Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

DRIVING IMPROVEMENT THROUGH INDEPENDENT AND OBJECTIVE REVIEW

Ionising Radiation (Medical Exposure) Regulations Inspection (announced)

Cwm Taf University Health Board: Royal Glamorgan Hospital, Radiology Department

3 and 4 November 2014

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1. Introduction

A compliance inspection against the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2000 and regulation amendments 2006 and 2011 for diagnostic imaging was undertaken on 3 and 4 November 2014 at the radiology department Royal Glamorgan Hospital as well as a follow up visit to Prince Charles Hospital which are both part of the Cwm Taf Health Board.

Our inspection considers the following issues in the context of the regulations:

- Quality of the Patient Experience
- Compliance with IR(ME)R
- Staffing Management and Leadership
- Delivery of a Safe and Effective Service

2. Methodology

HIW's 'IR(ME)R Inspections', selects a healthcare organisation as part of the annual announced IR(ME)R Inspection Programme.

We review documentation and information from a number of sources including:

- Information held to date by HIW
- Conversations with patients, relatives and discussions with staff
- Discussions with senior management within the health board
- Examination of a sample of patient medical records
- Scrutiny of policies and procedures which are required by IR(ME)R
- General observation of the environment of care and care practice

These inspections capture a snapshot of the standards of care patients receive. These inspections may point to wider issues about the quality and safety of services provided.

3. Context

Cwm Taf University Health Board is responsible for providing healthcare services to the population of Merthyr Tydfil and Rhondda Cynon Taf, estimated to be around 289,400 people. The services also extend to people living in the neighbouring areas of the upper Rhymney Valley, South Powys, North Cardiff and the Western Vale.

The health board provides the full range of hospital and community services from two district general hospitals and five community hospitals.

The radiology departments of both hospitals visited are filmless with digital images and reports available to clinicians across the sites

The services provided at both hospitals are the same with the exception of nuclear medicine and some interventional work, which is undertaken only at Royal Glamorgan. Services provided include:

- General radiography
- Ultrasound
- Computed Tomography (CT)
- Magnetic Resonance Imaging (MRI)
- Nuclear medicine
- Barium / fluoroscopy
- Mammography

At the time of the inspection we were informed that in the main imaging department at Royal Glamorgan Hospital over the last year, 45,183 general radiology examinations were carried out, 2133 fluoroscopy, 10,387 CT with 175 CT interventional procedures, 107 other interventional procedures, e.g. angiography and stents, 462 cardiology, 4,785 mammography, 1,000 dental, 5,329 MRI and 16,578 ultrasound examinations took place.

We were also informed that in addition to Royal Glamorgan Hospital, the Directorate was responsible for ionising radiation at Prince Charles Hospital, Ysbyty Cwm Rhondda, Ysbyty Cwm Cynon, Dewi Sant Hospital and Ysbyty George Thomas.

At the time of the visit the inspectors were told about the vision that managers had developed for the radiology department at Royal Glamorgan hospital of a diagnostic hub which would support a wider network of hospitals.

In addition, funding had been secured for updating imaging equipment and facilities at Prince Charles Hospital and plans were in place for this work to commence in the near future.

4. Summary

The inspection was well received by the departmental management team who approached the visit with openness and honesty. Advice was actively sought and appreciated as was constructive criticism which was provided at the time.

We received a positive welcome from both staff and patients who also provided feedback on a number of issues. At the end of the inspection we provided feedback on our main findings and key recommendations. The health board will be submitting an improvement plan in response to our findings.

Whilst we were satisfied that there were no major safety concerns it was disappointing to find that there had been little progress with a number of the recommendations made following the previous IR(ME)R inspection in July 2012.

In terms of compliance with IR(ME)R, a significant breach was in relation to the lack of training records. This had been highlighted previously and whilst some action had commenced at the Royal Glamorgan Hospital, it had not been completed. There was no evidence of any progress, however, at Prince Charles Hospital in relation to this recommendation.

