsequently had to sign to confirm that they had read and understood the document. We were informed that any changes were discussed in staff meetings. Staff we spoke with confirmed that they were able to access electronic versions of the policies and procedures, when required.

### **Justification of Individual Medical Exposures**

The employer had a written procedure in place for the justification and authorisation of medical exposures undertaken within the department. This procedure set out the required steps that had to be taken by staff to ensure that all examinations involving ionising radiation were justified and authorised prior to the procedure being undertaken. Staff we spoke with had a good understanding of the justification and authorisation process to be followed.

All carer and comforter medical exposures also had to be justified and authorised. There was an employer's procedure in place which aimed to clarify the process

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<sup>9</sup> Under IR(ME)R a referrer is a registered healthcare professional who is entitled, in accordance with the employer's procedures, to refer individuals for medical exposures.

<sup>10</sup> Under IR(ME)R a practitioner is registered healthcare professional who is entitled, in accordance with the employer's procedures, to take responsibility for an individual medical exposure. The primary role of the practitioner is to justify medical exposures.

<sup>11</sup> Under IR(ME)R an operator is any person who is entitled, in accordance with the employer's procedures, to carry out the practical aspects of a medical exposure

involved in justifying exposures involving carers and comforters. This included providing the individual with sufficient information around the benefits and risks, to ensure that they knowingly and willingly participated. If the individual was deemed to be of childbearing potential, a pregnancy enquiry would also be made. No individual would be allowed to carry out this carer and comforter role if they were, or it was possible they may be pregnant or were unable to understand the information / instructions provided to them. Staff we spoke with said that carers and comforters were only used to support patients who had reduced mobility or learning difficulties.

The employer's procedure that related to carers and comforters and the accompanying consent form, did not include evidence that the record of the pregnancy check had been made with the carer and comforter. There should be written evidence that the pregnancy check was carried out, in addition to the communication of benefits and risks information.

In addition, the employer's procedure stated that in order to ensure that the same individual did not repeatedly act as a carer and comforter and receive multiple exposures; the hospital set an annual dose constraint of less than one Sievert (Sv)<sup>12</sup> for any individual. The SAF further stated that a risk assessment had identified that the dose constraint was highly unlikely to be exceeded and individual monitoring of carers and comforters' doses within the hospital was not required.

#### Improvement needed

The employer is to ensure that the employer's procedure is changed to reflect the need to record evidence that the check is made of individuals of child bearing potential on the consent form.

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<sup>12</sup> The sievert (symbol: Sv) is a derived unit of ionizing radiation dose in the International System of Units (SI) and is a measure of the health effect of low levels of ionizing radiation on the human body.

## Optimisation

There were arrangements in place for the optimisation<sup>13</sup> of exposures. We noticed that the employer's procedure referenced patient contact shielding<sup>14</sup> and the new British Institute of Radiology (BIR) guidance on its use. However, whilst the senior staff we spoke with stated that shielding was not used, one member of staff referred to using shielding for pregnant patients. Consideration should be given to provide staff with further training on when and when not to use patient contact shielding.

We were also told that the relevant MPEs routinely provided advice and contributed to the optimisation of exposures including acceptance testing and scheduled X-ray equipment quality assurance (QA); contributing to establishing and reviewing employer's procedures; and patient dose audit. This may result in recommendations to optimise specific examination protocols. This was done to support exposures being kept as low as reasonably practicable.

### *Diagnostic reference levels (DRLs)*

There was an employer's written procedure in place for the use of DRLs. The procedure stated that at least once every 3 years the MPE would perform a patient dose audit, compare results with established DRLs, and issue a list to the Supervisor Radiographer. DRLs would be set to reflect local practice, patient demographics and equipment. DRLs were displayed in the control area for radiographers to reference. Local DRLs, where set, were either at or lower than National DRLs for the room where a patient dose audit had been conducted. We were told that due to the low numbers of exposures taken for some examinations, local DRLs were adopted from national DRLs, where available.

Consistently exceeded DRLs would be discussed with the MPE and reported on the risk management system called Datix. There was also a paper record for reporting in the department. A system was in place to ensure that operators record instances where the dose for an examination on an average size patient consistently exceeds the DRL, without an obvious explanation such as patient

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<sup>13</sup> Optimisation refers to the process by which individual doses are kept as low as reasonably practicable.

<sup>14</sup> Shielding, generally in the form of lead rubber, applied directly to patients has been practised for many years to reduce the dose to critical organs. However, some studies have questioned the efficacy of using such shielding.

size or examination complexity. The dose audit findings were shared in departmental meetings and the radiation protection group.

### *Clinical evaluation*

There was an employer's procedure in place, which detailed the arrangements regarding clinical evaluation<sup>15</sup> of medical exposures carried out within the department. The procedure set out to ensure that all examinations resulting from a medical exposure had a documented clinical evaluation, which was available to the referrer or other relevant staff involved in that patient's care. The procedure stated that all X-ray examinations had to be reported by a radiologist unless the duty has been delegated by mutual agreement to another department, for example, screening in theatres. A written evaluation report would be provided for the referrer and it was their responsibility to ensure the report was filed in the patient's medical notes.

Senior staff we spoke with said that, with regard to the NHS work undertaken at the hospital, the clinical evaluation would be sent back to referring health board via the image exchange portal. Swansea Bay University Health Board would complete the protocol on the referral as they had the same protocols and radiologists.

### **Equipment: general duties of the employer**

The employer had an inventory (list) of the equipment within the department. The inventory contained the information required under IR(ME)R 2017 including the name of manufacturer, model number, serial number, year of manufacture and year of installation.

There was a written employer's procedure for the quality assurance programme relating to IR(ME)R that included the need to ensure X-ray equipment is subject to a quality assurance (QA) programme. Equipment QA would include equipment testing prior to the first clinical use, routine testing and additional testing following any significant change that could affect patient dose. Examples of this include the replacement X-ray tube / image receptor or a major software update, also for routine equipment testing undertaken regularly or following servicing / repair. We were provided with the QA programme for the three items of X-ray equipment in the hospital.

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<sup>15</sup> Clinical evaluation is important to help inform the next stage of a patient's care and treatment.

The procedure stated that the Head of Clinical Services / Supervisor Radiographer, supported by an appropriate Medical Physics Expert (MPE), was responsible for ensuring that a suitable equipment QA programme was in place. The Supervisor Radiographer would ensure that a QA programme was in place for all imaging equipment used in the department. An appropriate MPE would also be involved in this process.

The hospital moved location in February 2021 from its original site on one side of Swansea to its current site. New equipment was purchased before the move. The MPE was involved in the choosing and procurement of the new equipment and it was chosen to make sure it had the most up to date technology. The equipment was bought approximately 12 months before the new site opened. The equipment was commissioned and in clinical use before the move and checked again when transferred to the current site. We were told that the MPE was available for advice on installation design and technical specification for new equipment as required. Two of the three available MPEs were also certificated radiation protection advisor (RPAs)<sup>16</sup> and were closely involved in all new radiological installations.

