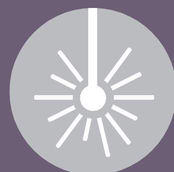
Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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

Nuclear Medicine Department, University Hospital Llandough, Cardiff and Vale University Health Board

Inspection date: 11 and 12 October 2022

Publication date: 12 January 2023



This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager

Healthcare Inspectorate Wales
Welsh Government

Rhydycar Business Park

Merthyr Tydfil

CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales
Website: www.hiw.org.uk

Digital ISBN 978-1-80535-232-7

© Crown copyright 2022

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 5

2. Summary of inspection 6

3. What we found 9

- Quality of Patient Experience 9
- Delivery of Safe and Effective Care 14
- Quality of Management and Leadership 21

4. Next steps 26

Appendix A – Summary of concerns resolved during the inspection 27

Appendix B – Immediate improvement plan.. 28

Appendix C – Improvement plan 29

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 (IR(ME)R) inspection of the Nuclear Medicine Department at the University Hospital Llandough, Cardiff and Vale University Health Board on 11 and 12 October 2022.

Our team for the inspection comprised of two HIW Senior Healthcare Inspectors and a Scientific Advisor 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 Nuclear Medicine 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. We also saw considerable efforts had been made to provide a pleasant environment for patients by displaying artwork and pictures throughout the department.

Relevant information was made available to patients both about their examination and the associated benefits and risks.

We saw the use of the Welsh language was promoted within the department. However, appointment letters sent to patients were in English only and the size of the text could make it difficult for some patients to read.

Suitable arrangements were described for patients to raise a concern or complaint about their care. While patients could provide feedback, we were told that since the COVID-19 pandemic, patient feedback had not been routinely obtained.

This is what we recommend the service can improve:

- Arrangements need to be made to make appointment letters bilingual, in both Welsh and English, and consideration should be given to revising the size of text used
- Arrangements need to be made to actively seek feedback from patients about their experiences of visiting the department.

This is what the service did well:

- Patients provided very positive feedback about the service they had received and the approach of the staff
- Artwork and pictures were displayed to provide a pleasant environment for patients
- There was good provision of information for patients displayed within the department.

Delivery of Safe and Effective Care

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

We were assured a third-party agreement for radiation protection services, including Medical Physics Expert (MPE) support, was in place. However, the written agreement provided to HIW showed this had expired in March 2022.

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

This is what we recommend the service can improve:

- Some of the employer's written procedures need to be updated and clearly show when they have been reviewed and the date for next review
- The equipment inventory needs to include all the equipment used in the department
- The third-party written agreement for radiation protection services, including MPE support, needs to show it has been formally renewed and is current
- Consideration should be given to developing written action plans following audit activity to demonstrate an analysis has been done and to capture the action taken/to be taken and follow up activity.

This is what the service did well:

- Local Diagnostic Reference Levels had been established and these were below National Diagnostic Reference Levels
- Senior staff demonstrated a good understanding of the differences between clinical audit and IR(ME)R audit and we saw improvements had been made as a result of audit activity
- Useful information on infection prevention and control matters and audit results was clearly displayed in the department for patients to see.

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 accountability were described and demonstrated.

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

Feedback from staff within HIW questionnaires was generally positive.

Training records for staff, in relation to IR(ME)R, were of a consistent format. These showed staff had completed training relevant to their area of work and had their competency assessed.

Information provided to HIW showed very good compliance with the health board's mandatory staff training programme.

This is what the service did well:

- The team presented as friendly and promoting a supportive environment for staff to work
- We saw very good compliance with mandatory staff training.

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 28 were completed. Not all respondents answered all of the questions.

Responses and comments indicate a positive patient experience at the Nuclear Medicine Department, across all areas. The questions attracting the most positive responses were those regarding dignified care and patient information, with patients making particularly positive comments about staff. The main suggestion for improvement made by patients was to increase the space available for both waiting and treatment areas.

Patients were asked in the questionnaire to rate their overall experience of the service, 25 of the 27 who answered rated the service as 'very good', and two rated it as 'good'.

