Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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

## Diagnostic Imaging Department, Morriston Hospital, Swansea Bay 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 (IR(ME)R) inspection of the Diagnostic Imaging Department at Morriston Hospital, Swansea Bay University Health Board on 21 and 22 February 2023.

Our team for the inspection comprised of three HIW Senior Healthcare Inspectors, one corporate services officer and two senior clinical officers 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:
There were suitable arrangements in place to promote the privacy and dignity of patients, and staff treated patients with respect and kindness.

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

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

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

This is what we recommend the service can improve:

- Ensuring appointment letters are bilingual, in both Welsh and English, and consideration should be given to revising the size of text used
- Promoting the availability for patients to speak to staff in Welsh.

This is what the service did well:

- There was good provision of information for patients displayed within the department
- Patients provided positive feedback about the service they had received and the respect shown by staff.

## Delivery of Safe and Effective Care

Overall summary:
Generally, there was good compliance with IR(ME)R 2017. Written employer's procedures were clear and comprehensive.

There was clear evidence that medical physics experts (MPEs) were available for consultation on all areas and staff were complimentary about their support. However, some routine quality assurance performance equipment testing and X-ray dose audits which are performed by the medical physics service, had not been completed in line with the recommended time frames as documented in

professional guidance (IPEM 91) due to a lack of medical physics resources. We were told the lack of resources had been escalated to the Chief Executive.

We also found suitable arrangements were in place to provide patients attending the department with safe and effective care.

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:

- Mitigating the risk of MPEs not completing the relevant equipment QA performance testing and dose audits
- Ensuring there is sufficient MPE cover for the hospital and the health board in general.

This is what the service did well:

- Written employer's procedures were clear and comprehensive
- Patient referral documents were completed comprehensively.

## 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 delegation and responsibilities were described and demonstrated.

Staff we spoke with demonstrated they had the knowledge, skills and training required to undertake their respective roles and scope of practice within the department.

Staff training records, competencies, entitlement and scope of practice were clearly documented and linked to the appropriate equipment training records provided. The radiologist's equipment training and entitlement records were noted to be of the same standard as the radiographers.

Whilst feedback from staff was generally positive, there were negative responses and comments from staff. These were mainly in relation to staffing, the rota/shift pattern, management and staff relations and management not acting on staff concerns reported to them.

The department's compliance with the health board's face to face mandatory training requirements needed to be improved.

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.

This is what we recommend the service can improve:

- Addressing the issues raised by staff in their comments and questionnaire replies, particularly regarding discrimination.

This is what the service did well:

- Documenting staff training records, competencies, entitlement and scope of practice.
- Ensuring compliance with online 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 issued paper and online questionnaires to obtain views and feedback from patients and carers. A total of 46 responses were completed. Responses were positive across all areas, with all patients who answered rating the service as ‘very good’ or ‘good’. Patient comments included the following:

> ***“Better signage.”***
> ***“Service was first class.”***
> ***“Busy department.”***
> ***“Service was fast, friendly and efficient.”***

One respondent stated that they ‘strongly disagree’ to most of the questions; however, they commented “I was more than happy with everything”.

## Staying Healthy

**Health promotion, protection and improvement**
Relevant health promotion material was displayed across the three waiting areas and also near the entrance of the hospital. There were posters displayed that provided information to patients about having an X-ray and to advise staff if they may be pregnant. Whilst the posters included language that reflect gender diversity, there were 'fixed' signs that referred to 'female patients', which should be removed.

‘No smoking' signs were clearly displayed within the waiting rooms and around the hospital in accordance with current legislation.

The posters displayed were in both Welsh and English.

## Dignified Care

**Dignified care**
We saw staff being polite and treating patients with respect. We also saw suitable arrangements in place to promote patients' privacy and saw staff made efforts to promote patents' privacy and dignity.

Doors to rooms where X-rays were performed were closed when being used. Individual changing rooms were available providing privacy when patients were required to change out of their clothes for their procedure.
Reception staff confirmed that consulting rooms were available to use for private conversations within the department. They were mindful of the need for discretion when answering telephone calls with private calls taken and made in rooms behind the reception area.

When asked whether staff treated them with dignity and respect, 98% of patients in the questionnaire agreed. When asked whether measures were taken to protect their privacy, 98% agreed.

A total of 98% of patients also stated they were able to speak to staff about their procedure without being overheard by other patients. All but one patient said that staff listened to them.

During the inspection we used online questionnaires to obtain views and feedback from staff. A total of 66 were completed.

When asked whether patients' privacy and dignity were maintained, 94% who answered agreed. A total of 92% of staff who answered agreed they were satisfied with the quality of care they gave to patients. A staff member said:

> ***"…. the radiology setting only works thanks to the staff working above and beyond to ensure patients are not left unseen and therefore untreated.***
> ***surveys are pointless if the information gained is not acted on."***

**Communicating effectively**
We saw bilingual signage in both Welsh and English and bilingual posters providing information for patients clearly displayed within the department.

We saw staff making efforts to deliver the 'Active Offer'. However, Welsh speaking staff could not be identified via badges or lanyards. Staff confirmed they would greet patients using the Welsh language and if patients or visitors were Welsh speaking the conversation could be continued in Welsh.

We were not assured that the hearing loop was working and the department need to ensure that it is serviceable.

Staff we spoke with described some of the arrangements in place to help people with hearing difficulties and with those whose first language was not English. They were aware of the translation service that was available. Staff were also aware of

a number of Welsh speakers in the department who they said wore lanyards or 'Iaith Gwaith' badges. Senior staff said that the modality supervisors also arranged with each other to see what Welsh speakers were available at any one point in time.

None of the patients who answered the question said that their preferred language was Welsh.

Seven of the staff who answered indicated they are Welsh speakers. One said they wore the 'Iaith Gwaith' badge or lanyard. Three said that patients were sometimes asked to state their preferred language and four said they are not. One said they actively used Welsh in everyday conversations, and three sometimes did. Three indicated they were sometimes given the opportunity to complete their training in Welsh and four indicated they were not.

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

All bar two patients said that they were given enough information to understand the risks and benefits of the procedure,

When asked whether staff had explained what they were doing, 98% of patients who answered this question agreed. Additionally, 95% of staff who answered the questionnaire agreed patients were informed and involved in decisions about their care, and three disagreed.

