Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Ionising Radiation (Medical Exposure) Regulations Inspection Report (Announced)

Diagnostic Imaging Department, Princess of Wales Hospital,

Cwm Taf Morgannwg University Health Board

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

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

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

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we conduct Ionising Radiation (Medical Exposure) Regulations inspections can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced Ionising Radiation (Medical Exposure) Regulations inspection of the Diagnostic Imaging Department at the Princess of Wales Hospital, 27 and 28 September 2022.

Our team for the inspection comprised of two HIW Senior Healthcare Inspectors and a Senior Clinical Officer from the Medical Exposures Group (MEG) of the UK Health Security Agency (UKHSA), who acted in an advisory capacity. The inspection was led by a HIW Senior Healthcare Inspector.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Patients provided positive feedback about their experiences of attending the Diagnostic Imaging Department at the hospital.

We saw suitable arrangements were in place to promote the privacy and dignity of patients and found staff treated patients with respect and kindness.

Relevant information was made available to patients about their examination and we saw the use of the Welsh language was promoted within the department. However, staff need to ensure that patients have read and understood the information displayed on the benefits and risks of having an exposure.

While arrangements were in place for patients to provide feedback about their experiences, senior staff expressed difficulty in accessing this.

This is what we recommend the service can improve:

- Staff need to confirm with patients they have read and understood the information displayed in the department on the benefits and risks of having an exposure
- Arrangements need to be made to allow relevant staff to have timely access to patient feedback.

This is what the service did well:

- Patients provided very positive feedback about the service they had received and the approach of the staff
- Information for patients was displayed on the approximate waiting time to be seen and advised patients to speak to staff if they had not been seen within a certain time
- Efforts were made to promote the Welsh language.

Safe and Effective Care

Overall summary:
Overall, we identified good compliance with The Ionising Radiation (Medical Exposure) Regulations 2017. We also found suitable arrangements were in place to provide patients attending the department with safe and effective care.

We saw the environment was clean, and appropriate arrangements were in place to promote effective infection prevention and decontamination within the department.

Staff we spoke to were aware of the health board's policies and procedures in relation to safeguarding. Staff could describe the actions they would take should they have a safeguarding concern.

This is what we recommend the service can improve:

- Some of the employer's written procedures need to be revised so they include further details, they reflect national guidance and to support staff with clear procedures to follow
- Delegated Authorisation Guidelines (DAGs) need to be revised so they follow a consistent format and updated to include sufficient details
- The process of informing GPs of their entitlement and scope of practice needs to be demonstrated
- The action plans produced following outcomes of investigations of incidents should include more details.

This is what the service did well:

- Local Diagnostic Reference Levels had been established and these were below National Diagnostic Reference Levels
- Protocols were well written, but consideration needs to be given to developing separate paediatric protocols
- We saw good records had been maintained for quality checks of ionising radiation equipment and a comprehensive quality check handbook was available for the department to use
- A good range of both IR(ME)R audits and clinical audits were included in the audit programme.

Quality of Management and Leadership

Overall summary:
The Chief Executive of the health board was the designated employer under IR(ME)R and clear lines of reporting and responsibility were described and demonstrated.

Staff demonstrated they had the correct knowledge and skills to undertake their respective roles within the department.

Feedback from staff was generally positive. However, there were negative responses and comments from staff mainly in relation to staffing levels and a perceived disconnect between senior management and staff.

Training records for staff, in relation to IR(ME)R, showed staff had completed training relevant to their area of work and had their competency assessed. However, it was not always clear when staff had completed their training as two dates were recorded. In addition, there was no evidence of refresher training being completed.

Information provided to HIW confirmed that compliance with mandatory training was low, especially for resuscitation and moving and handling.

Immediate assurances:
The health board was required to provide HIW with details of the action taken to:

- Improve staff compliance with resuscitation training and moving and handling training.

In addition to the above immediate assurances, this is what we recommend the service can improve:

- The health board needs to take action to address the less favourable comments highlighted within section 'Quality of Management and Leadership' section of this report
- Action needs to be taken to improve compliance with other mandatory training.

This is what the service did well:

- Feedback from staff indicated their organisation encourages teamwork and is supportive
- In addition, positive feedback was also received from staff regarding their organisation's approach to handling errors, near misses or incidents
- The staff team was flexible and worked hard to ensure patients received their radiological examinations in as timely a way as possible.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient Feedback

During the inspection we used paper and online questionnaires to obtain views and feedback from patients and carers. A total of 37 were completed.

Responses and comments made within the questionnaires indicate patients had a positive experience of using the service. The most positive responses were in relation to the good service and caring staff at the department. The main suggestions for improvement were around waiting times and the appearance of the building.