## **Safe care**

### **Managing risk and health and safety**

The department was located directly adjacent to the main reception / waiting area on the ground floor of the hospital. There was level access throughout the areas visited, to enable patients with mobility issues to navigate safely. The areas of the department seen were very clean and well maintained. The department appeared to be fit for purpose and the amount of chairs available within the waiting areas were sufficient for the amount of patients seen waiting. There was also a water cooler available in the waiting area for patients.

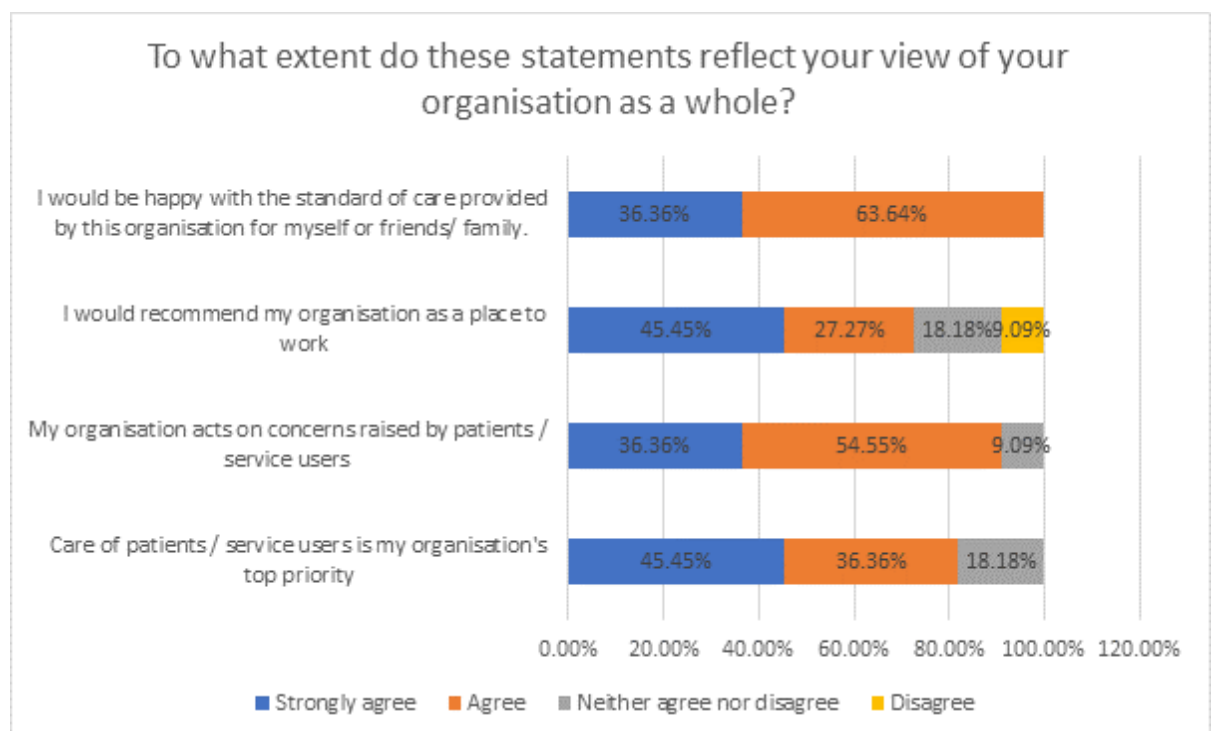
Arrangements were in place to promote the safety of staff, patients and visitors. For example, appropriate signage and restricted access arrangements were in place to deter and prevent unauthorised persons entering areas where radiology equipment was being used.

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<sup>16</sup> A radiation protection advisor or RPA is the recognised authority that ensures an organisation has an adequate level of radiation shielding protecting staff, operators and patients in the radiation area. The role of a radiation protection advisor is to examine the source of radiation, its surroundings and the application.

Overall, the department appeared well laid out, maintained and in a good state of repair. During our time within the department there were no hazards identified in any of the areas we visited.

Responses received via our staff survey highlighted that all respondents who expressed an opinion said that, if they were concerned about unsafe clinical practice, they would know how to report it. They would also feel secure raising concerns about unsafe clinical practice. Nine of the 11 respondents who expressed an opinion said that they were confident that their organisation would address their concerns and two answered “don’t know”.



### Infection prevention and control (IPC) and decontamination

At the time of our inspection, the department appeared visibly clean and free from clutter. There was a disability accessible toilet available for patients to use within the department waiting area with hand washing facilities. Handwashing facilities were also seen in the treatment rooms visited. We saw the relevant PPE in the treatment room visited. We were told during discussions with staff that there were no issues noted regarding the provision of PPE.

Patients would be contacted by telephone or appointment letter. Part of the patient contact process included checking that the patient did not have any symptoms of COVID-19 and explaining the above process. The hospital required that facemasks had to be worn in all areas within the hospital as required by the current government guidelines. Facemasks were provided at the main reception



if required. All visitors had their temperature checked as part of the checks carried out at reception. At reception, all visitors were asked questions including; whether they had any COVID-19 symptoms or had come into contact with anyone with COVID-19 recently. We were informed that staff were required to complete two lateral flow tests (LFTs) every week. Patients were asked to attend the hospital alone where possible. Any relatives who attend with the patient were asked to wait in the car until the appointment was completed.

Information provided by staff we spoke with indicated that adequate arrangements were in place for effective infection prevention and decontamination within the department. We were informed that these arrangements had been strengthened as a result of COVID-19.

All patients who completed the survey said that the setting was 'very clean' and that COVID-19 compliant procedures were 'very evident' during their time at the setting. All staff who expressed an opinion said infection prevention and control procedures were always followed.