A further issue in relation to compliance with IR(ME)R was a lack clarity around entitlement, both within the radiology department and in other departments.

The employer's procedures had been reviewed in March 2013 and were due for further review in March 2014. However, this had not happened and the overarching policy, which had been reviewed in March 2014, had not been approved. It was disappointing that there wasn't a robust process in place for document control and review.

A number of comments were made in relation to individual procedures and regulations which are outlined in the document. Detailed recommendations are also provided.

5. Findings

Quality of the Patient Experience

Overall we found that patients felt the quality of their experience whilst visiting the department was good. Positive feedback was received about the staff and their attitude, however they did comment that communication - particularly about the length of waiting times - could have been improved. The department should consider how information about lengths of wait is shared with patients

During our inspection at the Royal Glamorgan Hospital we spoke to a number of patients and/or their relatives about their experiences whilst attending the department.

Generally, patients indicated that they thought the department was clean and tidy. One patient did however comment that they thought the chairs in the waiting area were ‘tatty’ and torn.

All patients spoken with said that despite staff in the department being very busy, they were friendly and approachable. One person commented, however, that she felt they were particularly short staffed on the day of the visit. Three of the respondents commented that they had been waiting over an hour and one person commented that she thought it would have been helpful if staff had kept the patients informed about roughly how long they would be waiting.

Everyone we spoke to said they found their way to the department easily and that the signage was good.

One other patient also commented that the hand dryers in the toilet facilities were incredibly slow and that there was no alternative drying facilities.

Compliance with IR(ME)R

Duties of Employer

The definition in IR(ME)R states, "'employer" means any natural or legal person who, in the course of a trade, business or other undertaking, carries out (other than as an employee), or engages others to carry out, medical exposures or practical aspects, at a given radiological installation'.

Cwm Taf University Health Board has a policy document in place however, it does not clearly state who the employer is and it is unclear how the responsibilities are delegated to other personnel within the organisation

The Director of Therapies and health science (which includes the radiology department) reports directly to the Chief Executive and is also chair of the Radiation Safety Committee. Whilst the policy does explain the roles of individuals in relation to ionising radiation, the way delegation of responsibility works is unclear.

Recommendation

The policy document needs to clearly state who the employer is and clarify how the delegation of duties works in relation to IR(ME)R.

Procedures and Protocols

The regulations require the employer to have written procedures and protocols in place.

Whilst there was an overarching policy document in place, it needs further work to ensure it is fit for purpose and approved by the RSC in a timely fashion. Senior management should set an example and demonstrate their commitment to completing this requirement. Staff need to be aware of it and familiar with its contents. Employers procedures as required under IR(ME)R were also in place and also applied to all six sites within the health board. They do, however, need to be reviewed and updated to ensure they are also fit for purpose and compliant with the regulations.

The health board had an overarching Radiation Safety Policy in place for all sites entitled 'Medical Use of Ionising Radiation'. This policy had been reviewed in line with one of the recommendations made following the previous IR(ME)R inspection to Prince Charles Hospital in 2012. The document was written in March 2014 but it had not yet been approved by the Radiation Safety Committee. The document requires further simplification and clarification on

matters such as, who the employer is and their responsibilities including delegation of duties. This should be clearly outlined as part of the written procedures to ensure roles and responsibilities are clarified and undertaken in practice. Training requirements listed in Annex A-C need to encompass all duty holders and need updating expanding and clarification.

All of the employers procedures that were in place had been approved in March 2013 and were due to be reviewed in March 2014 but there was no evidence that any of the reviews had taken place.