## Timely Care

**Timely access**
Patients attending the various X-ray departments at the hospital were seen to receive timely care. We did not see large numbers of patients waiting for their treatment.

Reception staff confirmed there were no visual displays or posters to inform patients of waiting times. Staff confirmed that patients would be informed verbally of any delays, for example, due to an emergency.

Staff explained the arrangements in place for communicating waiting times to patients within the department. This included apologising to patients if there was a delay. Senior staff stated that delays did not happen with inpatients and outpatients where there is a booking system used. However, if there was a delay of over ten minutes, staff would inform the patients. When asked how long they had

to wait, 38 of the 46 patients who answered this question said they had to wait less than 15 minutes. Regarding whether they were told at the department how long they would likely have to wait, 84% of patients who answered this question agreed.

Most patients agreed it was easy to get an appointment. However, one patient commented:

> ***"Difficult to sometimes get an appointment".***

## Individual Care

**Peoples rights**
Staff were expected to complete equality and diversity training as part of the health board's mandatory training programme. Training records showed almost 92% compliance with Equality, Diversity and Human Rights training.

We noted that the hospital and department were accessible. However, appointment letters seen were only available in English and used a font size that some patients may find difficult to read.

Staff we spoke with had a good awareness of their responsibilities in protecting and promoting patients' rights when attending the department. All staff we spoke with confirmed the arrangements in place to promote equality and diversity in the organisation. This included mandatory training and weekly emails from the health board. Staff were also able to wear rainbow lanyards if they wished as a way to show support for the NHS at this time or for pride events and lesbian, gay, bisexual, transgender plus (LGBT+) groups.

Senior staff also spoke about 'Calon', the health boards LGBT+ and allies staff network and aimed to create a safe space and a community for likeminded colleagues to come together. 'Calon' worked with the health board to build a more inclusive place for the benefit of staff and patients.

Most patients said they were involved as much as they wanted to be in decisions about their treatment. Some comments about patient care included:

> ***"The staff were friendly, reassuring and professional."***
> ***"Very happy with care and outcome of procedure."***
> ***"Staff very kind and caring."***

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) 88% of patients who answered this question said they had.

**Listening and learning from feedback**

Information was clearly displayed on how patients could provide feedback or make a complaint about their care. However, there was no information displayed on how the department had made changes as a result of any feedback received.

Staff we spoke with described the arrangements in place to allow patients to provide feedback or raise concerns. They stated that questionnaires go out to patients on a regular basis. They also stated that they receive emails on how to improve following complaints. Staff would normally pass on any complaints to a more senior person, but they were aware of a patient's right to complain and 'Putting Things Right'.

Senior staff explained how they would manage complaints including speaking to the patient and the member of staff involved as applicable. Senior managers stated that whilst they were keen to engage with staff on feedback and concerns at various meetings, the attendance from staff was limited.

Whilst 67% of staff who answered the question in the questionnaire agreed patient experience feedback was collected within their department, 22% disagreed. Only 41% agreed that they received updates on patient experience feedback in their department, 57% disagreed. Furthermore, less than a third of staff agreed that feedback from patients is used to make informed decisions within their department. However, almost a half did not know. Whilst 85% of staff agreed their organisation acted on concerns raised by patients, only 36% agreed the organisation took swift action to improve when necessary.

# Delivery of Safe and Effective Care

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 and clearly completed. Where we required additional information or clarification in respect of the responses within the self-assessment, senior staff provided this promptly. Staff engaged positively with the inspection process both before and during the inspection to provide the relevant information to HIW.

## Compliance with Ionising Radiation (Medical Exposure) Regulations

**Duties of employer**

*Patient identification*

The written employer's procedure to correctly identify individuals undergoing exposures was clear and easy for staff to follow. The self-assessment completed also set out the steps that would be followed. However, the process described by senior management to address situations where more than one operator was directly involved in the exposure differed to that described by staff.

Staff we spoke with were able to describe how they would correctly identify individuals for an examination. This included, for those who may be unable to communicate such as unconscious trauma or anaesthetised patients. Staff referred to the World Health Organisation (WHO) checklist when there was a need to identify patients in theatre who were unable to identify themselves, as well as confirming their identity with the anaesthetic staff.

All bar one patient who completed a questionnaire told us 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.

The employer's written procedure was clear and easy for staff to follow. However, there was no information included on ensuring gender inclusivity for these enquiries. We were told that the health board was currently trialling a pregnancy checking procedure, which included guidance on gender inclusivity, at another site and that an All Wales decision on this point would be adopted.

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

We audited a random sample of ten referral forms where the examination had been completed. These showed operators had completed pregnancy enquires, in accordance with the employer's written procedure, where appropriate.

*Non-medical imaging exposures*
There was a clear explanation for non-medical imaging exposures given in the self-assessment form which confirmed the process described in the employer's procedure relating to this subject. The employer's procedure described how non-medical exposures were justified by a radiologist. However, authorisation guidelines for one type of non-medical exposure examination have been provided to enable staff to authorise these specified exposures. It was positive to note that the clinical director had provided this clearly written authorisation guideline for service efficiency.

*Referral guidelines*
It was noted that the clinical referral guidelines, iRefer, were used and provided on the organisation's Intranet for all healthcare professionals entitled to refer to follow.

The employer's written procedure on how to make a referral and referral criteria was clear and reflected the detail in self-assessment provided.

We noted that the chair of the Medical Exposures Group wrote to all medical staff in January 2022 highlighting the health board document 'Responsibilities when referring for radiological imaging' and it included information on availability of referral guidelines and access to free, online IR(ME)R awareness training.
This was considered to be a comprehensive document for referrers to remind them of their responsibilities under IR(ME)R.

Referrer responsibilities were defined in the health board Policy on the Implementation of the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) which was available on the intranet as well as being detailed in employer's procedures.

Staff we spoke with were clear in the actions to take to ensure that a referral was within the referrers scope of practice. Senior staff described suitable arrangements for how referrals for medical exposures were made to the department.

The random 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.

**Duties of practitioner, operator and referrer**
We confirmed there were arrangements in place to ensure the employer's written procedures were complied with by the referrer, practitioner and operator. Staff we spoke with demonstrated a good understanding of their duty holder roles and responsibilities under IR(ME)R. There was as an employer's written procedure in place providing guidance on making a referral for medical exposures.