When asked in the questionnaire to rate their overall experience of the service, 28 of the 33 patients who gave an opinion rated the service as 'very good' and 5 rated it as 'good'.

Patient comments included the following:

> ***"Excellent staff throughout. Very impressive efficiency and care."***
> ***"Staff achieved excellent balance between professionalism and friendliness."***
> ***"Felt very relaxed and respected."***
> ***"All staff are very lovely."***

We asked what could be done to improve the service. Comments included the following:

> ***"Age of building - looks tired."***
> ***"Check pre-procedure print outs are always legible."***
> ***"It is fine the way it is."***
> ***"Great service and care."***

Staying Healthy

Health Protection and Improvement
We saw posters clearly displayed advising patients to inform staff if they were pregnant or breastfeeding.

Written information was also available on the benefits of stopping smoking, providing details of support organisations for patients with cancer and their carers and on the hospital chaplaincy service.

There was no other health promotion material displayed or readily available for patients to read on other conditions.

Dignified care

Dignified care

We found staff to be treating patients with respect and kindness and engaging with them in a friendly yet professional manner.

Individual changing rooms were available providing privacy when patients were required to change out of their clothes for their examination. We also saw doors to examination rooms were closed when being used.

Staff we spoke to confirmed rooms were available should patients wish to speak with staff in private.

All 37 patients who completed a questionnaire agreed staff treated them with dignity and respect. When asked whether measures were taken to protect their privacy, 34 of the 35 patients who answered this question in the questionnaire agreed.

When asked whether they were able to speak to staff about their procedure or treatment without being overheard by other patients, 33 of the 34 patients who answered this question agreed. All 35 patients who answered the question in the questionnaire agreed staff listened to them and answered their questions.

During the inspection we used online questionnaires to obtain views and feedback from staff. A total of 20 were completed.

When asked whether patients' privacy and dignity are maintained, 19 of the 20 staff who completed a questionnaire agreed and 1 disagreed. All 20 agreed they are satisfied with the quality of care they give to patients.

Communicating effectively

We saw bilingual signage in both Welsh and English and bilingual posters providing information for patients clearly displayed within the department. We also saw a poster advising patients they may communicate in Welsh if they chose to do this.

Staff informed us there were a number of Welsh speaking staff working in the department and we saw staff wearing badges or lanyards to show they were happy to communicate in Welsh.

When asked about their preferred language, one patient indicated that Welsh is their preferred language, and they were not actively offered the opportunity to speak Welsh throughout their patient journey. The patient said they felt comfortable using Welsh within the hospital environment and that healthcare information was available in Welsh.

We saw a hearing loop was available at reception and staff confirmed they could access a translation service should this be required to assist communication with patients whose first language is not English.

Patient information
Information for patients on the benefits and risks associated with having an X-ray was prominently displayed within the department.

Senior staff confirmed benefits and risk discussions did not take place with patients prior to them having their exposure. Rather, there was a reliance on patients reading and understanding the information displayed within the department.

When asked whether they were given enough information to understand the risks and benefits of the procedure or treatment, 33 of the 34 patients who answered this question in the questionnaire agreed.

All 32 patients who answered the question in the questionnaire agreed they had been given information on how to care for themselves following their procedure or treatment.

Timely care

Timely Access
During the course of our inspection, we saw patients were seen promptly.

When asked how long they had to wait, 19 of the 35 patients who answered this question in the questionnaire said they had to wait less than 15 minutes to have their procedure, 10 waited between 15 and 30 minutes and 6 waited for more than 30 minutes.

A poster was displayed to advise patients to inform staff if they had been waiting for more than 20 minutes after their scheduled appointment time. We identified this as good practice to help ensure patients attending the department were seen.

When asked whether they were told at the department how long they would likely have to wait, 25 of the 36 patients who answered this question in the questionnaire agreed and 11 disagreed.

Individual care

People's rights
Staff we spoke to demonstrated a good awareness of their responsibilities in protecting and promoting patients' rights when attending the department.

Equality, Diversity and Human Rights awareness formed part of the health board's mandatory staff training programme. Information provided by senior staff confirmed most staff were up to date with this training.

All 34 patients who answered the question in the questionnaire agreed they were involved as much as they wanted to be in any decisions about their procedure or treatment.

All 20 staff who completed a questionnaire agreed patients are informed and involved in decisions about their care.

When asked whether 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) 31 of the 34 patients who answered this questionnaire felt they could and 3 said they felt they could not. Comments included:

> ***"Outstanding access, thank you."***
> ***"Waiting times seem to be longer."***
> ***"Yes, but sometimes with long waits."***

None of the 36 patients who answered the question in the questionnaire indicated they had faced discrimination when accessing or using the service.