Some of the discussions around individual procedures include:

Employer Procedure 11 (EP11) Reducing the probability and magnitude had little value as the points listed in the procedure including reject analysis, regular audit of procedures and documented equipment training are not carried out. There was no evidence of progress with the recommendation made at the previous inspection in relation to reject analysis, neither was there any evidence of any change in the way they record dose in general radiography

Employer Procedure 5 (EP5), entitled Quality Assurance, related almost entirely to equipment. In a regulatory context, however, this relates to and is consistent with the requirements of IRR99 rather than IR(ME)R. We explained that under IR(ME)R the procedures should relate to such things as ensuring document control, author, review dates. The process for reviewing and signing off together with timescales could also be described in the over arching policy document to ensure everyone is clear about what should happen and when.

There was no evidence of a clear process in place for ensuring staff were made aware of any new or updated procedures. We were informed that there is a read and sign process in place however we were also told that staff will read them but rarely sign. There was, therefore, no documentary evidence that an individual working in the department is aware of updates or changes made.

On examining the list of protocols in place many of them did not have document control in place and for some we also had to ask what they related to as they were not clear.

On the day of the visit we discussed the Standard Operating Procedures (SOP's) that had been included as part of the information submitted to HIW prior to the inspection. It was not clear to the inspection team what their purpose was. The management team were not able to explain what they were, when they had been written or when or if they were used.

Recommendations

The Health Board need to review the overarching policy to:

- ***Streamline the content with the employers procedures***
- ***Remove duplication***
- ***Ensure it is approved in a timely fashion***
- ***Reformat for ease of use and understanding***

The Health Board need to review the suite of employer's procedures that underpin the wider policy to ensure clarity and fitness for purpose

The Health Board need to progress the recommendation made at the previous inspection in relation to reject analysis as part of quality control

The Health Board need to clarify the purpose of the SOP, review and update content and ensure staff are aware of their function

Incident notifications

IR(ME)R states that where an incident has occurred in which a person, whilst undergoing a medical exposure, has been exposed to ionising radiation much greater than intended, this should be investigated by the healthcare organisation and reported to the appropriate authority (HIW).

There appears to be a clear process in place for the reporting of incidents. What was unclear, however, was whether this was understood by staff

The process for reporting incidents was described by the management team and was supported by a comprehensive procedure however it was unclear whether staff within the department understood this.

In discussions we held with staff they were unable to describe how learning from incidents was shared with them.

Recommendation

The Health Board need to review how new or revised policies and procedures are communicated to staff to ensure they have read and understood them.

The Health Board need to consider how the process for sharing learning with staff following an incident occurs and document this in EPs.

Diagnostic reference levels

The regulations require the employer to establish diagnostic reference levels (DRL) for radio diagnostic examinations stating that these are not expected to be exceeded for standard procedures when good and normal practice regarding diagnostic and technical performance is applied.

The whole process of establishing DRLs was of concern. The previous report recommended the need to establish appropriate DRLS immediately. Some local DRLs have been completed but discussions with the management team demonstrated they had concerns around the number of patients consistently exceeding these levels and whether these DRLs are appropriate.

We were informed that the department at Royal Glamorgan were working to both Local and National DRLs. Two of the general rooms were still working to National DRL's, as in July 2013 a new Fuji PACS was installed and as such were still working to the National levels. A dose audit needs to be undertaken in these two rooms. Log books were in place for recording when DRLs are consistently exceeded and all appeared to be in relation to 'larger' patients and higher exposure factors, it was therefore unclear to staff whether the LDRLs established were appropriate for the patient cohort.

The team also confirmed that no Paediatric DRLs had been established despite this being a recommendation which was due to have been achieved by December 2012.

Recommendations

The Health Board need to review the established LDRLs (with RPA) and clarify staff understanding around reporting consistently exceed DRLs.

The Health Board should ensure that the Employers procedure 7 (EP7) should reflect what happens in practice and include clarification around reporting consistently exceeded DRLs

The Health Board should establish paediatric DRLs in line with the recommendation made in July 2012

Duties of Practitioner, Operator and Referrer

Entitlement

The regulations require that duty holders must be entitled, in accordance with the employer's procedures for the tasks they undertake.