**Justification of individual exposures**
The process of how and where justification was recorded was explained in the self-assessment provided. It was noted that generally authorisation guidelines were well written in the written employer's procedure, with clear criteria described.

However, there were references to IR(ME)R 2000 that needed to be updated.

Senior staff explained that the clinical director was the practitioner for all authorisation guidelines. This required clarification in the authorisation guidelines.

Staff we spoke with were able to describe the justification and authorisation process along with their duty holder roles when performing these tasks.

Where there was a carer and comforter involved in with an exposure, staff described the use of delegated authorisation guidelines (DAG) for the justification of these exposures. However, the guidelines for staff to follow presented at inspection required ratification.

**Optimisation**
Senior staff were able to describe the arrangements for the optimisation of medical exposures performed at the department.

It was noted that the health board had convened a multidisciplinary image optimisation team for CT (CT User Group), led by a MPE to review and optimise exposures, develop consensus imaging protocols and share best practice across the organisation. Whilst this was considered to be good practice, the CT User Group had not met since 2019 and needs to restart. The MPE described the desire to

support and reinstate this group, but there was a lack of resource in this area to restart this work. Consideration should be given to forming optimisation teams in other areas of radiology.

*Diagnostic reference levels (DRLs)*
Staff we spoke with were able to describe what to do in the event of DRLs being consistently exceeded and who to report this to. This included stopping using the room, to run quality assurance checks and to call an engineer. However, staff that we spoke with were not clear whether they were using national or local DRLs, this needs to be clarified for staff.

Senior staff explained that local DRLs were issued to the department with the requirement that they were displayed prominently next to each X-ray control console. National DRLs were also available where insufficient local dose data was available.

*Paediatrics*
Senior staff confirmed X-ray examinations were performed in the department on paediatric patients. In addition, there were written protocols available for paediatric imaging. Staff described the protocols would be reviewed annually or if any change in practice was made. We were told that radiographers would use the digital radiography equipment whenever possible when imaging paediatric patients.

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

*Clinical evaluation*
There was an employer's written procedure in place for carrying out and recording an evaluation for medical exposures performed at the department.

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

The self-assessment provided described how clinical evaluations were undertaken and evidenced for each type of exposure. This stated that all radiological examinations were reported by a radiologist or suitably trained reporting radiographer, unless this duty had been delegated, by mutual agreement to another department, for example the orthopaedic department for follow-up radiographs at the fracture clinics.

**Equipment: general duties of the employer**
The department tour highlighted there was a lot of new equipment installed and being programmed to be installed.

The self-assessment highlighted a number of items of aging equipment. Any equipment with a trend of faults or of an age over the equipment lifespan was noted on the health board risk register and as appropriate the capital SharePoint system for review as part of health board capital allocation.

Senior staff explained that if any piece of radiology equipment became defective it would be taken out of action immediately. Staff were informed not to use the equipment and signs were placed on the equipment to inform all operators that it was currently not in use. The appropriate engineer service would be called to site to repair the unit. Certain manufacturers can dial in remotely to assess the faults.

An example was described by staff of where a piece of fluoroscopy equipment was taken out of use when the MPE report to the Medical Exposure Group noted the mean patient dose for barium swallows in this room exceeded the national DRL by 40%. As a result, the room was taken out of use and is to be decommissioned.

We were told that the equipment replacement schedule was reviewed and prioritised annually across the whole service and opportunities for improving or transforming current services was considered throughout this process.

The equipment inventory supplied as evidence in the self-assessment did not include serial numbers and this needs to be actioned.

## Safe Care

**Managing risk and health and safety**
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. We saw waiting areas were of a sufficient size for the numbers of patients attending the department. We also noted that there were chairs available of different heights to help patients sit up easily. Whilst this was in the main X-ray department only, senior staff confirmed chairs were on order for the outpatient department.

Whilst there was some building work being carried out in parts of the department, 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.

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

We were told that safety notices, alerts and other communications were shared and acted on by emails to modality leads to cascade down to their teams. Additional methods included using email, notices and WhatsApp groups.

Within the main X-ray department we saw two changing cubicles were used as storage rooms. These were not locked and one contained oxygen cylinders, which may present a hazard. Oxygen warning signs were required and cubicles should be labelled as storerooms or store cupboards and secured against unauthorised access. That being said there was a good staff presence in this area which should prevent unauthorised access.

Staff commented that in addition single patient use slide sheets would be useful for infection control.

A total of 88% of patients stated that they were able to find the department easily at the hospital.

**Infection prevention and control (IPC) and Decontamination**
We found suitable infection prevention and control and decontamination arrangements were in place.

We saw sharps bins in use and stored safely in the main X-ray and outpatient departments. Staff confirmed these were rarely used but available if needed.

We saw handwashing and drying facilities were readily available in all areas of the department.

Personal protective equipment (PPE) was available within the examination rooms and staff we spoke with confirmed they had access to suitable PPE that was readily available. We also saw cleaning wipes to decontaminate shared equipment and staff demonstrated a good understanding of their role in this regard.

There was clear evidence that staff had completed IPC training, with overall compliance at over 93%. Staff we spoke with were aware of their responsibilities in relation to infection prevention and control and decontamination.

All the patients who completed the questionnaire said that the setting was clean. When asked whether COVID-19 infection control measures were being followed, where appropriate, 84% of patients said they were.

Almost all staff agreed appropriate infection prevention and control procedures were in place. Additionally, 92% of staff agreed their organisation had implemented the necessary environmental changes to become COVID-19 compliant. A similar percentage agreed their organisation had implemented the necessary practice changes.

Regarding PPE, 90% of staff agreed there had been a sufficient supply of PPE. All bar two staff who answered agreed there were decontamination arrangements for equipment and relevant areas.

**Safeguarding children and safeguarding vulnerable adults**
Staff we spoke with were aware of the health board's safeguarding policies and procedures and where to access these. Staff were also able to describe the actions they would take should they have a safeguarding concern. Whilst overall training compliance at level one was about 90% for both adult children safeguarding, level two training compliance was only 30% for both adult and children.

## Effective Care

**Participating in quality improvement activities**
*Clinical audit*
There was an employer's written procedure in place for carrying out clinical audit.