Listening and learning from feedback
Senior staff described suitable arrangements for managing concerns and complaints made by patients about their care. A system was also described for patients to provide feedback electronically about their experience of visiting the department.

Posters advising patients of how to make a complaint or provide feedback were prominently displayed in the department. However, senior staff confirmed they were unable to access feedback submitted electronically.

When asked about patient feedback, 18 staff who completed a questionnaire agreed patient feedback is collected and 2 did not know, 13 agreed they receive updates on patient experience feedback, 6 disagreed and 1 did not know, and 12 agreed feedback from patients is used to make informed decisions and 8 did not know.

With the exception of one respondent, all staff who completed a questionnaire agreed their organisation acts on concerns raised by patients. When asked whether the organisation takes swift action to improve when necessary, 16 staff who completed a questionnaire agreed and 4 disagreed.

Delivery of Safe and Effective Care

Compliance with Ionising Radiation (Medical Exposure) Regulations

HIW required senior staff within the department to complete and submit a self-assessment questionnaire prior to our inspection. This was to provide HIW with detailed information about the department and the employer's key policies and procedures in respect of the Ionising Radiation (Medical Exposure) Regulations 2017. This document and the supporting documents submitted were used to inform the inspection approach.

The self-assessment questionnaire was returned to HIW within the agreed timescale and was comprehensive. Where we required additional information or clarification in respect of the responses within the self-assessment, senior staff provided this promptly.

Duties of employer

Patient identification

There was an employer's written procedure in place to correctly identify the individual to be exposed to ionising radiation. This included the procedure to follow where individuals are unable to verbally confirm their personal details such as unconscious patients.

The employer's written procedure clearly instructed staff that the investigation/treatment should not proceed if an individual's identity could not be confirmed. It did not provide details of the checks staff could take if discrepancies were identified in relation to identity and laterality.

We saw evidence to demonstrate that staff correctly confirmed the identity of individuals in accordance with the employer's procedure. Staff we spoke to showed a clear understanding of the patient identification procedure.

All 37 patients who completed a questionnaire agreed they were asked to confirm their personal details.

Individuals of childbearing potential (pregnancy enquiries)

There was an employer's written procedure in place for making enquires of individuals of childbearing age. This reflected the diversity of the gender spectrum in the population when making pregnancy enquiries as staff were required to ask all individuals within the specified age group.

The referral form included a section for recording pregnancy enquiries; however this indicated it was relevant to female patients only. Senior staff confirmed the wording

on the form was to be updated as part of a wider review of documents used within the health board.

We saw written evidence to demonstrate that staff had made enquires in accordance with the employer's procedure.

Non-medical imaging exposures
Senior staff confirmed that non-medical imaging exposures were performed at the department.

There was an employer's written procedure in place for these types of exposures. However, the procedure did not included details of the types of non-medical imaging exposures currently being performed. In addition, the guidance references listed in the procedure have been superseded by updated guidance.

Referral guidelines
The employer had established referral guidelines for the range of exposures to be performed within the department.

Senior staff confirmed all entitled referrers had access to these guidelines through their employment within the NHS.

Duties of practitioner, operator and referrer
Staff we spoke to demonstrated a good understanding of their roles and responsibilities under IR(ME)R.

Senior staff described suitable arrangements for how referrals for medical exposures are made to the department. There was an employer's written procedure in this regard.

We examined a sample of ten referral forms. These showed referrals had been made in accordance with referral guidelines and the forms included sufficient clinical details and had been appropriately completed.

Senior staff described appropriate arrangements to audit compliance with the employer's written procedures by those individuals entitled as referrer, practitioner and operator.

Justification of individual exposures
Senior staff confirmed a medical exposure is not carried out unless it has been justified and authorised by the practitioner, or an operator is authorising an exposure in accordance with guidelines issued by the practitioner. There was a

suitable employer's written procedure for the justification and authorisation of medical exposures.

The referral forms we examined showed the above procedure had been followed. However, where exposures have been justified 'out-of-hours' the name of the specific practitioner had not been recorded. Rather a generic term was used to indicate these had been justified by a 'radiologist reporting online'.

We were provided with examples of Delegated Authorisation Guidelines (DAGs). These did not follow a consistent format and those in relation to computerised tomography (CT) referrals and Tuberculosis (TB) screening did not contain sufficient detail. The DAG for CT referrals did not contain sufficient detail on excluded patients and the TB screening did not contain sufficient detail on the number of views required.