The entitlement process and delegation of who can entitle duty holders did not appear clear in procedures and this was reflected in discussions with staff, where there was some confusion around which duty holder role they were performing.

From our discussions with staff at the time of the visit it was obvious that not all staff were clear about their roles and responsibilities as duty holders. In the entitlement procedure (EP2) entitlement is described by group, not all groups are covered and their scope of practice is not apparent. There was no mention of reporting radiographers in the operator entitlement within the procedure. It was accepted by the radiology team that this area was a 'work in progress'.

Appendix A was referred to in the procedure but was not attached to the document submitted. This was handed to the team later in the day and appeared to contain the entitlement and competencies for individuals. This form had not, however, been completed for staff but was merely an example of the form to be used

The entitlement for practitioner's states that all radiographers are entitled for all general radiography plus specific entitlements as defined in Appendix A, individual duty holder entitlement, which has not yet been completed.

Recommendation

The Health Board need to review the entitlement procedure and staff need to understand their entitlement and individual scope of practice.

Referrer

IR(ME)R states that a referrer is a healthcare professional who is entitled in accordance with the employer's procedures to refer individuals to a practitioner for medical exposures.

Since the previous inspection referral criteria (iRefer) has been made available Trust wide. It was unclear, however, from discussions with the management team how a new GP would obtain this information. It was also unclear who or how this would be communicated.

On the day of the visit we discussed the issue of non medical referrers. The procedure states that this group are entitled by the Clinical Director Radiology. We discussed how non-medical referrers are deemed competent to perform their scope of practice within the Trust. We asked to see evidence of local competency training for nurse practitioners in ED as an example. However, no records were produced.

Recommendation

The Health Board needs a robust process in place for ensuring referrers are aware of the referral criteria. The entitlement procedure for non medical referrers needs to be clearly documented and robust processes put in place to ensure the management team are aware of the process and can provide evidence this is being carried out appropriately

Justification of Individual Medical Exposures

The regulations require that all medical exposures should be justified and authorised prior to the exposure. The practitioner is responsible for the justification of the medical exposure. Authorisation is the means by which it can be demonstrated that justification has been carried out and may be undertaken by the practitioner or, where justification guidelines are used, an operator.

There appeared to be some confusion between practice in the department and the answers in the self assessment form (SAF) relating to justification and authorisation and operators using guidelines to authorise exposures.

The SAF indicated that operators were authorising to guidelines and that i Refer, a publication produced by the Royal College of Radiologists (RCR), was used as justification guidelines in the RGH.

It was explained that justification is an intellectual activity and is the primary role of the practitioner. When justifying an exposure, appropriate weight must be given to matters such as previous imaging, medical history, age, pregnancy status, expected benefit i.e. will treatment be altered etc.

There were further discussions to explain why i Refer could not be used as justification guidelines. Justification/authorisation guidelines must be produced by a named practitioner (often, but not always, the lead radiologist). The individual who produces these guidelines takes responsibility for any exposure authorised using these guidelines i.e. they are the practitioner. The author and review/revision dates must be clearly defined. i Refer is published by the RCR- a specific named practitioner cannot be identified to take responsibility for individual medical exposures at Royal Glamorgan Hospital form this publication.

Following discussion with the operational superintendent radiographer it became clear there are no operators authorising to guidelines in Royal Glamorgan Hospital.

The term ‘vetting’ was also used in the SAF to explain the evidence of how exposures are justified. It was unclear what the term vetting meant in the radiology department –whether it was scheduling, protocolling, justifying or authorising to guidelines.

It was requested that procedures clarified the process of determining how staff were aware an examination had been justified and how staff identified the practitioner for an examination.

Recommendation

The Health Board need to clarify what the use of the term 'vetting' means as stated in the self assessment form in the context of the employers procedure

Identification

The regulations state that written procedures for medical exposures should include procedures to correctly identify the individual to be exposed to ionising radiation.