Staff we spoke with were aware of clinical audits taking place but were not all involved in this process, although they confirmed that they would be emailed results as well as seen any notices in the viewing areas. Staff interviewed were also trained in how to perform quality control testing on the X-ray equipment in their scope of practice.

We noted a multidisciplinary range of relevant clinical audits. The clinical audit process was explained and we were told that staff within the department working on clinical audits would inform the chair of the Educational Group when their audit was available for presentation to the Group. There were usually three or four audits presented every month depending on the amount of completed audits available. Any change in practice that would be recommended as a result of the audit would be discussed and any decisions shared with relevant staff within the department.

*Expert advice*
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.

The self-assessment completed stated that MPEs were available for consultation on all areas of diagnostic imaging including high dose interventional and CT examinations. Specific areas of involvement included advising on optimisation, quality assurance, patient dosimetry and accidental or unintended exposures. The MPEs were also described as being a key member of the health board image optimisation team for CT (CT User Group) with the key aim to achieve harmonisation and optimisation of CT protocols/examinations across all health board's CT scanners. This group is not meeting currently due to a lack of MPE resource.

However, routine quality assurance performance equipment testing was at 70% completed across the health board due to lack of medical physics resources. We understand this and the lack of resources has been escalated by the medical physics service to the Chief Executive. Additionally, only 50% of X-ray rooms three yearly dose audits have been completed which delays the review of DRLs and potential optimisation of radiation doses. We were told this had also been raised through quality and safety channels. This needs to be addressed for the organisation to ensure patient safety. The medical physics service has taken a risk based approach with all high dose equipment, for example CT and interventional equipment, have had their routine quality assurance performance testing completed.

There was also an equipment procurement programme underway which had good MPE engagement. We were told that an additional cardiac catheterisation laboratory was planned, but there was not a revenue stream attached to the procurement to provide for the required medical physics support.

Additionally, there are quality control tests on equipment that are performed on a daily, weekly and monthly basis by radiographers which provide additional assurance for the MPE performance testing. The sample documentation provided for general radiography shows that these tests were not conforming to the timelines set out in the equipment quality assurance manual. These need addressing.

*Medical Research*

Medical research was not currently performed at the hospital, although it was performed at other sites within the health board. However, an employer's procedure was available and clearly written.

**Records management**
Generally, we found suitable arrangements were in place for the management of records used within the department.

A sample of five current patient referral documentation and five retrospective patient referral documentation were examined. The sample showed that the referral records had been completed fully to demonstrate appropriate patient checks had been performed. This included patient identification, sufficient clinical details, enquiries made of pregnancy status where applicable, justification had been carried out and the referral appropriately signed by an entitled referrer.

# 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 66 were completed. Not all staff answered all the questions in the questionnaire.

Responses from staff were generally positive, with most respondents being satisfied with the quality of care they give to patients and 60% being happy with the standard of care provided by this organisation for themselves, friends or relatives. Two-thirds of respondents recommended the service as a place to work.

Areas attracting positive comments were opportunities for professional development. There were some negative comments from staff, indicating room for improvement. The main issues raised were staffing, the rota/shift pattern, management-staff relations and, worryingly, management not acting on staff concerns reported to them.

Staff comments included the following:

> ***"We have experienced staff who have been here a long time starting to leave. Retention of these staff (particularly ones who are experienced) is critical for our NHS to survive."***
>
> ***"I really enjoy the work that I do and love my profession. I pride myself with patient satisfaction and positive feedback in forms of emails and letters support my belief. However, we are constantly being expected to go above and beyond without any respite. it can be devastating to the moral after working on late or helping cover sickness, to be told we need to do more and cover more workload."***
>
> ***"Staff are feeling that this site is extremely busy and are looking to move to smaller hospitals for a better work life balance. Turnover of staff is higher following the covid pandemic."***

We asked staff how the setting could improve the service it provided. Staff suggested:

> ***"Regular updates informed verbally and via email to ensure everyone is aware. Regular staff meetings to inform all staff of any new changes or***

*updates. More staff employed to relieve current staff of the working hours they currently do to allow for a better work life balance."*

*"More staff would allow for a 24-hour service that does not break working time directive as it is at the moment. a better work life balance would be fair and overall satisfaction at the workplace will improve moral. The constant pushes from the manager to get us to take on more workload where other sites in the same trust have less workload are not being utilised."*

## Governance, Leadership and Accountability

**Duties of the employer**

*Entitlement*

A written employer's procedure was in place to identify individuals entitled to act as referrer, practitioner or operator within a specified scope of practice.

Staff we spoke with described how they were made aware of their duties and scope of entitlement under IR(ME)R. This included a period of induction before they were signed off in the relevant areas. They were also able to describe where to find the written employer's procedures and that they had signed to confirm they had read them.

The entitlement for Everlight radiologists providing third party clinical evaluation could not be seen in the policy or employer's procedures. We were told that the clinical director entitled this group. For clarity this group should be included in the relevant written employer's procedure, or radiation safety policy as to how entitlement for this group is managed.

There was a clear and robust process for non-medical referrers training and assessment. Non-medical referrers were entitled by the Clinical Director on satisfactory completion of requirements of the health board policy. The scope of practice was specified in the application for entitlement and included in the letter to the referrer.

*Procedures and protocols*

The employer had written procedures and protocols were in place as required under IR(ME)R. The procedures were clear, well presented and had been updated to take account of the recommendations from an inspection in the health board in 2020.

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

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

Changes were communicated to appropriate staff via internal email and staff meetings. Staff were asked to read and sign the new procedures.

*Significant accidental or unintended exposures*
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.

Staff we spoke with described the procedure for reporting accidental or unintended exposures / other incidents, these would be input onto DATIX. Staff described the lessons learned process and senior staff said they were introducing a radiographer to attend clinical governance meetings and any lessons learned would be collated and passed down in lunchtime meetings.

We were told that the interim site lead was responsible for immediate management of errors and involved the medical physics team at this point. Details would be sent to the Director of Therapies and then via email to HIW.

Staff confirmed near misses were also input onto Datix and would be treated in the same way as those incidents which were notifiable. They would all be reviewed and themes looked into. The consultant radiologist, as the governance lead described how learning from errors and near misses was disseminated. Monthly clinical governance meetings reviewed all errors, near misses, complaints and compliments.