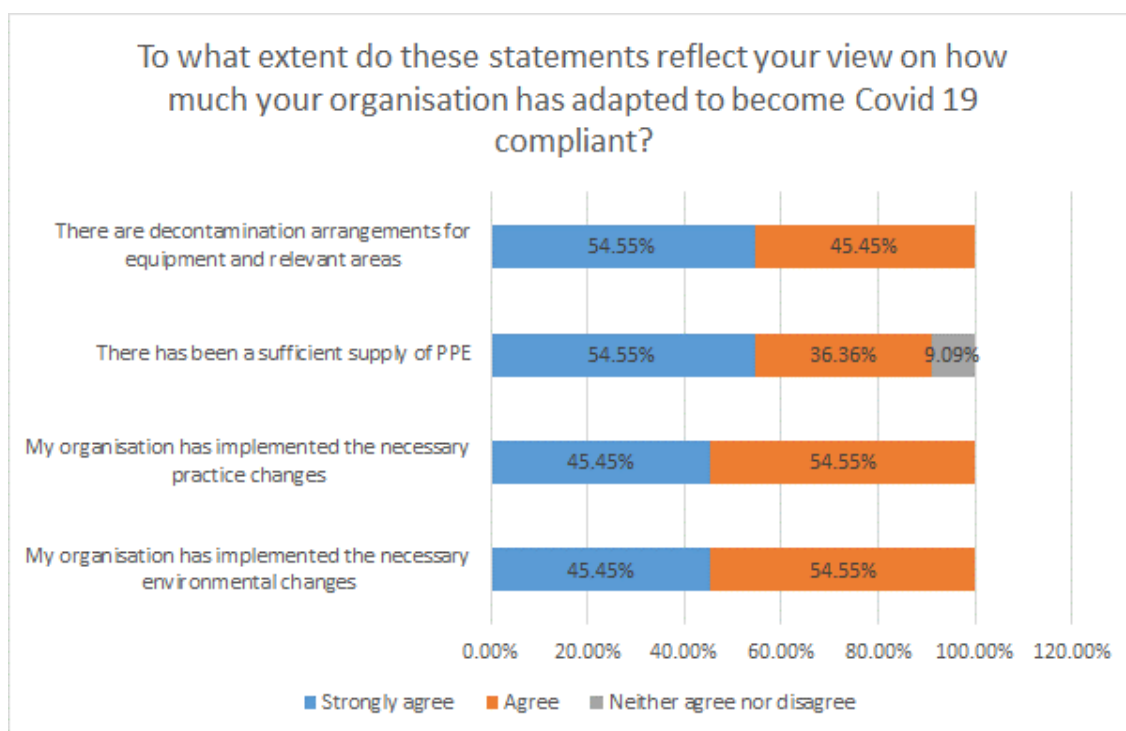
Hand washing facilities and hand sanitiser gel boxes were available throughout the department. All chairs available within waiting areas were wipe clean, to allow for adequate cleaning. Signs were displayed throughout the department to remind staff, visitors and patients of the social distancing requirements.

Senior managers confirmed that arrangements were in place to ensure that there was a sufficient supply of personal protective equipment (PPE) available within the department for staff. We were also informed that staff had received training on donning and doffing<sup>17</sup>.

We asked staff a series of questions in the questionnaire relating to COVID-19 compliance, the responses are shown below.

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<sup>17</sup> Donning – putting on personal protective equipment (PPE); Doffing – taking off personal protective equipment (PPE)



## Safeguarding children and safeguarding vulnerable adults

All staff we spoke with said that staff had received the relevant safeguarding training to level two and also training in the Mental Capacity Act. They were able to describe the process should a safeguarding issue be identified. Staff we spoke with were also aware of the organisation's policies and procedure for safeguarding children and adults at risk. Staff were also aware of the hospital safeguarding lead.

## Effective care

### Participating in Quality Improvement Activities

#### *Clinical audit*

There was a written employer's procedure for quality assurance programmes relating to IR(ME)R. This stated that the person with responsibility for clinical audit was the Head of Clinical Services. The procedure further described that a written rolling clinical audit programme had to be established to include the audit of employer's procedures to ensure they were in place and being followed. The procedure also gave examples of the types of audit that had to be carried out regularly.

The list of audits provided appeared to be IR(ME)R audits as opposed to clinical audit. Clinical audits should be aimed at improving patient care through

identifying areas for improvement and to promote effective use of resources and enhance clinical services. They should also highlight any discrepancies between actual practice and standards.

There was evidence of IR(ME)R audits in place to ensure compliance and this was being routinely monitored, with improvements being made where required. However, the documentation provided did not include the aims and purposes of the audit and other information as described in the employer's procedure. The hospital is required to establish a clinical audit programme. The audit documentation should include the information as required in the employer's written procedure.

#### Improvement needed

The employer must ensure that:

- A clinical audit programme is put in place covering the areas of clinical audit described in the procedure and the areas discussed during the inspection
- The audits include the purpose and aims of the audit as well as the audit reports and subsequent implementation of changes.

#### *Expert advice*

As previously detailed, there was an SLA in place between the hospital and Swansea Bay University Health Board, for the provision of MPE advice and support to the department. We were informed that MPEs were involved in practical aspects of the service including dose audits, routine performance QA of equipment, optimisation and analysis of accidental or unintended exposures. We were also informed that there was MPE involvement in all relevant meetings relating to radiation exposures as well as providing training and MRI safety advice. The SLA was reviewed annually.

There was evidence to demonstrate that there was good interaction and engagement between MPEs and the department. Staff we spoke with confirmed that they were able to contact an MPE for advice and support whenever they needed to.

Senior staff we spoke with including the MPE, stated that the MPEs provided comparative assessments where similar systems were installed in South West Wales. There were also plans to develop an image optimisation team for digital radiography and to bring the hospital into the wider South West Wales teams and the subsequent shared learning.

The SAF stated that MPEs regularly hold radiation protection training and update sessions providing advice on compliance with the regulations including lessons learned from statutory inspections.

#### *Medical research*

There was an employer's procedure in place in relation to imaging procedures undertaken for the purposes of medical research studies. Senior managers confirmed that the department did not currently participate in any research relating to medical exposures. The employer should ensure that the employer's procedure is updated to detail that research exposures are not currently carried out within the hospital.

#### **Improvement needed**

The employer must ensure that the written procedure in relation to research exposures is updated to detail that these exposures are not currently undertaken within the department at the hospital.

#### **Records management**

We reviewed a sample of four current patient referral records and three retrospective patient referral records. The records reviewed had been completed with appropriate details by those staff involved in the exposure. The forms were clear and completed to a good standard with relevant clinical information seen to justify the referral.

## Quality of management and leadership

*We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the National Minimum Standards for Independent Health Care Services*

An organisational structure was in place for the overall radiology department with clear lines of reporting.

Overall, feedback from staff indicated that they were happy with the level of support and engagement from their immediate line manager and from senior managers within the service.

Systems were in place to routinely monitor mandatory training and personal appraisals and overall compliance levels within the department was good.

Employer's procedures, policies and protocols provided as evidence were very well detailed. However, a few areas were highlighted that would further enhance the clarity of the procedures.

HIW issued an online survey to obtain staff views on the Diagnostic Imaging Department at the hospital. In total, we received 11 responses from staff at the hospital. These responses included radiographers, consultants and "other" staff.

The majority of responses indicated a positive staff experience, with 73% (8 of 11) recommending this organisation as a place to work. The staff view on the patient experience was also positive with all being satisfied with the quality of care they give to the patients, and all indicating that they would be happy with the standard of care provided by this organisation for themselves or their family.