The procedure has been updated to include scenarios as required following the previous inspection. Further work is required, however, to develop and clarify the format of the procedure.

The team have included, when reviewing the procedure, scenarios where straight forward identification cannot be used into the patient identification procedure. Staff, when questioned, were clear about who they asked and what to do if the medical officer was not available in theatre, but it was unclear from further discussion with the management as to what happens in relation to theatre and who the radiographers ask to identify the patient in this situation. The importance of ensuring the procedure reflects what happens in practice was explained at the time of the visit. It was positive however, a reference had been made in the procedure to safeguarding in the event that this would be required.

Recommendation

The Health Board needs to undertake further work to ensure there is clarity in respect of what happens in theatre in relation to patient identification and to ensure that all staff are clear about who they need to ask

Females of child bearing age

IR(ME)R states that written procedures for medical exposures should include procedures for making enquiries of females of child bearing age to establish whether the individual is or maybe pregnant.

The procedure was comprehensive but very lengthy. It was suggested the introduction of a flowchart may help to improve understanding

The procedure for ‘females of Child bearing age’ has been reviewed following the previous inspection to take account of the issues highlighted. It was noted however that the procedure is now lengthy and it was suggested that by introducing the use of a flowchart it may help to make the procedure more concise and user friendly.

Recommendation

The Health Board should consider the introduction of a flowchart into the procedure to assist with clarity

Optimisation

The regulations state that the operator and practitioner should ensure that the dose arising from the exposure is kept as low as reasonably practicable for the intended purpose.

See comment in section headed Procedures and Protocols about employers procedure 11 (EP11) for detail in respect of optimisation.

Paediatrics

IR(ME)R states that the practitioner and operator shall pay special attention to the optimisation of medical exposures of children.

In the self assessment form submitted to HIW prior to the inspection it states that there is specific reference to paediatrics in the employers procedures, however no references could be found other than the reference to safeguarding issues in employers procedure 4 (EP4) Procedure for checking Pregnancy.

There is also a need to review the current paediatric protocols to reflect on extending the age ranges available and to also consider using size specific information regarding weight, height or BMI

Recommendation

The Health Board should ensure that appropriate references are made in the procedures in relation to the optimisation of medical exposures of children.

Clinical evaluation

The regulations state that the employer shall ensure a clinical evaluation of the outcome of each medical exposure is recorded in accordance with written procedures.

The procedure states that a registrar or radiologist will provide a written report on RADIS for all radiographic examinations however it does not refer to reporting radiographers.

It was also suggested, during discussions, that it would been seen as good practice to ensure clinical evaluation is being appropriately completed by non radiology staff (for example, Nurse Practitioners in each department) who evaluate and treat and then perhaps record this in the patients notes.

Recommendation

The Health Board should review the employer's procedure to ensure the inclusion of reporting radiographers and any other staff groups who may clinically evaluate

Clinical audits

IR(ME)R states that employer's procedures shall include provision for carrying out clinical audits as appropriate.

There was evidence that clinical audit takes place, though this was not documented in any of the procedures observed

Whilst there is no requirement in IR(ME)R to have a procedure in place for clinical audit, Regulation 8 does state that the organisation shall provide provisions for carrying out clinical audit. There was nothing documented in the paperwork we scrutinised that refers to this however we did see a meeting agenda which demonstrates that clinical audit is being carried out.

In addition within the department there was evidence of departmental audits taking place on a regular basis as well as the findings being used to influence change.

Recommendation

The Health Board should consider the development and introduction of a procedure which describes the process for identifying and carrying out clinical audit

Expert advice

IR(ME)R states that the employer shall ensure a Medical Physics Expert (MPE) is involved as appropriate in every radiological medical exposure.