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.

Staff responses in the questionnaire were as follows:

- Their organisation encouraged them to report errors, near misses or incidents – 96%

- Their organisation treated staff who were involved in errors, near misses or incidents fairly – 85%

- When errors, near misses or incidents were reported, their organisation took action to ensure that they do not happen again – 81%, staff comments included:

  ***"I am aware of all the reported incidents in the radiology departments across the three sites due to my role… We promote to active reporting of all incidents for the purpose of learning and improving."***

- In the last month, they had seen errors, near misses or incidents – twenty members of staff

- The last time they saw an unintended exposure, error, near miss or incident, they or a colleague reported it – 78%, a total 19% said they did not know, staff said:

  ***"…. the last incident was a doctor mis-identifying an inpatient. it was corrected but I don't know if it was documented."***

- They were given feedback about changes made in response to reported errors, near misses and incidents – 72%

- If they were concerned about unsafe practice, they would know how to report it – 94%

- They would feel secure raising concerns about unsafe clinical practice – 70%

- They were confident their concerns would be addressed – 50%, with 22% saying they were not confident.

**Governance, leadership and accountability**

The chief executive was designated as the 'employer' as required under IR(ME)R. Whilst they had overall responsibility for ensuring the regulations were complied with, where appropriate the employer had delegated tasks to other professionals working in the health board to implement IR(ME)R.

There was also a clear governance and management structure demonstrated within the self-assessment, which was completed comprehensively and was clear, as well as being provided within the timescale required. The management team demonstrated a commitment to learn from HIW's inspection findings and make improvements where identified.

Staff agreement, in the questionnaire, was as follows

- They were content with the efforts of their organisation to keep them and patients safe – 74%

- Care of patients was their organisation's top priority – 83%

- They knew who the senior managers were – 83%

- Senior managers were visible – 31% agreed but 69% disagreed, staff told us:

> ***"Senior Management is terrible and could be more supportive, however cannot fault immediate line managers / superintendents."***

- Communication between senior management and staff was effective – 29% agreed but 71% disagreed, staff commented:

> ***"A lot of staff leaving, including senior members off staff who have been here years, because of senior management not acting on anything to improve conditions. I quote 'if they want to leave let them leave' from one senior manager about a very experienced senior member of staff leaving who wouldn't have gone if something was put in place for AMU. The manager knew this to be the case."***

> ***"Our line manager and seniors above her seem to only care about numbers there is no room for care for patients in Morriston, for example Neath get 20 mins per patient, in Morriston we have to have 15 mins per patient, bear in mind Morriston deals with all the trauma patients and critical care patients. There is no support. in CT we have had 4 staff members leave and there has been no backfill, we have had senior staff leave and still no back fill and yet still expected to provide a safe service. Also, the only reasons there is training forms that are completed is only because there is an IRMER inspection."***

- Senior managers were committed to patient care – 54%

- Their immediate manager could be counted on to help with a difficult task at work – 77%, staff stated:

> ***"Our line manager said that because there was an increase datix submissions there was a need to have a reflection on it. Most of***

*the datix are due to extravasations and if you look up the reports you will see that we do all we can to make sure it doesn't happen. It just felt like a way to put us off reporting. regardless we still reported as such and didn't stop."*

- Their immediate manager gave them clear feedback on their work - 79%
- Their immediate manager asked for their opinion before making decisions that affected their work – 64%
- Their organisation encouraged teamwork – 84%
- Their organisation was supportive – 57%.

## Staff and Resources

**Workforce**
We spoke with three radiographers and one member of the reception staff and all confirmed they felt supported by their colleagues and managers. Our discussion indicated they enjoyed their work and the department was a good place to work.

We viewed a sample of competency records for five staff and the training and entitlement matrix maintained by the department. The training records – entitlement, scope of practice and competency were well documented and linked to the appropriate equipment training records provided. It was good to see that there were radiologist equipment training and entitlement records to the same standard as radiographers.

We were told that there were vacancies for radiographers in the cardiac catheterisation laboratories and there were currently four vacancies across the site. Management also described that it was difficult to recruit band five radiographers The service stated that they had implemented proactive recruitment measures and workforce planning in place for example interviewing students' pre-qualification and four had been appointed in anticipation.

The shift system changes, which were comprehensive, were described as being made with staff engagement in the decision-making processes.

Only 29% of staff agreed that there were enough staff to enable them to do their job properly, with 71% in disagreement. Staff told us:

*"More staffing across the board - Porters, admin, Radiographers"*

*"More staff, better shift pattern so staff are not fatigued when dealing with patients, more staff available for manual handling patients."*

An electronic system was used with a red, amber, green system to identify those staff who are up to date or required updated mandatory training soon or were overdue. There was clear evidence that staff had completed health and safety online training.

Compliance with level one training in moving and handling, fire safety and violence and aggression was over 90%. However, only 13.3% had completed the face-to-face level two moving and handling training. Similarly, whilst almost 79% had completed level one resuscitation training, only 23.5% had completed the face-to-face level two training. 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.

There was clear evidence that staff had completed other training identified by the organisation as mandatory such as dementia awareness 88% and violence against women 86%.

A total of 76% of staff said they have had appropriate training to undertake their role, staff commented:

*"I have drawn on my experiences from elsewhere to support myself whilst undertaking tasks within department. I feel I have had a mixture of training. Some areas I feel that I have been well supported in understanding my roles and responsibilities whereas others I don't feel as confident."*

*"…not sufficiently trained in DSA and Gamma… I'm often expected to work in these areas with someone who is less experienced than myself."*

We asked if there was any other training staff would find useful. Staff told us:

*"Morriston Hospital is very lucky to have a wide range of modalities. I think it would be a good idea for new starters to have a modalities week which includes cardiac, nuclear med, DSA, MRI, and ultrasound. This helps new starters get an insight into the different departments of radiology in Morriston and how they run, and it could also spark an interest in a modality which they may not have considered before…"*

*"I feel further training with regards to PACS, image transfer, what to do when patients request a copy of their images etc. would be beneficial."*

When asked whether their training, learning and development helped them to do their job more effectively and deliver a better patient experience, 95% agreed and 90% agreed this helped them to stay up to date with professional requirements. A staff member said:

*"The training offered for the ultrasound training is very detailed and well planned out."*

Annual appraisal compliance was at about 71%. Senior staff described the work in process to improve compliance. There was a list displayed in the office showing the lines of reporting and who was responsible for conducting these appraisals.