There were some areas with less positive responses, indicating potential for improvement. These were staffing, relations with senior management, and perceived reduced ability for staff to influence their workspace, such as suggesting improvements, identifying and solving problems and being involved in decisions that affected their work.

Prior to our inspection, HIW required senior staff within the department to complete and submit a self-assessment questionnaire (SAF). This was to provide

HIW with detailed information about the department and the employer's key policies and procedures in place, in respect of IR(ME)R 2017. This document was used to inform the inspection approach.

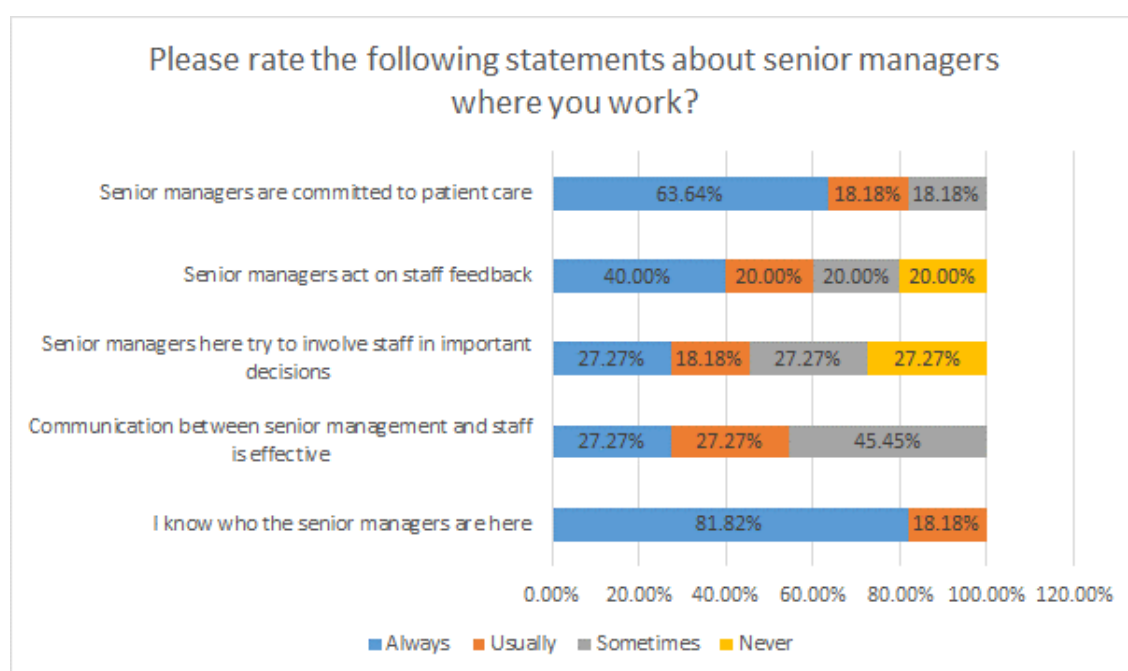
The SAF was completed to a high standard, demonstrating an understanding of the regulations and their implementation into clinical practice. It was returned to HIW within the agreed timescales and was comprehensive. When additional clarity was required regarding some of the responses provided, senior staff provided the additional information promptly.

On the days of our inspection, senior management staff made themselves available and facilitated the inspection process. They were receptive to our feedback and demonstrated a willingness to make improvements as a result of the issues highlighted.

## Governance and accountability framework

There was an organisational chart that demonstrated the link between the employer and the department and showed clear lines of accountability within the service.

Senior managers confirmed that arrangements were in place to ensure that there was regular engagement with department staff including through staff meetings and emails. We were told that senior managers visited the department and engaged with staff on a regular basis. Responses received via our survey relating to statements about senior managers at the hospital are shown below.



## Duties of the employer

### *Entitlement*

There was an employer's procedure in place in relation to the process for entitlement under IR(ME)R 2017. There was also an Ionising Radiation Safety Policy document, which showed the delegation of responsibilities in various areas.

The Ionising Radiation Safety Policy stated that the overarching HMT was the IR(ME)R employer. The document also listed the delegation of responsibilities down to appropriate individuals. The Ionising Radiation Safety Policy also incorporated IR(ME)R employer's procedures.

Evidence of an entitlement matrix for staff working within the department was seen. This document provided the required level of detail and specifically set out the tasks that individuals were entitled to undertake.

As previously detailed, duty holder training, competency and entitlement records reviewed were clear and comprehensive.

Senior managers confirmed that medical referrers were sent letters confirming their entitlement and scope of practice for referring patients to the department.

### *Procedures and protocols*

In line with the detail included within the Ionising Radiation Safety Policy, senior managers confirmed that the employer is Healthcare Management Trust with the Hospital Director accountable for IR(ME)R compliance within the hospital

As previously noted, staff we spoke with as part of our inspection confirmed that they were able to access relevant policies and procedures when required. Senior managers confirmed that arrangements were in place to notify relevant staff on the occasions where updates were made to written procedures or protocols, as well as to confirm that staff had read and understood these documents.

As described above there was an employer's procedure in place in relation to the QA of written procedures and protocols. This document set out the QA programs for all policies, procedures, protocols and equipment pertinent to IR(ME)R 2017. The document detailed the review frequency and review responsibilities for each type of document in use within the service. The procedure set out the document control information which must be included on every document, which included; owner, date approved, review date and version number. The procedure also set out the responsibilities and frequency of the audits.

Overall, the written policies, procedures and protocols provided as evidence were clear and contained the required detail. However, we noted a number of minor areas which were discussed with staff to give further clarity and to correct some presentation errors in the employer's procedures (EPs). These were:

EP No	Procedure Name	Error correction
2	Procedure for referral and referral criteria	Detail on how incomplete or insufficient referrals are managed.
5	Procedure for checking pregnancy status of individuals of childbearing age.	Update the employer's procedure for pregnancy checking, and the form, to consider gender diversity.
7	Procedure for assessment & recording of patient dose.	Consider the process for recording dose for plain radiography (referral form and not RIS) as it differs to fluoroscopy according to the table.
10	Procedure for reporting and investigation of accidental or unintended radiation exposures.	Add a reference to the root cause analysis and how learning was shared, as well as any contributory factors.  Add a link to the reporting policy.
12	Procedure for reducing the probability and magnitude of accidental or unintended exposures.	Include into the list pregnancy enquiries and audit programme.
14	Procedure for non-medical imaging exposures.	Update this procedure to include step 7 as it is currently missing.
15	Procedure for provision of adequate information to individuals to be exposed relating to benefits and risks	The employer's procedure and the WHO checklist needs to include the requirement for benefits and risks for patient, to ensure consistency and potential training and information.