The DAG for carers and comforters made reference to 'the practitioner for the patient exposure will also act as the practitioner for the carer and comforter', however this will not be the case if the examination is not covered under the DAG. If the practitioner justifying the exposure does not know a carer and comforter is required, this cannot always be done by the same person.

Optimisation
Information provided by senior staff showed consideration had been given to ensure doses arising from medical exposures performed in the department are kept as low as reasonably practicable.

Arrangements to train staff on the correct use of equipment, regular servicing and quality checks of equipment, the use of protocols for standard examinations and input from the Medical Physics Expert (MPE) were described.

We examined a sample of the protocols and saw these were comprehensive.

Diagnostic reference levels
There was an employer's written procedure in place for the use and review of diagnostic reference levels (DRLs) established for X-ray examinations performed in the department.

We confirmed local DRLs had been established and these were below national DRLs. We identified this as good practice. Both local and national DRLs were clearly displayed in work areas within the department for staff to refer to.

Staff we spoke to confirmed they were aware of the employer's written procedure. They described the action they would take should they identify a DRL has been exceeded and this was in accordance with the employer's procedure.

Paediatrics
Senior staff confirmed X-ray examinations are performed in the department on children. There was an employer's written procedure in place for performing medical exposures on paediatrics.

We saw a room had been designated for performing X-ray examinations on children which had been decorated to provide a child friendly environment.

Written protocols were in place for standard examinations, however these were not specific to children.

Clinical evaluation
There was an employer's written procedure in place for the carrying out and the recording of an evaluation for each medical exposure.

The records we examined had a clinical evaluation recorded for each medical exposure carried out.

Equipment: general duties of the employer
There was an employer's written procedure in place to ensure a quality assurance programme in respect of equipment was followed. This was supported by a separate, comprehensive handbook which included test protocols and record sheets for the department to use. A link to the handbook was not included in the employer's written procedure.

We confirmed the employer had suitable arrangements in place for the acceptance testing of new equipment, performance testing at regular intervals and performance testing following equipment maintenance.

There was an employer's written procedure in place for the assessment of patient dose and administered activity. Suitable arrangements were described for recording dose indicators for equipment used within the department. This information was available to MPEs for audit when recommending and reviewing DRLs.

We confirmed the employer had suitable arrangements in place to improve inadequate or defective equipment. This involved processes for identifying, reporting and escalating equipment faults to senior staff and taking corrective action, including removing equipment from service.

An inventory of equipment installed at the department was available. This included the information required under the regulations.

Safe Care

Managing risk and promoting health and safety
The environment appeared well maintained and in a good state of repair. We did not identify any obvious hazards to the health and safety of staff working in the department or to patients and other individuals visiting the department.

The department was clearly signposted from the main entrance of the hospital. There was level access to the hospital and the department was located on the ground floor making it accessible to patients using wheelchairs or with mobility difficulties. We saw waiting areas were of a sufficient size for the numbers of patients attending the department.

All patients who completed a questionnaire agreed they were able to find the department easily.

Senior staff described plans for upgrading the department environment and those areas which had been completed provided improved facilities for both staff and patients.

We saw signage clearly displayed to alert patients and visitors not to enter controlled areas where ionising radiation was being used.

Infection prevention and control (IPC) and Decontamination
All areas of the department and the equipment we inspected were visibly clean and tidy.

Suitable handwashing and drying facilities were available and hand sanitising stations were located throughout the department. Personal protective equipment (PPE) was readily available for staff to use.

Staff we spoke to were aware of their responsibilities in relation to infection prevention and control and decontamination.

We saw screens were installed between chairs in the waiting room and information for patients on other precautions in place to reduce the spread of Covid-19 was clearly displayed.

When asked how clean the department was, 31 of the 34 patients who answered this question in the questionnaire said it was ‘very clean’ and 3 said it was ‘fairly clean’. When asked whether COVID-19 infection control measures were being followed,

where appropriate, 35 patients who answered this question said they were and 1 said they either didn't know or did not notice.

When asked about infection prevention and control measures, all 20 staff who completed a questionnaire agreed appropriate measures were in place. When asked about COVID-19, all 19 staff who answered this question in the questionnaire agreed the organisation had implemented the necessary environmental issues to become COVID-19 compliant. In addition, 18 agreed the organisation has implemented the necessary practice changes and 1 disagreed.

All 19 staff who answered the question in the questionnaire agreed there has been a sufficient supply of PPE and there are decontamination arrangements for equipment and relevant areas.

Safeguarding children and safeguarding adults at risk
Staff we spoke to were aware of the safeguarding policies and procedures in place and where to access these. Staff were also able to describe the actions they would take should they have a safeguarding concern.