Patient comments included the following:

> ***"The service today has been quick"***
> ***"Straight forward. No problems. Helpful."***
> ***"Very happy with the service I received during my appointment…"***
> ***"The nurse I had was very helpful, seemed to know her job …"***
> ***"Overall I was very satisfied."***
> ***"Friendly people in this hospital."***
> ***"Outstanding care and lovely staff."***

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

> ***"Bigger waiting area"***
> ***"The working area was a bit cramped."***
> ***"I would provide a larger premises for staff. They are doing an invaluable job."***
> ***"Speed the scan up."***
> ***"No improvement needed, very clean and calming room and setting."***
> ***"I don't think they can improve. They have been so good to me."***

Staying Healthy

Health Protection and Improvement

We saw posters clearly displayed within the department advising patients to inform staff if they were pregnant or breastfeeding.

We also saw a range of other health promotion related material displayed both within the department and also near the main reception area.

Dignified care

Dignified Care

We found staff treated patients with respect and kindness, 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 with confirmed there was a room where patients could speak to staff in private, without being overheard by people in the waiting room.

All 27 patients who answered the question in the questionnaire told us staff treated them with dignity and respect. In addition, all 27 who answered agreed measures were taken to protect their privacy.

When asked whether they were able to speak to staff about their procedure or treatment without being overheard by other patients, all 27 who answered this question agreed. All 27 patients who answered the question also 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 10 were completed.

When asked whether patients' privacy and dignity are maintained, all 10 staff who completed a questionnaire agreed. In addition, all 10 agreed they are satisfied with the quality of care they give to patients

Communicating effectively

We saw a hearing loop was available at reception and staff we spoke with confirmed they could access a translation service to help them communicate with patients whose first language is not English.

Staff we spoke with described a record management system was used to capture patients' details. Staff explained this could be used to identify patients who require the translation service so this could be arranged in a timely way.

We saw some written information was made available bilingually in both English and Welsh. We were told some of the staff working in the department were available to communicate with patients using the Welsh language. A poster was also displayed advising patients they may communicate in Welsh should they wish to do so. However, it was not possible to identify staff who were Welsh speakers as they were not promoting this, for example, by wearing a badge or a lanyard to show they were a Welsh speaker.

Signage with pictograms and colour coded directions were displayed to help patients and visitors find their way to the department.

Patient information

Written information for patients on the benefits and risks associated with having an X-ray was prominently displayed within the department. This was displayed in both Welsh and English.

We also saw relevant written information was displayed for patients on the types of examinations performed at the department and on audit activity that had been conducted.

All 27 patients who answered the question in the questionnaire agreed they were given enough information to understand the risks and benefits of the procedure.

When asked whether they had been given information on how to care for themselves following their procedure all 25 patients who answered this question in the questionnaire agreed.

In addition, all 26 who answered the question in the questionnaire agreed they had been given written information on who to contact for advice about any 'after-effects' from their procedure.

We were provided with an example of a letter sent to patients ahead of their appointment at the department. We saw that this was made available in English only and we considered the font size to be small. This may make it difficult to read by people with sight problems.

Timely care

Timely Access

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

When asked how long they had to wait, 22 of the 27 patients who answered this question in the questionnaire said they had to wait less than 15 minutes to have their procedure, 3 waited between 15 and 30 minutes and 2 waited for more than 30 minutes.

A poster was displayed to advise patients to inform staff if they had been waiting for more than 15 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 26 patients who answered this question in the questionnaire agreed and 1 disagreed.

Individual care

People's rights

Staff we spoke with 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 all staff were up to date with this training, which needed to be completed every three years.

All 27 patients who answered the question in the questionnaire said they are involved as much as they want to be in decisions about their treatment.

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) 25 of the 27 patients who answered this question felt they could and 2 said they felt they could not.

None of the 28 patients who completed a questionnaire indicated they had faced discrimination when accessing or using this health service.

Listening and learning from feedback

Senior staff described suitable arrangements for managing concerns and complaints made by patients about their care. These arrangements were in keeping with 'Putting Things Right'.

We saw posters were prominently displayed in the department advising patients in both English and Welsh of the complaints procedure to follow.

While patients could provide feedback, we were told that since the COVID-19 pandemic, patient feedback had not been routinely obtained. Our discussions with staff confirmed this was an area for improvement that had been identified and work was actively being done to put suitable arrangements in place in this regard.

When asked about patient feedback, seven staff who completed a questionnaire agreed patient feedback is collected and three did not know, three agreed they receive updates on patient experience feedback, two disagreed and five did not know. When asked whether feedback from patients is used to make informed decisions, six agreed and four did not know.

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, again all staff who completed a questionnaire agreed.