Cwm Taf University Health Board has appointed a Radiation Protection Advisor (RPA) and there are service level agreements in place for four Medical Physics Experts (MPE's). The RPA sits on the Radiation Safety Committee and is

available for advice on the telephone. He also advises on any building projects planned, provides equipment quality assurance and advises on protocol optimisation.

Equipment

The regulations state that the employer shall keep an up to date inventory of equipment for each radiological installation.

Equipment records in the form of an inventory is in place

There were discussions around the appropriateness of equipment in relation to resilience given the volume of work RGH was putting through one CT scanner. We did however note the efficiency of CT throughput.

Management and Leadership

During the visit the management team were honest and open about all of the issues we discussed with them. They accepted that many issues highlighted at a previous inspection remained incomplete. For a number of issues advice was sought from the inspection team and constructive criticism was received in a positive way. All of the staff we spoke to at the time of the visit were clearly committed and enthusiastic about the work they do and they too were honest and open in their discussions with us.

One of the issues that we highlighted as a significant concern was the lack of progress that had been made in relation to training. IR(ME)R requires records be in place and up to date. There was little evidence that progress had been made regarding the action agreed at the previous inspection and which should have been completed by March 2013.

In order to achieve compliance it is important that the senior management team fulfil their responsibility in ensuring this work is supported and completed.

Training

The regulations require that all practitioners and operators are adequately trained for the tasks undertaken and the employer keeps up to date records of this training.

There were no comprehensive or completed training records in place throughout the six hospitals. There was no documentation identifying entitlement or scopes of practice for the staff groups.

There were no training records for radiologists seen at the time of the inspection. We were informed that radiologists would only have equipment training records for new pieces of equipment and would not have records for older pieces of kit. It is important that senior management demonstrate their responsibility to ensure that this work is completed in a timely fashion as they remain non compliant with this regulation despite being previously informed of what is required. New fluoroscopy equipment was however in place and there were no radiologist training records for this despite it being new.

It was discussed at the time how the team know that all staff groups, including radiographers and radiologists are trained and competent including those individuals who support the community hospitals if there are no completed records in place. The records for staff at one of the other sites were reviewed on the day however these were not dated or signed.

Since the last inspection the team had developed a new staff induction and preceptorship records which is a good document however we were told at the time of the visit that these were no longer fit for purpose and were not being completed.

It was reported that out of hours CT was outsourced with additional support from a local radiologist on call from home for any queries. This arrangement was not documented in any of the employer's procedures and does need to be clarified for staff to ensure their understanding of who the practitioner is in these situations.

Recommendation

The Health board needs to review the training documentation for all staff groups and ensure that this is in place.

Delivery of a Safe and Effective Service

The inspection team were content that there were no major breaches apart from the lack of progress with training records occurring in relation to regulations and there were no significant concerns in relation to safety however it was a concern to discover that little progress had been made in relation to the recommendations made following the previous inspection in July 2012.

6. Next Steps

The health board is required to complete an improvement plan (Appendix A) to address the key findings from the inspection and submit their improvement plan to HIW within two weeks of the publication of this report.

The health board improvement plan should clearly state when and how the findings identified within the radiology at the Royal Glamorgan (and follow-up visit to Prince Charles) Hospital will be addressed, including timescales. The health board should ensure that the findings from this inspection are not systemic across other departments/ units of the health board.

The health board's improvement plan, once agreed, will be published on HIW's website and will be evaluated as part of the ongoing dignity and essential care inspection process.