### Improvement needed

The employer should ensure that the employer's procedure are updated as described in the table above and as discussed during the inspection.

#### *Significant accidental or unintended exposures*

There was an employer's procedure in place setting out the required actions for reporting and investigating potential and actual accidental or unintended exposures. The procedure detailed the process to be followed by relevant staff to ensure that the incident was appropriately investigated, documented, and if required, reported to HIW in a timely manner. Staff we spoke with described the arrangements in place in regards to accidental and unintended exposures, which reflected the documentation reviewed.

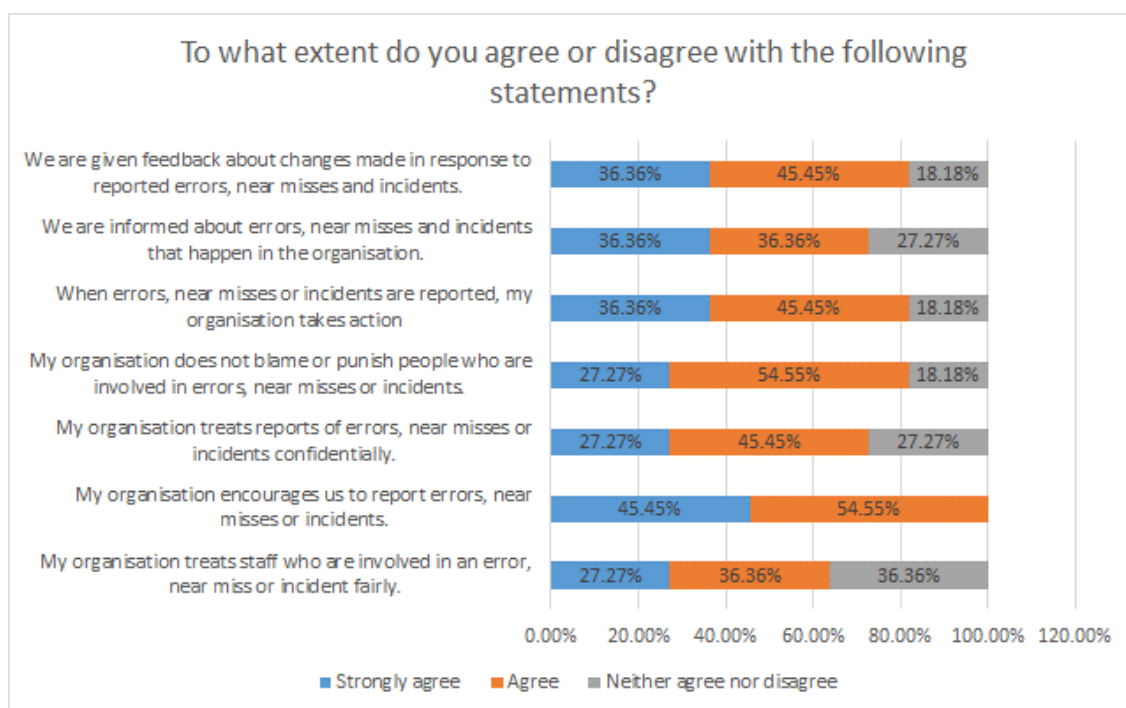
We were informed that all incidents and near misses were recorded in Datix and the MPE would be informed. No incidents had been reported which met the criteria for reporting under IR(ME)R during the last year. Any changes which would be recommended, as a result of any incidents or near misses, would be routinely shared with staff.

We were provided with a copy of the Reporting and Management of Incidents, including Serious Incidents. The purpose of this policy was to set out the steps that must be followed for reporting all incidents. The policy was comprehensive but was not specific to Wales and included references to the Care and Quality Commission, the independent regulator of all health and social care services in England. The hospital must ensure that the policy is adapted for use in Wales.

None of the staff who expressed an opinion in the survey said they had seen an accidental or unattended exposure incident affecting patients in the last month. 4 of the 11 staff who responded said they had seen patient safety errors, near misses, or incidents in the last month. Seven said that the last time they saw an unintended exposure, error, near miss or incident they reported it, two said they had not and one answered "don't know". One member of staff commented:

*"Never been involved in an error, near miss or incident in order to comment but am aware of the Datix system for reporting things."*

The staff were asked a series of questions relating to errors, near misses or incidents, their responses are shown below.



One member of staff commented:

*“... it’s the next level of management that usually interferes/impacts on the running of the department and puts extra strain on my line manager!”*

As part of the SAF we were provided with an investigative report which we considered to be a good example of how the learning from the incident in 2020 was good and showed what not to do and how to do it correctly.

## Staff and resources

### Workforce

Discussions were held with senior managers for the service as part of our inspection, as well as a selection of staff working within the department. As described above, a staff survey was made available to provide all staff working within the department with the opportunity to provide their views.

Overall, positive responses were received from staff regarding their immediate line manager in relation to providing support, feedback and engagement prior to making decisions that affect their work. We asked whether staff had faced discrimination at work within the last 12 months. Nine respondents indicated they had not but two answered “prefer not to say”. Seven of the ten respondents who answered the question agreed that staff had fair and equal access to workplace opportunities (regardless of age, disability, gender reassignment, marriage and

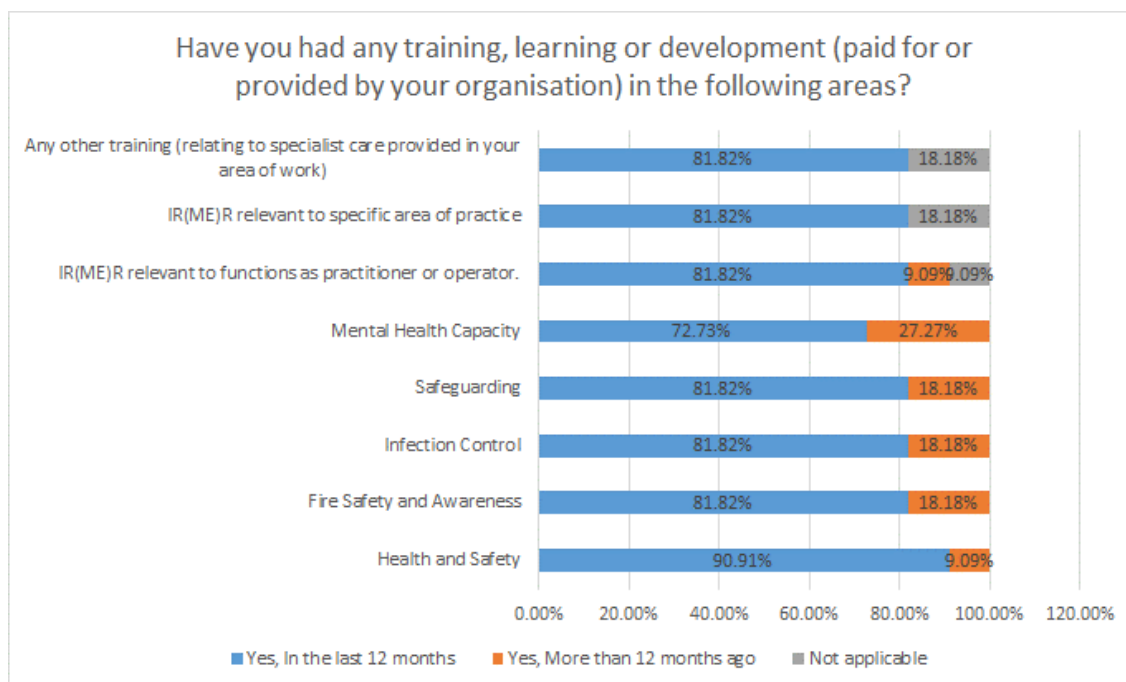
civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation), one said they did not, and two answered “prefer not to say”. 9 of the 11 respondents who expressed an opinion agreed their workplace was supportive of equality and diversity, but two answered “prefer not to say”.