From evidence supplied it was clear that staff were being developed, with development opportunities available, including working in other radiology departments within the health board.

Almost 89% of staff said they had an annual review or appraisal within the last 12 months, of these 76% stated that training, learning or development needs were identified. Additionally, two thirds of staff said that their manager supported them to receive training, learning or development.

When asked about whether they agreed staff had fair and equal access to workplace opportunities (regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation), 74% agreed. Staff told us:

*"Male staff are not offered fair return to work hours when they've had children."*

Whilst 59% agreed that their job was not detrimental to their health, 41% disagreed. Also, whilst 64% agreed their organisation took positive action on health and wellbeing, 36% disagreed. A staff member said:

*"A better work-life balance is needed. A few radiographers have left/are thinking about leaving this hospital as it does double the work for the same pay of other hospitals. It is a treat for band 5 radiographers to have an entire weekend off, which highlights how we work most weekends. This does not give individuals the chance to unwind before they are back in again for a variety of shift patterns which messes up sleeping/eating times etc."*

Only 38% of staff agreed that their current working pattern / off-duty allowed for a good work-life balance, with 62% disagreeing. We were told:

> ***"Increasing staffing levels to safe levels and changing to provide a better work /life balance."***

Whilst 54% of staff agreed they would recommend their organisation as a place to work, 46% disagreed. Staff commented:

> ***"I really enjoy the work that I do and love my profession. I pride myself with patient satisfaction and positive feedback in forms of emails and letters support my belief. However, we are constantly being expected to go above and beyond without any respite. it can be devastating to the moral after working on late or helping cover sickness, to be told we need to do more and cover more workload."***

> ***"This department is full of wonderful people committed to patient care and to helping one another. However, it does feel like it is stuck in a time warp with regards to how it runs."***

It was positive to note that the majority of staff (82%) said they were aware of the occupational health support available to them. However, only 60% agreed that they were offered full support in the event of challenging situations.

It was disappointing to note that 8 of the 49 staff who answered the question indicated they had faced discrimination at work within the last 12 months. Based on this and some other less positive comments listed in this report, the health board is required to address the staff comments and various areas from the staff survey.

That being said, 82% agreed that their workplace was supportive of equality and diversity. We were told:

> ***"No initiatives but we are an inclusive team."***

Other replies to the questionnaire included:

- That staff could meet the conflicting demands on their time at work – 60%
- They had adequate materials, supplies and equipment to do their work – 57%
- Access to ICT systems they needed to provide good care and support for patients – 90%

- That they were involved in deciding on changes introduced that affected their work area - 86%.

# 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 |
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# Appendix B - Immediate improvement plan

## Service: Morriston Hospital - Diagnostic Imaging Unit

## Date of inspection: 21 and 22 February 2023

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:<br><br>• to improve mandatory staff training compliance in respect of both resuscitation training and safe moving and handling training<br><br>• to promote patient safety in the interim. | Standard 7.1 Workforce<br><br>Standard 3.1 Safe and Clinically Effective Care | Improving Training Compliance:<br><br>• Improvement plan actions to be achieved in full by August 2023<br><br>• Calendar of training developed to monitor and track compliance against targets until compliance is reached<br><br>Due to data transfer issues within ESR systems some staff on rotational training, who have completed mandatory training in other organisations are NOT being pulled through to their new post. | Persons responsible for completion of all actions:<br><br>Alexandra Simmonds - Radiology Services Manager<br><br>Janine Sparkes - Morriston Interim Site Lead<br><br>Ceri White - Morriston Deputy Interim Site Lead | August 2023 - Original compliance at inspection for face to face training was 23.5% Resuscitation training and 14.5% for Manual Handling<br><br>Complete - Compliance monitored and minuted at CSS directorate board. |

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| | | • Establish a local Radiology process for maintaining and monitoring all training compliance ensuring visibility of face to face compliance levels also at CSS directorate board against 85% target.<br>• Liaise with Health board training teams to identify opportunities to expedite ILS & ELS training and manual handling.<br>• Manual handling service have agreed to prioritise Radiology training to urgently improve compliance<br>• Liaise with Resus and Manual handling training teams to ensure any cancellations available are re-directed toward improving Morriston Radiology compliance.<br>• Options for departmental based training for Resus & Manual Handling are being explored, to enable a wider training cohort for radiology staff.<br>• Plan to be developed to explore options to utilise Radiology Directorate Matron who is an ALS trainer to facilitate additional training | Alexandra Simmonds – Radiology Services Manager | March 2023<br><br>Complete – Meetings held w/c 27th Feb.<br><br>Complete - 10 slots pcm protected per cohort for radiology training<br><br>March 2023<br><br>April 2023<br><br>March 2023 – plan to be developed and discussed in March 2023 CSS Board |

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| | | • Since the inspection date further training dates have been booked for Resus training.<br><br>Promoting Patient Safety:<br><br>Due to unavailability of face to face training throughout the pandemic a significant backlog developed. As the health board recovered and training face to face recommenced it was required to prioritise training availability on a risk basis which has limited the available places to non-bedside professions and lower risk services until November 2022, whereby additional capacity has recently been put in place to mitigate the risk.<br><br>• E-Learning compliance above health board targets for Resus & Manual Handling, which is supporting staff skills & knowledge until face to face compliance can be achieved.<br>• Reiterate to all staff the awareness of local resus practice to ensure resus team is called in the event of a medical emergency<br>• Morriston Radiology based Manual Handling Coaches are available within the service currently to support staff until compliance is | | Complete – 3 staff members allocated training dates<br><br>Current E-learning Compliance –<br>Resus = 85.2%<br>Manual Handling = 92.6%<br><br>March 2023 - Radiology Governance Meeting and CSS Board<br><br>Complete – staff making contact with coaches as required |