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 (IR(ME)R) 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 details of the action to be taken by staff where patients are unable to identify themselves, such as unconscious patients. In addition, it addressed those situations where more than one operator is directly involved in the exposure.

Staff we spoke with described the action they would take to correctly identify individuals, which was consistent with the employer's written procedure.

All 27 patients who answered the question in the 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 enquiries of individuals of childbearing potential to establish whether the individual is or may be pregnant or breastfeeding.

Staff we spoke with described the action they would take to make enquires in this regard, which was consistent with the employer's written procedure.

We examined a sample of six referral forms. These showed operators had made enquires in relation to pregnancy status, however, two of the forms had not been completed fully. Whilst both patients had signed the forms to show they had been

asked, one form did not show the responses to the questions asked and the other had not been signed by the operator.

Non-medical imaging exposures
Non-medical imaging exposures were not performed at the department. Therefore, the arrangements for performing these exposures were not considered at this inspection.

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

Senior staff confirmed all entitled referrers were made aware of these referral guidelines within their entitlement letters. We were told they were able to access these guidelines through arrangements as part of their employment with the NHS in Wales.

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

The sample of referral forms we examined, showed referrals had been made in accordance with the established referral guidelines. We saw the forms included sufficient clinical details and had been appropriately completed.

We confirmed there were arrangements in place to ensure the employer’s written procedures are complied with by the referrer, practitioner and operator.

Justification of individual exposures
Senior staff described the processes for the justification and authorisation of medical exposures. These were set out within the associated employer’s written procedure.

It was evident that 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 were Delegated Authorisation Guidelines (DAG) in this regard, which clearly identified the practitioner who had issued the DAG and included a clear flowchart outlining the process to follow, for operators using the DAG.

With the exception of the DAG for Sentinel lymph node procedures, the sample we examined included the file name, agreed date and review date.

The sample of referral forms we examined showed the above processes had been followed.

We confirmed practitioners held a valid licence in order to justify exposures involving the use of radioactive substances.

Optimisation

Senior staff described the arrangements for the optimisation of exposures performed at the department.

It was evident practitioners and operators would give consideration to ensuring doses arising from diagnostic medical exposures are kept as low as reasonably practicable (ALARP). Senior staff also described how practitioners and operators pay particular attention to optimising exposures to individuals who may be pregnant and who are breastfeeding.

Senior staff provided examples of relevant written protocols. We identified references were made to Administration of Radioactive Substances Advisory Committee (ARSAC) certificate holders. These protocols should be revised and updated to reflect the requirement of the current regulations where practitioners who administer radioactive substances must hold a practitioner licence.

Senior staff confirmed medical exposures of children and those involving high doses to individuals were not performed at the department. Therefore, the arrangements for performing these exposures were not considered at this inspection.

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. This clearly described the process to define and use DRLs in practice. Whilst the employer's written procedure included some information on nuclear medicine DRLs, it did not include the frequency of reviews of nuclear medicine DRLs.

We confirmed local DRLs had been established and these were below national DRLs. We identified this as good practice. The established local DRLs were displayed in the clinical pharmaceutical preparation area for staff to refer to.

Paediatrics

Senior staff confirmed medical exposures of children were not performed at the department. Therefore, the arrangements for performing this type of exposures were not considered at this inspection.

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 performed at the department.

The sample of referral forms we examined included three retrospective referral forms. These all showed evidence of a timely clinical evaluation being completed.

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.

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. However, the written third-party agreement for radiation protection services, including MPE support for the QA of equipment, showed this agreement had expired in March 2022. While staff confirmed this agreement was still active a copy of the current agreement was not available at the time of inspection.

Senior staff described a clear process 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. For the equipment listed, most of the information required under the regulations was included. However, the model number of the gamma camera was not recorded. In addition, the calibrators and gamma probes used by the department were not listed and the inventory included equipment that had been removed from service.

Safe Care

Managing risk and promoting health and safety
The department 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 and most patients who completed a questionnaire agreed they were able to find the department easily.

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. However, responses from some patients indicate this was an area that could be improved upon.

We also saw considerable efforts had been made to provide a pleasant environment for patients by displaying artwork and pictures throughout the department.

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

We were told patients attending for injections prior to sentinel node biopsies accessed the department via a separate entrance allowing patients direct access to the examination room. This had been introduced in response to COVID-19 as a safety measure and had been continued to promote patient safety.