Given the issues highlighted in the staff responses, the hospital should review the processes in place to allow staff to report any issues of concerns internally. This is in order to ensure it is an inclusive process that encourages staff to voice their concerns without fear of recrimination, as well as to ensure that any concerns raised are responded to and appropriately investigated. The hospital must also ensure that staff are reminded of the relevant process in place.

Senior managers confirmed that staffing levels on the unit were appropriate and safe. The hospital were in the process of employing a full time manager of the department and stated that they could meet the demand of the requirements of patients at the hospital. Six of the ten staff who responded to the questionnaires expressed an opinion that there were always or usually enough staff working in the department to do their job properly and four said there sometimes were. Eight of the ten who expressed an opinion said they were always or usually able to meet all the conflicting demands on their time at work, and two said they sometimes were.

Senior managers confirmed that arrangements were in place to ensure that all staff received supervision and appraisals. We were told that staff received annual appraisals and six monthly supervision. Management were looking at sourcing an external supervisor to manage the supervision. Staff received peer reviews currently. At the time of our inspection the appraisal compliance level was 100 percent. 10 of the 11 who expressed an opinion said they had an annual review or appraisal within the last 12 months. Eight of the ten who answered the question said their training, learning or development needs were identified during the appraisal.

Staff were asked a variety of questions relating to their training, the responses received are shown below.



We received two comments on types of training staff would find useful, these are shown below:

*“Cardiac MRI training”*

*“PACS”.*

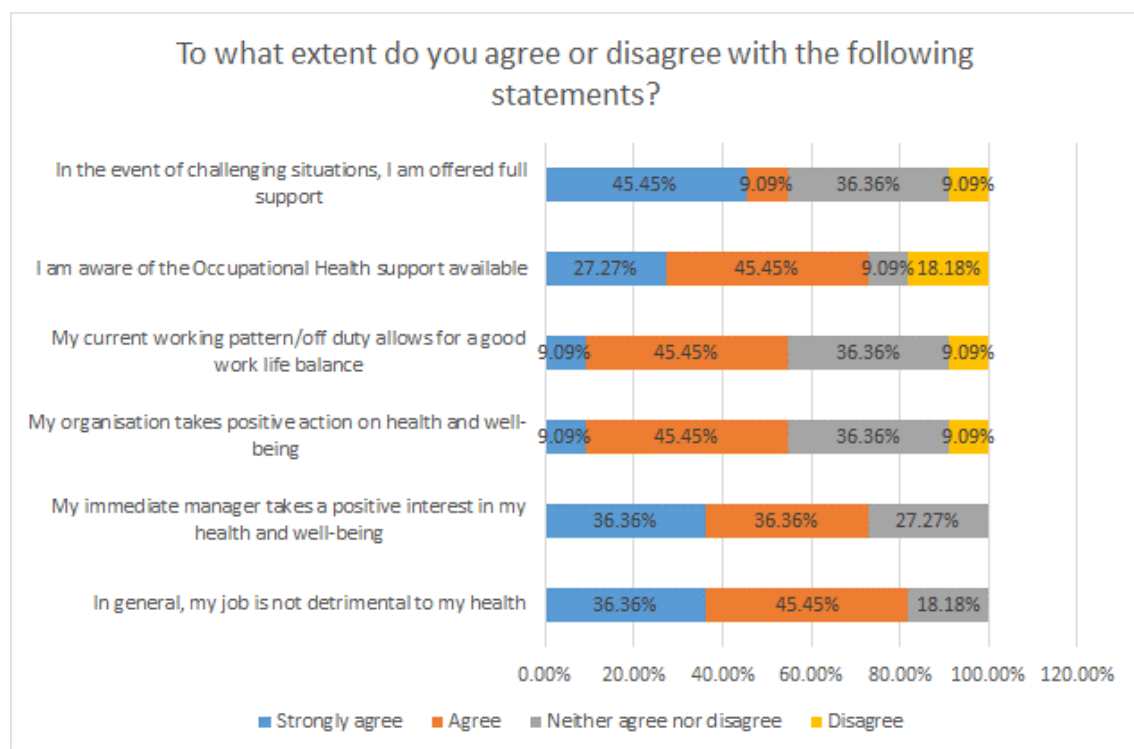
Seven of the ten who answered the question, said their manager supported them to receive training and development and three said they did not. All bar one member of staff who expressed an opinion said training always or usually helped them do their job more effectively and one said it sometimes did. All respondents who expressed an opinion said training always helped them stay up-to-date with professional requirements. All bar one members of staff who expressed an opinion said it always or usually helped them deliver a better patient experience and one felt this was not applicable to them.

We checked a sample of the training records of five members of staff, which showed that they had completed the relevant mandatory training and health and safety training. Three of the five staff had completed infection prevention and control training and were in date, the other two were due to complete annual training. Four of the five members of staff had completed safeguarding training to the required level. There was clear evidence that staff have completed resuscitation training. We also noted that all clinical staff received training up to immediate life support. Training records were clear and there was an appropriate system to identify when training was due.

Senior staff said there were a number of support arrangements in place for staff. These included a manager on call service and an occupational health named mental health champion. Recently all staff had been informed of the arrangement between the hospital and a provider of a healthy living programme. Senior staff also informed us about the welfare calls to staff, regular meetings to check in on staff, as well as one to one meetings.