Safeguarding training was mandatory for staff. Training records provided to HIW showed that staff were expected to complete training to a level suitable to their role. However, compliance with training was below the percentage expected by the health board.

Effective care

Quality improvement, research and innovation
Clinical audit
There was an employer's written procedure in place for carrying out clinical audit.

Senior staff provided a copy of the clinical audit programme and examples of clinical audits that had been completed. We saw a good range of audit activity had taken place and senior staff described how improvements had been made as a result of audit activity.

Expert advice
We confirmed the employer had appointed and entitled MPEs to provide advice on radiation protection matters and compliance with IR(ME)R.

Senior staff described and demonstrated suitable arrangements for the MPEs to be involved in, and provide advice on, medical exposures performed at the department.

Senior staff confirmed that new equipment was to be purchased and installed within the department and at another site managed by the department. Given the current

MPE resource position described, this may impact negatively on the routine testing of existing equipment and on training provided by MPEs.

Medical Research
Senior staff confirmed the department did participate in research programmes, however there were none ongoing at the time of our inspection.

There was an employer's written procedure in place for medical exposures performed for research.

Record keeping
We found suitable arrangements were in place for the management of records used within the department.

For the sample of referral records we examined, the layout was clear and these had been completed fully to demonstrate checks had been conducted to promote patient safety.

Quality of Management and Leadership

Staff Feedback

During the inspection we used online questionnaires to obtain feedback and views from staff working in the department. A total of 20 were completed. Not all staff answered all the questions in the questionnaire.

Responses from staff were generally positive. The most positive responses were in relation to the organisation's approach to handling errors, near misses or incidents.

However, there were negative responses and comments from staff. The main issues raised were staffing versus demand and perceived disconnect between senior management and staff.

Staff comments included the following:

> ***"Overall it's a good place to work - lots of us staff work way over our contracted due to staffing shortages, we are paid well but it can be very tiring and busy."***
> ***"There is more of a focus on 'meeting numbers' instead of creating an environment that helps staff have a better work-life balance. We have had more staff leaving than we are actually recruiting. Most of the staff here have the same mindset that they no longer want to work here as working conditions [are] very poor."***
> ***"The department has undergone several major building programmes recently which have greatly improved several rooms however there is a continuous neglect of patient areas. These include waiting areas, changing cubicles & toilets - some of which have been within the department since the hospital opened nearly 40 years ago."***

We asked staff what could be done to improve the service. Staff suggestions included the following:

> ***"More staff required for the ever increasing workload & continuous training required, this would minimise areas of concern & mean fewer incidents or near misses."***
> ***"Training & development could be improved & progressed in a more appropriate & available manner. This would provide ongoing development for staff within the department, Health Board & within Wales."***
> ***"Management in different modalities being present and available."***

"I wish that the managers actually listen and do something about concerns raised by staff instead of focusing on "meeting the numbers".

Governance, Leadership and Accountability

Governance, Leadership and Accountability
The Chief Executive of the organisation was the designated employer under IR(ME)R and had overall responsibility for ensuring the regulations are complied with. Where appropriate the employer had delegated tasks to other professionals working in the organisation to implement IR(ME)R.

Senior staff submitted details of the organisational structure. Clear lines of reporting and responsibilities under IR(ME)R were described and demonstrated.

Senior staff confirmed arrangements were in place to monitor the quality and safety of services provided in the department and to provide assurance to the health board as part of the governance arrangements.

When asked whether they were content with the efforts of the organisation to keep them and patients safe, 19 staff who completed a questionnaire agreed and 1 disagreed. In addition, 17 staff agreed care of patients is their organisation's top priority and 3 disagreed.

When asked whether they know who senior managers are, 19 staff who completed a questionnaire agreed and 1 disagreed. When asked whether communication between senior management and staff is effective, 14 agreed and 6 disagreed. Of the 19 staff who answered the question in the questionnaire, 18 agreed that senior managers are committed to patient care and 1 disagreed.

Most staff who completed a questionnaire agreed their immediate manager can be counted on to help with a difficult task at work and gives them clear feedback, however four disagreed. Additionally, 14 of the 20 staff agreed their immediate manager asks for their opinion before making decisions that affect their work and 6 disagreed.

When asked whether their organisation encourages teamwork and is supportive, 17 staff who completed a questionnaire agreed and 3 disagreed.

Duties of the employer
Entitlement
There was an employer's written procedure in place to identify individuals entitled to act as referrer or practitioner or operator within a specified scope of practice.

This described GPs being entitled to refer for all diagnostic radiology examinations, however senior staff confirmed GPs did not make referrals for MRI scans.