Infection prevention and control (IPC) and Decontamination

All areas of the department we inspected were visibly clean and tidy. Equipment was also observed to be clean.

Suitable handwashing and drying facilities were available, and hand sanitising stations were located throughout the department. We saw personal protective equipment (PPE) was readily available for staff to use. Staff we spoke with also confirmed they had access to suitable PPE.

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

We saw information on the precautions in place to reduce the spread of COVID-19 was clearly displayed in the department.

When asked how clean the department was, 22 of the 28 patients who answered this question in the questionnaire said it was ‘very clean’ and 6 said it was ‘fairly clean’. When asked whether COVID-19 infection control measures were being followed, where appropriate, 22 patients who answered this question said they were and 6 said they either didn’t know or did not notice.

When asked about infection prevention and control measures, all ten staff who answered the question in the questionnaire agreed appropriate measures were in place. When asked about COVID-19, all nine staff who answered the question in the questionnaire agreed the organisation had implemented the necessary environmental issues and practice issues to become COVID-19 compliant.

Most of the nine staff who answered the question in the questionnaire, agreed there has been a sufficient supply of PPE, however one disagreed. All nine agreed there are decontamination arrangements for equipment and relevant areas.

Safeguarding children and safeguarding adults at risk
Staff we spoke with 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 formed part of the health board's mandatory staff training programme. Information provided by senior staff confirmed all staff were up to date with this training and that staff had completed training to a level suitable to their role.

Effective care

Quality improvement, research and innovation
Clinical audit
Senior staff provided a copy of the clinical audit schedule together with examples of clinical audits that had been completed. While the schedule included input from a range of staff groups, which we identified as good practice, medical physics staff were not involved.

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. We identified this as good practice. However, consideration should be given to developing written action plans following audit activity to demonstrate an analysis has been done and to capture the action taken/to be taken and follow up 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. Good examples were provided of how the MPE is involved in the optimisation of exposures.

Medical Research
Senior staff confirmed research involving medical exposures has previously been performed at the department. However, at the time of our inspection the department was not currently participating in any research activity.

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, generally, 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 10 were completed. Not all staff answered all the questions in the questionnaire.

Responses from staff were generally positive. Staff comments included the following:

> ***"The nuclear medicine department provides a high standard of care to all our patients. We are often thanked verbally and received the occasional box of treats from patients. We work well as a small team and part of a wider network with our colleagues at UHW."***
> ***"Nothing to note, largely happy with the working environment and team."***

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

> ***"I believe a few more staff generally would benefit the department greatly."***

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, all 10 staff who completed a questionnaire agreed. In addition, all 10 staff agreed care of patients is their organisation's top priority.

When asked whether they would recommend their organisation as a place to work, eight of the ten staff who completed a HIW questionnaire agreed and two disagreed. In addition, nine would be happy with the standard of care provided by the organisation for themselves and one disagreed.

When asked whether they know who senior managers are, the nine staff who answered this question in the questionnaire agreed. When asked whether communication between senior management and staff is effective, seven of the nine staff who answered this question agreed and two disagreed. Of the nine staff who answered the question in the questionnaire, eight agreed that senior managers are committed to patient care and one disagreed.

All 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. Additionally, eight of the ten staff agreed their immediate manager asks for their opinion before making decisions that affect their work and two disagreed.

When asked whether their organisation encourages teamwork 10 staff who completed a questionnaire agreed and most felt their organisation is supportive.

Duties of the employer

Entitlement

Senior staff described a clear process for the entitlement of duty holders. This process was reflected in the employer's written procedure to identify individuals entitled to act as referrer, practitioner or operator within a specified scope of practice.

We were told non-medical referrers had been entitled to refer patients for nuclear medicine examinations. The details of non-medical referrers was maintained on a database within the department. Senior staff described a review was taking place to ensure this information was up-to-date.

Senior staff provided an example of the scope of practice for one non-medical referrer. We recommended the process for identifying individuals' scope of practice could be streamlined and senior staff confirmed work was being undertaken with representatives from other NHS organisations in this regard.

Procedures and protocols

The employer had written procedures and protocols were in place as required under IR(ME)R. However, it was not always clear when these had been reviewed or when they were due for review. We identified some policies had passed their scheduled review date and senior staff confirmed they were actively addressing this.

Senior staff described a clear process for the quality assurance of written policies and protocols. This process was reflected in the employer's written procedure for the quality assurance of written procedures and protocols.