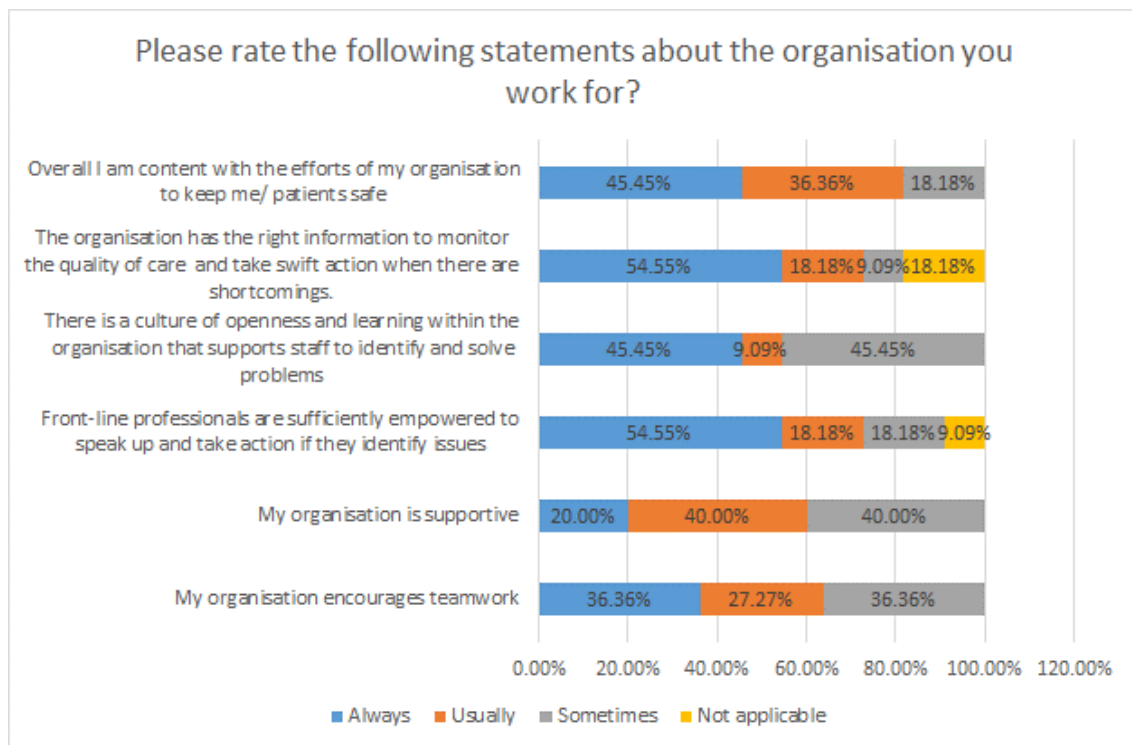
It was also positive to note that new members of staff were allocated a named senior radiographer to act as a mentor with the responsibility to provide support and any necessary training. This was particularly important during the key period when the radiographer was gaining experience of the department and its practices.

With regard to health and wellbeing, staff who completed the survey answered as follows:

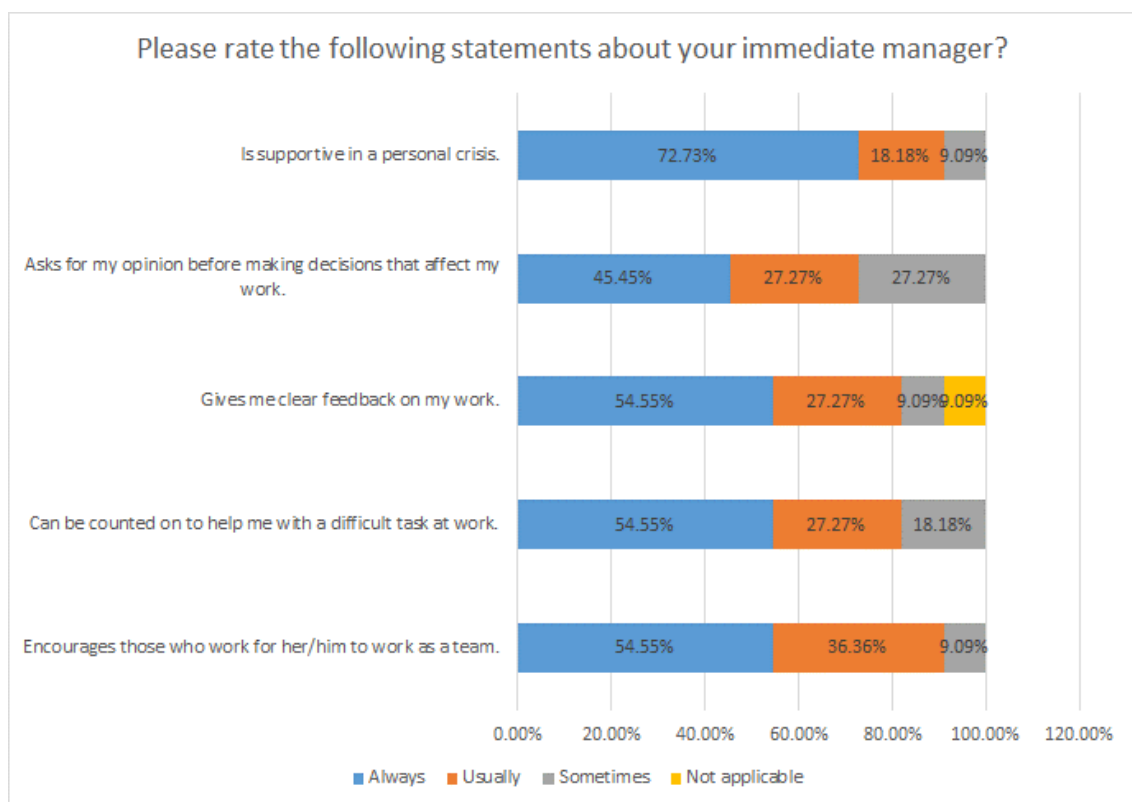


We asked staff a series of questions about the organisation and senior management. Their responses are shown below.

## Organisation



## Immediate Manager



### Improvement needed

The hospital must:

- Confirm that processes are in place to allow any member of staff to report any issues of concern internally, as well as to ensure that any concerns raised are appropriately investigated and responded to
- Confirm that processes are in place to ensure that staff are treated fairly and equally in regards to workplace opportunities, and that any instances of discrimination will not be tolerated and appropriate action taken
- Ensure that all staff are up to date with all the mandatory and required training.

## 4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Where we identify any serious regulatory breaches and concerns about the safety and wellbeing of patients using the service, the registered provider of the service will be notified via a [non-compliance notice](#). The issuing of a non compliance notice is a serious matter and is the first step in a process which may lead to civil or criminal proceedings.

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.



## 5. How we inspect services that use ionising radiation

HIW are responsible for monitoring compliance against the [Ionising Radiation \(Medical Exposure\) Regulations 2017](#) and its subsequent amendment ([2018](#)).