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| | | improved, supporting education and awareness as appropriate.<br>• The low levels of compliance; reduced availability of face to face mandatory training and reduced ability to release staff to train has been added to the risk register.<br><br>To ensure compliance and the agreed trajectory for improvement in face to face training is being monitored, the interim Head of Nursing for Clinical Support Services and Radiology Service Manager will meet initially fortnightly prior to Radiology Governance meetings. This is to ensure all available opportunities are being accessed to support the required immediate improvement and long term sustainability. | Alexandra Simmonds – Radiology Services Manager<br><br>Jonathan Gates Interim Head of nursing CSS | Complete – Risk escalated for addition to risk register. Review will be completed at CSS board meeting March 2023. |

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):** **Ceri Matthews**

**Job role:** **Interim Nurse Director, Morriston Service Group**

**Date:** **02/03/2023**

# Appendix C - Improvement plan

## Service: Morriston Hospital - Diagnostic Imaging Unit

## Date of inspection: 21 and 22 February 2023

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 |
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| 1. The health board is required to remove all signage that is not gender inclusive. | Standard 6.2 Peoples Rights | • Remove all non-gender neutral signage, peer review of signage to be undertaken to evidence<br>• Explicit inclusion of standard within baseline information/notice board requirements across all Morriston Service Group locations from April 2023<br>• Escalation of standard and improvement target at the Health Board's Patient Safety & Compliance Group (06/04/2023). | • Site Lead Radiographer & Deputy site lead Radiographers<br>• Group Head of Quality, Safety & Patient Experience | May 2023 – *Peer review of signage to evidence action completed.*<br>April 2023 – *to be peer reviewed as part of standard monthly site walk-abouts by Hospital Ops Team* |

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| 2. 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. | Standard 3.2 Communicating Effectively | • Cymraeg lanyards & pin badges are not advocated for clinical staff due to infection risk and patential risk of skin damage during close contact.<br>'Laith Gwaith' badges to be embroidered on clinical staff tunics, as per Infection Control guidance<br><br>• Inclusion of Welsh Language Skills monitoring within Health Board monthly performance review. | • Site Lead Radiographer & Deputy site lead Radiographers<br><br>• Group Welsh Language Lead/HR Business Partner | May 2023 - *Peer review of identifiable welsh speakers required to evidence action completed.*<br><br>April 2023 – *monitoring assured by dedicated Welsh Language Service within Health Board as part of overall organisational performance management framework* |
| 3. The health board is required to provide HIW with details of the action taken to ensure that letters | Standard 6.2 Peoples Rights | • All current letters and leaflets to be reviewed; | • Site Lead & Radiology Radis and | May 2023 - *Peer review of patient letters required* |

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| sent to patients are bilingual and of a font size that all patients could read. | | updated and standardised where applicable<br>• Once reviewed all standardised letters and leaflets to be approved by patient information group<br>• Once approved by Patient information group, all letters and leaflets to be translated into Welsh<br>• All letter and leaflet templates to be uploaded into Radiology Booking software<br>• National Imaging programme – Quality Work stream is developing standardised documentation at an all Wales level, this will be translated and then locally adopted once finalised<br>• National Imaging programme – Quality Work stream has developed a draft, bi-lingual Benefit & Risk leaflet relating to Radiation protection. This will be | administration managers | *to evidence action completed.*<br><br>August 2023 - *Peer review of documentation to evidence new templates as action completed.*<br><br>November 2023 - *Peer review of documentation to evidence new templates as action completed.*<br><br>Feb 2023 – *Radis print outs to evidence bi-lingual documentation* |

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| | | locally adopted once available. | | |
| 4. The health board is required to provide HIW with details of the action taken to improve the system of providing staff and patients with updates on patient experience feedback and of the changes made because of this feedback. | Standard 6.3 Listening and Learning from Feedback | • Business case for quality lead radiographer submitted to senior management team. Funding stream to be identified<br>• Patient experience notice board to be developed within main reception area. To include "you said we did"<br>• Plan to improve patient feedback received each month by 50%<br>• Workforce Plan required to enable better attendance at radiology clinical governance meetings: to be developed and shared with Senior Management for visibility of any funding requirement | • Unit Management Team/Planned Care Board<br>• Site Lead & Deputy site lead Radiographers<br>• Site Lead & Deputy site lead Radiographers<br>• Site Lead & Deputy Site Lead Radiographers. Consultant Governance Lead | November 2023 – *Cost Centre to evidence post created and filled.*<br>May 2023 - *Peer review of site required to evidence action completed.*<br>August 2023 – *Patient feedback report to evidence 50% increase from baseline pcm.*<br>July 2023- Workforce plan to be reviewed and approved at quality & governance meeting. Minutes to evidence |

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| | | • Patient Experience and actions taken to be discussed in quality section of Staff Meetings, including updates on complaints management<br>• Improvement work to be shared at the Health Board's Patient & Stakeholder Experience Group (next available meeting 02/05/2023). | • Site Lead & Deputy site lead Radiographers<br>• Group Head of Quality, Safety & Patient Experience | May 2023 – *Meeting attendance lists and outcome notes maintained as a record of the meeting*<br>May 2023 – *next available meeting* |
| 5. The employer is required to ensure that staff are aware of the correct procedure to identify patients where more than one operator was directly involved in the exposure. | Schedule 2 1 (a) of IR(ME)R 2017 | • Employers procedure EP5 to be re-issued in an e-mail reminder to all radiographic staff to be reinforced<br>• Modality leads where staffing model is 2 operators per room, to reinforce understanding of EP5.<br>• Inspection feedback disseminated in Staff & Governance Meetings to highlight and reinforce the correct procedure | • Site Lead & Deputy Site Lead Radiographers<br>• Modality leads<br>• Site Lead & Consultant Governance Lead. | May 2023 – *Email to evidence actions taken.*<br>May 2023 – *Evidenced through audit.*<br>May 2023 – *Meeting minutes to evidence action taken.* |

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| | | • Audit of compliance to be performed. | • Site Lead & Deputy Site Lead Radiographers | June 2023 – *Audit outcomes shared at governance meeting to evidence action taken.* |
| 6. The employer is required to ensure that the authorisation guidelines clearly identify the clinical director is the practitioner. | IR(ME)R 2017 Regulation 11(5) | • Delegated authorisation guidelines to be reviewed and updated to include relevant practitioner information (Radiology Clinical director or appropriately entitled practitioner). | • Site Lead & Deputy Site Lead Radiographers. Medical Physics Expert (MPE) | August 2023 – *Clinical Governance and Education Meeting minutes to evidence action taken.* |
| 7. The employer is required to ensure that documentation relating to authorisation guidelines for exposures to carers and comforters for CT scans, is ratified and formally accepted as part of the IR(ME)R documentation. | IR(ME)R 2017 Regulation 11 (5) | • Delegated Authorisation guideline for carers and comforters has been ratified and will be formally presented at Radiology governance meeting on 27th April 2023. | • Site Lead Radiographer<br>• Lead Governance Radiologist | May 2023 – *Meeting minutes to evidence approval and acceptance.* |