The sample of written procedures and protocols we examined included all the essential information as set out in the employer's written procedure.

Significant accidental or unintended exposures

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

Senior staff were aware of the requirement to notify HIW of such incidents.

There was an employer's written procedure in place for reporting and investigating significant accidental or unintended exposures. However, the procedure included two different contact email address for HIW, one of which was out of date. We recommended a link was included to the relevant HIW internet page within the employer's written procedure so staff had access to up to date information on reporting requirements. We saw that a recognised coding system was used when recording incidents.

Senior staff described a proactive approach to sharing learning from incidents and near misses.

When asked about the organisation's approach to handling incidents, all nine staff who answered this question in the questionnaire agreed the organisation encourages them to report errors, near misses or incidents. They also all agreed that 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 all nine staff who answered this question in the questionnaire agreed.

When asked whether they would know how to report a concern about unsafe practice, all nine staff who answered this question in the questionnaire agreed they would know how to report it. Of the nine staff who answered the question, seven felt confident their concerns would be addressed and two did not know.

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

Workforce

Senior staff provided details of the number and skill mix of staff working in the department. A system of staff rotation within the department was described as being in place. Senior staff confirmed this arrangement worked well and the staffing and skill mix was sufficient to provide the service.

We were told the number of radiologists and level of MPE support was sufficient to maintain the current service provision. We were also told that while there was a commitment to develop the service further, there was no current staffing capacity to achieve this.

When asked whether they agreed there are enough staff to enable them to do their job properly, seven of the ten staff who answered the question in the questionnaire agreed and three disagreed.

We examined the staff training records, in relation to IR(ME)R, for three staff working for the department. These showed staff had completed training relevant to their area of work and their competency had been assessed.

We also examined staff training records in relation to mandatory training. These showed staff were expected to complete training on a range of topics. We saw very good compliance with the organisation's mandatory staff training programme.

All staff who completed a HIW questionnaire told us they felt they had the appropriate training to perform their role. In addition, all staff who completed a questionnaire felt their training had helped them to do their jobs more effectively, stay up to date with professional requirements and deliver a better patient experience.

When asked whether they had an appraisal of their work, all staff who completed a questionnaire confirmed they had an appraisal within the last 12 months.

When asked whether training, learning or development needs were identified, seven staff confirmed this was the case and all seven told us their manager had supported them to attend such training, learning or development.

Of the seven staff who answered the question in the questionnaire, six agreed staff have fair and equal access to workplace opportunities and one disagreed. All seven

staff who answered the question in the questionnaire, agreed their workplace is supportive of equality and diversity.

While six staff who completed a questionnaire agreed their job is not detrimental to their health, three disagreed. In addition, when asked whether the organisation takes positive action on health and wellbeing, seven agreed and two disagreed.

When asked whether they agreed their current working pattern/off duty allows for a good work-life balance, six staff who answered this question in the questionnaire did agree and three did not.

Of the nine staff who completed the question in the questionnaire, eight agreed they are offered full support in the event of challenging situations and one disagreed.

All nine staff who completed the question in the questionnaire were aware of the Occupational Health support available to them.

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 on this inspection			

Appendix B - Immediate improvement plan

Service: Nuclear Medicine Department, University Hospital Llandough

Date of inspection: 11 and 12 October 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
No immediate improvement plan required.				

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

Service: Nuclear Medicine Department, University Hospital Llandough

Date of inspection: 11 and 12 October 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 help patients identify Welsh speaking staff working in the department. Consideration needs to be given to guidance for health services, issued by Welsh Government, on delivering the 'Active Offer'	Standard 3.2 Communicating Effectively	Font size to be increase on appointment letters and appointment letters to be translated and issued in Welsh as well as English. This will be implemented on a phased approach due to the large number of examinations with differing pre-exam preparation requirements. Phase one will involve the appointment letter only being issued in Welsh. Phase two will involve the addition of the patient preparation being issued in Welsh.	Directorate Management Team	Phase one 28/02/2023 Phase two 30/6/23