We saw evidence demonstrating duty holders were informed of their entitlement and scope of practice. However, this was not available in relation to GP referrers

Procedures and protocols
The employer had written procedures and protocols as required under IR(ME)R. However, links to supporting documents were not always included in the primary written procedures. In addition, some of the employer's written procedures could include more detail as highlighted in this report.

There was an employer's written procedure in place for the quality assurance of written procedures and protocols. The sample of procedures we examined followed a consistent format and reflected the written procedure.

The sample of protocols we examined were also well written. However, none were specific to paediatrics.

Significant accidental or unintended exposures
Senior staff described a suitable process for undertaking preliminary and detailed investigations into accidental or unintended exposures. This process included involvement of MPEs so that an assessment of the dose can be performed to identify whether the incident is notifiable to HIW.

Senior staff also described suitable arrangements for informing the referrer, the practitioner and the patient or their representative of clinically significant incidents together with the outcome of the analysis of the incident.

There was an employer's written procedure in place for reporting and investigating accidental and unintended exposures. Senior staff were aware of the requirement to notify HIW of such incidents.

We were provided with examples of action plans developed in response to the outcome of investigations and found these could include more details of the root causes and contributory factors, a trend analysis, what was implemented, who is responsible, a timeline to show the action completed and how findings are fed back to relevant committee groups.

When asked about the organisation's approach to handling incidents, all 19 staff who answered this question in the questionnaire agreed the organisation encourages them to report errors, near misses or incidents, the organisation treats staff involved fairly and the organisation takes action to ensure that they do not happen again.

When asked whether they are given feedback about changes made in response to reported errors, near misses or incidents 18 of the 19 staff who answered this question in the questionnaire agreed and 1 disagreed.

When asked whether they would know how to report a concern about unsafe practice, 16 of the 19 staff who answered this question in the questionnaire agreed they would know how to report it and 3 disagreed. Of the 19 staff who answered the question, 13 felt confident their concerns would be addressed, 3 did not and 3 did not know.

When asked about whether they feel secure raising concerns about unsafe practice, 14 of the 18 staff who answered this question said they would, 2 said they would not and 2 did not know.

Staff and Resources

Workforce

Senior staff provided details of the number and skill mix of staff working for the department. They confirmed staff of varying grades were being recruited or had been recruited and bank staff were used where necessary to support the existing team to provide radiology services.

It was clear from our conversations with staff that the team was flexible and worked hard to ensure patients received their radiological examinations in as timely way as possible.

When asked whether they agreed there are enough staff to enable them to do their job properly, 4 of the 19 staff who answered this question in the questionnaire agreed and 15 disagreed.

We examined staff training records, in relation to IR(ME)R, for a range of staff working for the department. These showed staff had completed training relevant to their area of work and their competency had been assessed. However, it was not always clear when staff had completed their training as two dates were recorded. In addition, there was no evidence of refresher training being completed.

We also examined staff training records in relation to mandatory training. These showed staff were expected to complete training on a range of topics. However, compliance was generally below the percentage expected by the organisation. Senior staff were aware of this had had started to take action to improve compliance in this regard.

The compliance with resuscitation training and moving and handling training was very low. We required the health board to take immediate action in this regard and to submit an immediate improvement plan to HIW confirming the urgent action taken to address this.

When asked whether they have received appropriate training to undertake their role, 17 of the 20 staff who completed a questionnaire felt they had, 2 felt they partially have and 1 felt they have not. We asked if there was any other training staff would find useful. Staff comments included:

> ***"Training such as CPR and manual handling in person."***
> ***"Project management & Quality improvement. Educational qualification."***
> ***"Being given allocated time to do our mandatory training would help."***

All staff who completed a questionnaire agreed their training, learning and development helped them do their job more effectively and helped them deliver a better patient experience.

Most staff who completed a questionnaire indicated they had an annual review or appraisal within the last 12 months, however, two indicated they had not. Of the 18 who had an annual review or appraisal, 15 stated that training, learning, or development needs were identified and 3 stated they were not. Responses indicated that their manager supported them to receive this training, learning or development.

Of the 18 staff who answered the questions in the questionnaire, 17 agreed staff have fair and equal access to workplace opportunities and their workplace is supportive of equality and diversity and 1 preferred not to say.

Whilst 16 staff who completed a questionnaire agreed their job is not detrimental to their health and that the organisation takes positive action on health and wellbeing, 4 disagreed. In addition, 16 staff agreed they would recommend their organisation as a place to work and would be happy with the standard of care provided by the organisation for themselves, 4 disagreed.

When asked whether they agreed their current working pattern/off duty allows for a good work-life balance, 13 staff who completed a questionnaire did agree and 7 did not.