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| 8. The employer is required to clarify to staff, which DRLs, local or national, are used for examinations. | IR(ME)R 2017 Regulation 6(5)(c) | • MPE to review format of DRL information<br>• All radiographic staff to be reminded via E-mail which radiology rooms use local and which use National DRL's<br>• Inspection feedback disseminated in Staff Meetings to highlight need to understand and know which DRL's are in use. | • MPE<br>• Modality Leads<br>• Site Lead & Deputy site lead Radiographers | July 2023 – *Meeting minutes or email confirmation to evidence*<br>May 2023 – *Site lead to be cc'd into Emails to evidence action taken.*<br>May 2023 – *Meeting minutes to evidence approval and acceptance.* |
| 9. The employer is required to ensure that the management of the group entitlement of Everlight radiologist providing third party clinical evaluation is included in the Policy on Implementation of IR(ME)R 2017 and employer's procedures. | IR(ME)R 2017 Regulation 6(1) | • Health board IR(ME)R policy and Employers Procedures to be updated to included operator entitlement for third parties providing clinical evaluation. | • MPE & Radiology Clinical Director | October 2023 – *Medical Exposure Committee or Radiation Protection Meeting minutes to evidence action taken.* |

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| 10. The employer is required to record the serial numbers of equipment on the inventory for the department. | IR(ME)R 2017 Regulation 15(2)(c) | • Equipment inventory updated with serial numbers. | • Site Lead & Deputy site lead Radiographers | April 2023 – *Local Equipment Asset Register to evidence.* |
| 11. The health board is to ensure that rooms within the department are secured, accurately labelled as storerooms and with oxygen warning signs as applicable. | Standard 2.1 Managing Risk and Promoting Health and Safety | • Oxygen & Compressed gas signage to be placed where in use/stored. Advice on correct signage to be sought form medical gas trainer. | • Site Lead & Deputy site lead Radiographers | May 2023 – *Peer review of signage to evidence actions taken.* |
| 12. The employer is required to provide HIW with the actions they will take to ensure patient safety and compliance with the professional body guidance relating to:<br>• Mitigating the risk of MPEs not completing the relevant equipment QA performance testing and dose audits<br>• Ensuring there is sufficient MPE cover for the hospital | IR(ME)R Regulation 14 (2)(d)(I)(ii)(iii)<br>Regulation 14 (3)(a)(b)<br>Regulation 15(3)(b) | • SBAR submitted to executive team regarding MPE workforce to meet IR(ME)R 2017 compliance. Recommendations within the SBAR are being reviewed. | • Employer/Executive team | July 2023 – *Feedback on progress of SBAR and future recommendations to evidence action taken.* |

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| and the health board in general. | | | | |
| 13. The employer is to ensure that radiographer's quality control tests on equipment conform to the timelines set out in the equipment quality assurance manual recommended by the MPE. | IR(ME)R Regulation 15 (1)(a)<br><br>Regulation 15 (3)(b) | • Audit of timeliness of completion of equipment QA to be undertaken<br><br>• Results & timeliness of Equipment QA to be presented biannually at Medical exposure group and action to address any issues arising following quality assurance checks to be addressed. | • Modality leads & Deputy Site Lead | April 2023 – Initial Audit completed, reviewed by RSM to confirm within compliance timeframe. Centralised template to be completed quarterly and reviewed by Deputy site lead.<br><br>October 2023 – *Medical Exposure Committee or Radiation Protection Meeting minutes to evidence action taken.* |
| 14. The health board is required to inform HIW of the action taken to improve compliance with the annual appraisal process. | Standard 7.1 Workforce | • Radiology is committed to achieve the 85% health board target for PADR compliance. | • Site Lead & Deputy site lead Radiographers | August 2023 – *Compliance at inspection 70.07%.* |

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| | | | | *Professional split =*<br><br>*Radiographers 76.7%*<br><br>*Nurses 100%*<br><br>*A&C = 11%*<br><br>*Rad Assistants = 71%* |
| 15. The health board is required to inform HIW of the action taken to address the issues relating to staff discrimination and other less positive staff comments and percentage agreements in the report. | Standard 7.1 Workforce | • Staff direct engagement sessions to be undertaken by May 2023 regarding themes of feedback received<br>• Regular internal staff surveys to commence from July 2023 to capture staff feedback<br>• Diversity & Inclusion Champion to be identified and training supported to improve staff<br>• Service Workforce plans to be made more visible, | *All the staff below share responsibility toward delivering these actions*<br><br>• Radiology service manager.<br>• Site Lead & Deputy Site lead Radiographers.<br>• Clinical Director.<br>• HR Business Partner | May 2023 – *Slides on Inspection Feedback and minutes of engagement sessions to evidence action taken*<br><br>May 2023 – *Evidence Survey shared across workforce* |

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| | | including recruitment actions being taken<br>• Review of the On Call Out of Hours Service to support plans to revise current model and improve work life balance<br>• Health board; Service Level Newsletters and performance information shared routinely, review further opportunities to provide enhanced visibility of new developments; Service specific challenges; Service 'Champion' updates (well-being; inclusivity etc), recruitment and retention plans, including 'you said we did' for service wide issues that may arise. | | May 2023 – *Evidence of a named champion*<br><br>May 2023 –*Plans shared in staff meeting minutes or email updates*<br><br>October 2023 – *Plan for revising the current OoH's model visible with clear timeline for delivery*<br><br>June 2023 – *Newsletter developed and shared via email across workforce and in paper format in key staff areas. Peer review of email and staff room notice boards to* |

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| | | | | *evidence action taken* |

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):** **Kate Hannam**

**Job role:** **Service Group Director (Morriston Hospital)**

**Date:** **18/04/2023**