Appendix A

Improvement Plan

Hospital: Royal Glamorgan and Prince Charles

Ward/ Department: Diagnostic Imaging

Date of Inspection: 3 and 4 November 2014

IR(ME)R Reference	Recommendation	LHB Action	Responsible Officer	Target Date
Regulation **4(3) c and 4(6)**	**Diagnostic Reference Levels (DRLs)** In line with the previous recommendation, appropriate local diagnostic reference levels (LDRLs) need to be established for their patient cohort. Action date for completion following previous inspection was December 2012 Some LDRLs are in place however it was apparent that these are regularly exceeded and require review. The remaining rooms using National DRLs require a dose audit to be undertaken	DRLS will be reevaluated with specific advice from RPA to advise on fitness and use of DRL Further Examination of the setting of DRL with RPA – this will be revised where advised appropriate.	CK PW AR Superintendents	Feb 15

	There is a need to review the local DRLs in place and ensure the two rooms where National DRLs are used has a dose audit undertaken	Initial RPA meeting set for 12.11.14. Advice on application / operation of local DRLs from RPA Weight measurements for patients taken to establish local DRL sample Dose audit will be completed across radiology rooms. Radiographers recording doses into Radis. All rooms will have appropriate DRL set.	CK AR CJ SM Superintendents Radiographers CJ SM Superintendent Radiographers	Completed Completed 31.1.15
Regulation 4(1) Schedule	**Procedures** The overarching IR(ME)R policy need to be reviewed to ensure it is fit for purpose and: • The content is streamlined with the employers procedures • Duplication is removed • Ensure it is approved by the Radiation Safety	Cwm Taf Policies and Procedures to be reviewed and signed off by Radiation Safety Committee. "Good practice" Documentation obtained.	CK PW CK	23.12.14 Completed

	Committee The employers procedures need to be reviewed based on the detailed feedback given at the time of the inspection visit. The review date on all procedures is March 2014 A process needs to be put in place and adhered to in relation to procedure review which includes version control, review dates, author and date approved Revision and updating of the Standard Operating Procedures (SOP's) and Standard Views documents are required along with clarification for all staff as to their requirement and use	Radiation Safety Committee booked for December 2014 – will underwrite revised documents Cwm Taf will assure document control for new editions of documentation. First Draft of Procedures and Policies to COO for consultation in Health Board Consultation ends / feedback amended / incorporated. Standard Views / SOP to be combined and submitted for approval to RSC	CK AT CK PJ CW CK PJ CW CK PJ CW CJ PJ	Booked / completed 23.12.14 10.12.14 19.12.14 23.12.14
Regulation 11(4) Schedule 2	**Training** Whilst we acknowledge the approach being taken to develop appropriate training records based on the previous	Training records will be completed for radiology equipment across Cwm Taf.	CK PW	28.2.15

	recommendation, progress in this area has been extremely slow. This was due to be completed in March 2013 however there is still a vast amount of work to be completed. Less progress had been made with this process in Prince Charles hospital It is important that when progressing the above action, all groups of staff, including medical staff have training records for all types of equipment	All Staff groups will be included. Radiographers Training record completion Radiologist Training Record Completion Training record completion to be cascaded to Senior Radiographer Staff	Superintendent Radiographers / CD CJ SM Superintendent Radiographers PW CJ SM Superintendent Radiographers CK PJ CJ SM	28.2.15 31.12.14 31.01.15 5.12. 2014
Schedule 1b	**Entitlement** Despite some progress having been made in this area based on the previous recommendation it was confirmed by discussions with staff at Royal Glamorgan hospital that they were not clear about their roles under IR(ME)R. The employer procedure requires further review to ensure staff are clear about their entitlement and duty holder roles.	Employer Procedures will be reviewed for RSC in December 2014 Staff will have individual entitlement reviews and documentation. Entitlement / roles will be clarified during	CK PW PJ Supt Radiographers	23.12.14 28.2.15

		review. Radiographer entitlement documentation completed and signed off by radiographers. Radiologist entitlement documentation completed and signed off by medical staff	CJ PJ SM Supt Radiographers PW PJ CJ SM Supt Radiographers	31.1.15 28.2.15

Health Board Representative:

Name (print): ……..Chris Kalinka.....

Title: .....Radiology Directorate Manager....

Signature: .....C Kalinka.....

Date: .....1.12.14.....