Of the 20 staff who completed a questionnaire, 18 agreed they are offered full support in the event of challenging situations and 2 disagreed.

Most staff were aware of the Occupational Health support available to them, 17 of the 19 staff who answered this question in the questionnaire indicated they are and 2 indicated they are not.

4. Next steps

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.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- 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
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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.

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.			

Appendix B – Immediate improvement plan

Service: Diagnostic Imaging Department, Princess of Wales Hospital

Date of inspection: 27 and 28 September 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.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The health board is required to provide Healthcare Inspectorate Wales (HIW) with details of the action taken: • to improve mandatory staff training compliance in respect of both resuscitation training and safe moving and handling training • to promote patient safety in the interim.	Standard 7.1 Workforce Standard 3.1 Safe and Clinically Effective Care	The Radiology Department has put in place robust mechanisms to monitor compliance levels against resuscitation and moving and handling training targets. An end of month report will be issued for each module. Colleague awareness has been raised and responsibility to remain compliant has been reiterated by way of an all colleague email and will be reiterated via departmental meetings. As needed, departmental managers will support colleagues to identify time attend training with minimal impact on service delivery.	Superintendent Radiographer Quality Governance	31st October 2022

		Following the HIW feedback meeting on the 28th September, immediate provision for colleague training in resuscitation was arranged and sessions were held on 29th September, 30th September and 3rd October. Further sessions are scheduled for week ending 7th October. 33 additional colleagues have received Basic Life Support training since the HIW visit. All nursing colleagues in Radiology are up to date with their ILS training.	Interim Head of Radiography (Princess of Wales Hospital)	7th October 2022
		Manual Handling sessions have been arranged: 17 colleagues will receive training between 20th October and 6th December. A sustainable model for training delivery is being progressed by the department, with 2Radiology colleagues receiving training to become trainers.	Superintendent Radiographer Quality Governance	6th December 2022
		All colleagues in Radiology are committed to providing safe patient care. Improved access and a targeted focus on training will result in a rapid improvement in		

	compliance, awareness, and safety within the department.		

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): **SD**

Job role: **Interim Head of Radiography**

Date: **04/10/22**

Appendix C - Improvement plan

Service: Diagnostic Imaging Department, Princess of Wales Hospital

Date of inspection: 27 and 28 September 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
The health board is required to provide HIW with details of the action taken to improve the provision of health promotion material within the Radiology Department.	Standard 1.1 Health Promotion, Protection and Improvement	Health promotion leaflets and posters will be displayed on notice boards in patient waiting areas.	General Supt radiographer Governance Supt Radiographer	31/12/ 2022
The employer is required to provide HIW with details of the action taken to demonstrate staff have confirmed with patients they are aware of the benefits and risks of having an exposure.	IR(ME)R Regulation 6 1(a), 1(b) and 2 Schedule 2 1(i)	Princess of Wales staff will ask every patient if they are aware of the risk benefit of having an exposure before the examination commences. There are posters in all patient waiting areas.	Governance Supt Radiographer Cardiac Supt Radiographer General Supt radiographer	31/12/ 2022

The health board is required to provide HIW with details of the action taken to allow relevant staff to have timely access to patient feedback.	Standard 6.3 Listening and learning from Feedback	CIVICA can now be accessed to retrieve patient feedback. Staff training to use the system is being arranged.	Interim Site Lead	28/02/2023
The employer is required to provide HIW with details of the action taken to revise the employer's written procedure to include the action to be taken by staff should discrepancies be identified in relation to identity and laterality.	IR(ME)R Regulation 6 1(a), 1(b) Schedule 2 1(a)	We have added additional detail to Employer Procedure 7 to describe the action to be taken by staff should discrepancies be identified in relation to identity and laterality.	Governance Supt Radiographer	Immediately actioned following HIW inspection – Immediate reminder of change to all staff
The employer is required to provide HIW with details of the action taken to revise the employer's written procedure to include the types of non-medical imaging exposures performed at the department and update the guidance references.	IR(ME)R Regulation 6 1(a), 1(b) Schedule 2 1(m)	We have added additional detail to Employer Procedure 13 to describe the types on non-medical imaging exposures performed at the department and updated the guidance references	Governance Supt Radiographer	Immediately actioned following HIW inspection – Immediate reminder of change to all staff
The employer is required to provide HIW with details of the action taken	IR(ME)R Regulation 11	CT Superintendent to reinforce to all CT staff the importance of	CT Supt Radiographer	Immediately actioned following HIW