The regulations are designed to ensure that:

- Patients are protected from unintended, excessive or incorrect exposure to medical radiation and that, in each case, the risk from exposure is assessed against the clinical benefit
- Patients receive no more exposure than necessary to achieve the desired benefit within the limits of current technology
- Volunteers in medical research programmes are protected

We look at how services:

- Comply with the Ionising Radiation (Medical Exposure) Regulations 2017
- Meet the National Minimum Standards for Independent Health Care Services in Wales 2011
- Meet any other relevant professional standards and guidance where applicable.

Our inspections of healthcare services using ionising radiation are usually announced. Services receive up to twelve weeks notice of an inspection.

The inspections are conducted by at least one HIW inspector and are supported by a Senior Clinical Diagnostic Officer from the the Medical Exposures Group of the UKHSA, acting in an advisory capacity.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

These inspections capture a snapshot of the standards of care relating to ionising radiation.

Further detail about [how HIW inspects the NHS](#) can be found on our website.

## Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified during this inspection.			

## Appendix B – Immediate improvement plan

**Hospital:** HMT Sancta Maria Hospital  
**Ward/department:** Diagnostic Imaging Department  
**Date of inspection:** 15 and 16 February 2022

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Immediate improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
No immediate assurance issues were identified during this inspection.				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

**Service representative:**

**Name (print):**

**Job role:**

**Date:**

## Appendix C – Improvement plan

**Hospital:** HMT Sancta Maria Hospital  
**Ward/department:** Diagnostic Imaging Department  
**Date of inspection:** 15 and 16 February 2022

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
<b>Quality of the patient experience</b>				
The employer must ensure that the information theatre patients are receiving on the benefits and risks of the radiation exposure is formally agreed and made available to enable staff to give a consistent approach in their explanation.	Standard 9 Patient Information and Consent Regulation 6 Schedule 2 (i)	The benefits and risks of the radiation exposure will be added to a crib sheet to enable staff to give a consistent approach in their explanation.  This will be reviewed by the new Radiology services manager on her appointment on 20-6-22.	Radiology Services Manager	To be completed by 30-6-22.
The hospital must ensure that arrangements are in place to provide patients with regular updates on the patient experience feedback received by	Standard 5 Citizen engagement and feedback	A “ <i>You Said We Did</i> ” poster has been introduced and any actions/	Supervisor Radiographer	Completed

Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
the service, as well as any subsequent actions taken.		improvements are highlighted using this poster.		
<b>Delivery of safe and effective care</b>				
The employer must ensure that the employer's procedure is updated to refer to individuals of child bearing potential rather than females.	Regulation 11 (1) (f), Schedule 2 1 (C)	EP 5 amended.	Supervisor Radiographer/ MPE	Completed
The employer is to ensure that the employer's procedure is changed to reflect the need to record evidence that the check is made of individuals of child bearing potential on the consent form.	Regulation 6 Schedule 2 1 (c)	This will be added in to the EP.	Supervisor Radiographer/ MPE	To be completed by 30-6-22
The employer is to ensure that MPEs are entitled as operators and added to the employer's procedure table for entitlement.	Regulation 6 Schedule 2 1 (b)	MPE's added to matrix.	Supervisor Radiographer	Completed
The employer must ensure that a clinical audit programme is put in place covering the areas of clinical audit described in the procedure and the areas discussed in the inspection.	Regulation 7	The clinical audit programme has been updated to include clinical audit as well as IR(ME)R.	Supervisor Radiographer	Completed

Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
The employer must ensure that the audits include the purpose and aims of the audit as well as the audit reports and subsequent implementation of changes.	Regulation 7	<p>The clinical audit programme has been revised to include the purpose and aims, these have been added to the electronic audit system- RADAR.</p> <p>This will be reviewed again by the new Radiology services manager on her appointment on 20-6-22.</p>	Radiology Services Manager	To be completed by 30-6-22
The employer must ensure that the written procedure in relation to research exposures is updated to detail that these exposures are not currently undertaken within the department at the hospital.	Regulation 6 Schedule 2 1 (g)	EP 9 amended.	Supervisor Radiographer	Completed
<b>Quality of management and leadership</b>				
The hospital must ensure that the employer's procedure are updated as described in the table above and as discussed during the inspection.	Regulation 6 Schedule 2 1	This will be added in to the EP.	Supervisor Radiographer/ MPE	30-6-22

Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
The hospital must confirm that processes are in place to allow any member of staff to report any issues of concern internally, as well as to ensure that any concerns raised are appropriately investigated and responded to	Standard 25 Workforce Recruitment and Employment Practices	<p>There are well established Policies and Procedures in place and available to all staff through SharePoint to enable them to raise any concerns. These include:</p> <ul style="list-style-type: none"> <li>➤ Bullying &amp; Harassment policy</li> <li>➤ Grievance policy</li> <li>➤ Whistle blowing policy</li> <li>➤ Equality, Diversity and Human Rights policy</li> </ul> <p>All clearly outline the steps that can be taken to raise any concerns but also set out the processes that would be followed if any issues were raised formally. These policies ensure any issues of concern raised are addressed appropriately. There is a full time HR officer on site who is available for staff to speak to. HMT are also running HR Clinics on 10<sup>th</sup> and 11<sup>th</sup> May where staff can speak directly to</p>	Head of HR	Completed

Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
		the Chief of People regarding any concerns if they felt unable to do so to their immediate and senior management.		
The hospital must confirm that processes are in place to ensure that staff are treated fairly and equally in regards to workplace opportunities, and that any instances of discrimination will not be tolerated and appropriate action taken.	Standard Workforce Recruitment and Employment Practices 25	<p>All staff are required to complete Equality &amp; Diversity training and our expectations are set out in our Equality, Diversity and Human Rights Policy.</p> <p>The Healthcare Management Trust, (HMT) is committed to promoting equality and diversity and fostering a culture that actively values difference and recognises that people from different backgrounds and experiences can bring valuable insights to the workplace and enhance the way we work.</p> <p>HMT is committed to ensuring that all members of staff and job applicants receive equal treatment, regardless of any protected characteristics such as age, disability, gender reassignment, marital or civil partner status, pregnancy</p>	Head of HR	Completed



Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
		<p>or maternity, race, colour, nationality, ethnic or national origin, religion or belief, sex or sexual orientation.</p> <p>HMT recognises the importance of diversity and inclusion within the workplace. In order to ensure that we continue to encourage and embrace diversity, we have taken steps to support diversity champions at each of the sites.</p> <p>All staff complete an annual Staff Survey and any required actions are overseen by HR.</p>		
The hospital must ensure that all staff are up to date with all the mandatory and required training	Standard 24 Workforce Planning, Training and Organisational Development	All training is recorded through Relias E-Learning which is regularly reviewed and reported on. The training completion is monitored in monthly KPI's and reminders send to Heads of Departments to ensure training is completed.	People's Relations Officer	Completed