		Appointment letters to be amended to advise patients if they would like their examination in Welsh to contact the department in advance to ensure this can be accommodated, otherwise this will be accommodated where possible on the day. Current signage within department already provides an 'Active Offer' by indicating staff with emblem on their uniform, lanyard or badge speak Welsh.	Directorate Management Team	28/02/2023
The health board is required to provide HIW with details of the action taken to actively obtain patient feedback on their experiences of visiting the Nuclear Medicine Department and to share this with relevant staff.	Standard 6.3 Listening and Learning from Feedback	Patient experience survey has been drafted with involvement of the Health Board's patient experience feedback team. Survey will initially be run as a focused pilot via QR code and in paper form to identify effectiveness before being implemented department wide. Results of all future surveys and	QSE Lead Radiographer	Pilot completion - 28/02/2023 There will be ongoing work to implement Radiology wide following pilot survey

		any subsequent actions will be shared via posters for both patient and staff information. Results will also be shared at the Radiology Safety and Quality forum. A rotational schedule will be developed following evaluation of the pilot survey to capture patient feedback The Civica system has now been implemented across the Health Board and QR codes will be displayed in every clinical area to allow patients to access the system and to provide feedback	Assistant Director of Patient Experience	01 February 2023
The employer is required to provide HIW with details of the action taken to ensure staff comply with the employer's written procedure in relation to recording enquiries of individuals of childbearing potential.	IR(ME)R Regulation 6 2	Reminder to staff of their previous acknowledgement to read and comply with Employer's Procedures. Increase frequency of regular retrospective audits and	Professional Head of Radiography / QSE lead Radiographer	Complete In place and will be monitored monthly

		observations of practice against staff where compliance levels are not met. Actions will be recorded and monitored. Monitored alongside regulatory compliance audits. Monitored through monthly clinical board regulatory compliance meetings.	Modality superintendents / Professional Head of Radiography	and adjust frequency according to level of compliance.
The employer is required to provide HIW with details of the action taken to revise written protocols so they reflect the requirement of the current regulations where practitioners who administer radioactive substances must hold a practitioner licence.	IR(ME)R Regulation 6 4	Protocols updated to include current regulation requirement where practitioners who administer radioactive substances must hold a practitioner licence. Updated documents are disseminated to staff via document management system and where applicable staff are required to acknowledge they have read it.	Nuclear Medicine Superintendent	Complete

The employer is required to provide HIW with confirmation that the third party agreement in relation to radiation protection services, including MPE support, remains current and copy is available for inspection upon request.	IR(ME)R Regulation 14 1	Update and sign agreement between Health Board and Radiation Protection Service. An agreed continuation of radiation protection services is in place and on-going. The service agreement and has been submitted to the radiation protection service for final approval	Directorate General Manager	31/01/23
The employer is required to provide HIW with confirmation that the equipment inventory has been reviewed and updated to ensure all information is included for all relevant equipment used by the department.	IR(ME)R Regulation 15 1(b), 2	Equipment inventory reviewed and updated where required. Annual review currently in place, any new equipment is added when first installed/acquired.	Site Superintendent / Nuclear Medicine superintendent	31/12/2022
The employer is required to provide HIW with details of the action taken to: • develop written action plans following audit activity to demonstrate an analysis has	IR(ME)R Regulation 8 3	Review currently underway of audit templates which will include the addition of an action plan where this is not already in place.	QSE lead Radiographer / Professional Head of Radiography	28/02/2023

been done and to capture the action taken/to be taken and follow up activity. • Include medical physics staff within the clinical audit programme		Medical physics staff invited to attend and participate in the Radiology Safety and Quality meeting. Within the specific Nuclear Medicine Clinical Audit program there will be a requirement for a minimum of 2 clinical audits annually.	Medical Physics Expert	Complete
The employer is required to provide HIW with details of the action taken to update the following employer's written procedures as follows: • EP F (Observation and Monitoring of Diagnostic Reference Levels (DRL'S)- DRLs should include equivalent information for nuclear medicine as for general radiology • EP L (Clinically Significant Unintended or Accidental Exposures) must be revised to	IR(ME)R Regulation 6 1 Schedule 2 1(f), 1(l)	Employers procedure F updated to include Nuclear Medicine audit frequency. Employers procedure L updated to include the correct email address for HIW.	Professional Head of Radiography / QSE lead Radiographer	Complete

remove reference to the incorrect email address for HIW				
The employer is required to provide HIW with details of the action taken to review those policies that have passed their scheduled review date.	IR(ME)R Regulation 6 Schedule 2	Policies have been updated and approved via appropriate Governance structures. Within Radiology, including Nuclear Medicine, a document management system is utilised and notifies of upcoming document review dates.	Professional Head of Radiography	Complete

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): Alicia Christopher

Job role: Directorate General Manager

Date: 21/12/22