to ensure staff record on the referral forms the name of the specific practitioner justifying the exposure.	(1)(b) (c)	documenting the referrers name on the referral when using Everlight. The referral will be scanned into synapse as a patient record.		inspection – Immediate reminder to all CT staff
The employer is required to provide HIW with details of the action taken to revise the Delegated Authorisation Guidelines (DAGs) so they follow a consistent format and include sufficient detail.	IR(ME)R Regulation 6 1(a), 1(b)	Standardisation of all Delegated Authorisation Guidelines is underway so that they follow a consistent format. Concise detail will added to enable staff to follow them when working Out of Hours	Governance Supt Radiographer	31/12/ 2022
The employer is required to provide HIW with details of the action taken to develop written protocols for standard examinations specific to paediatrics, where needed.	IR(ME)R Regulation 6 1(a), 1(b), 4 Regulation 12 8(a)	Separate written paediatric protocols are being written in all areas.	CT Supt Radiographer General Supt radiographer Supt Radiographer	31/12/ 2022
The employer is required to provide HIW with details of the action taken to ensure routine testing of existing equipment and training provided by	IR(ME)R Regulation 14	Princess of Wales hospital will include Swansea Bay UHB Medical Physics Expert team in any capital upgrade discussions so we can assess the impact and	Care Group Service Director Diagnostics, Therapies and Specialities	**31/12/ 2022**

MPEs is not adversely affected by the equipment upgrade programme.		then and work collaboratively to circumvent any issues.	Interim Head of Radiography	
The employer is required to provide HIW with details of the action taken to: • revise the employer's written procedure to reflect the scope of practice of GP referrers • demonstrate how GP referrers are made aware of their entitlement and scope of practice	IR(ME)R Regulation 6 1(a), 1(b) Schedule 2 1(b)	All GPs will be sent a document to reiterate the iRefer guidelines. Employer Procedure 1 to be amended to state that GP's are not permitted to refer for MRI Local Management Committee (LMC) attended by representatives from secondary care. At this meeting referral rights and entitlements to GPs are discussed.	Clinical Lead Medical Director	**31/12/ 2022**
The employer is required to provide HIW with details of the action taken to make staff aware of supporting documents to the employer's written procedures	IR(ME)R Regulation 6 1(a), 1(b)	Hyperlinks will be added in the EPs to directly take staff to appropriate guidance – we need resource for document management for the whole of Cwm Taf Morgannwg UHB to be able to manage this effectively.	Interim Head of Radiography	**31/01/2023**

The employer is required to provide HIW with details of the action taken to include more information within action plans in respect of incidents, so they contain more details of: • The root causes and contributory factors • A trend analysis, what was implemented • Who is responsible • A timeline to show the action completed • How findings are fed back to relevant committee groups.	IR(ME)R Regulation 8 3	The Action Plan in respect to incidents is being updated to include all detail suggested in the report	General Supt radiographer Governance Supt Radiographer Cwm Taf Morgannwg UHB Governance Department	**31/12/ 2022**
The health board is required to provide HIW with details of the action taken to improve compliance with staff mandatory training.	Standard 7.1 Workforce	Improvements have already been noted and staff have been given allocated time slots to complete their mandatory training. Basic Life Support Training is now at 76%	Governance Supt Radiographer Interim Site Lead	**31/12/ 2022**

The employer is required to provide HIW with details of the action taken to clearly show the dates when IR(ME)R related training, including refresher training, has been completed by staff.	IR(ME)R Regulation 17 4	Princess of Wales hospital will introduce e IRMER modules for staff to complete. These will be completed every 3 years in accordance with IRMER recommendations. Personal Development Plans/Your Conversation will document if staff have completed the refresher training and will be monitored alongside the mandatory Electronic Staff Register (ESR) modules.	Governance Supt Radiographer Cardiac Supt Radiographer	**31/12/ 2022**
The health board is required to provide HIW with details of the action taken to respond to the less favourable staff comments noted in the 'Quality of Management and Leadership' section of this report.	Standard 7.1 Workforce	Staff have worked prudently through the Covid 19 pandemic and have stepped in to cover staff sickness to keep all services going. The waiting times for all patients reflect this work but management acknowledge that staff have worked extremely hard. There is a workforce plan to support all imaging modalities	Clinical Lead Medical Director Interim Head of Radiography	**31/12/ 2022**

		but further resource is required to support extra sessions and extended working days to cope with the increasing demand on the service. A staff forum will be held alongside the monthly emailed staff communications to inform staff on future appointments. A reminder will be sent to all staff to reiterate wellbeing support is readily available.	Interim Site Lead	

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): Sharon Donovan

Job role: Interim Head of Radiography – Princess of Wales hospital

Date:17/11/22