Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

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

Nuclear Medicine Department, Morriston Hospital, Swansea Bay University Health Board

Inspection date: 11 and 12 June 2024
Publication date: 01 October 2024

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Digital ISBN 978-1-83625-687-8

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

Our purpose

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

Our values

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

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

Our goal

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

Our priorities

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced Ionising Radiation (Medical Exposure) Regulations inspection of the Nuclear Medicine Department at Morriston Hospital, Swansea Bay University Health Board on 11 and 12 June 2024. During our inspection we looked at how the department complied with the Regulations and met the National Minimum Standards for Independent Health Care Services in Wales.

Our team for the inspection comprised of two Senior HIW healthcare inspectors and a Senior Clinical Officer Nuclear Medicine 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 Senior HIW healthcare inspector.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. A total of 17 questionnaires were completed by patients or their carers and 14 were completed by staff. Feedback and some of the comments we received appear throughout the report.

Where present, quotes in this publication may have been translated from their original language.

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Patients provided positive feedback about their experiences of attending the Nuclear Medicine Department. We found staff treated patients with courtesy, respect and kindness. Feedback from patients also supported this. We also found staff provided care in a way that protected and promoted patients' rights.

Patients told us they had been provided with sufficient information and had been involved as much as they had wanted to be in their care.

This is what the service did well:

- Patients provided positive feedback and comments about the attitude and approach of the staff looking after them
- Promotion of the Welsh language through signage, information and staff identification meant that the 'active offer' of Welsh was available
- Patients told us they didn't have to wait long for their examination or scan
- The environment was bright and airy.

Delivery of Safe and Effective Care

Overall summary:
We found good compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017 across the Nuclear Medicine Department.

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

Most staff we spoke with had a good understanding of their roles and responsibilities under IR(ME)R 2017 regulations.

This is what we recommend the service can improve:

- Improve the information included in patient information to ensure clarity and understanding around the radiation risk
- Make arrangements to clearly show the outcome of clinical audits, the actions to be taken, the person responsible and the date for completion
- Continue the efforts to ensure that quality assurance (QA) procedures and documentation is standardised and duplication minimised

- Review processes and training of staff to ensure that processes and documentation are consistent.

This is what the service did well:

- Senior staff working for the Nuclear Medicine Department provided a broad range of examples of IR(ME)R audits as well as clinical audits
- Medical physics support was available and their knowledge extensive.

Quality of Management and Leadership

Overall summary:
Clear lines of reporting and accountability were described and demonstrated during the inspection.

Feedback from staff was generally positive around the leadership and management of the organisations they worked for.

This is what we recommend the service can improve:

- Reviewing and consolidating employers' procedures, documentation and patient information
- Review and improve efficiencies around the allocation of administrative tasks to clinical staff.

This is what the service did well:

- Introduction of a cloud based document control system that has been newly introduced.

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
HIW issued online and paper questionnaires to obtain patient views on services carried out at the department to complement the HIW inspection in June 2024. In total, we received 17 responses from patients at this setting. Responses were positive across all areas, with all who answered rating the service as 'very good'. Some comments we received about the service are shown below:

> *"If I could rate overall service as excellent I would. The staff were superb. I don't like scans of needles and they took time to make sure I was ok. Putting me at ease."*

> *"Very friendly staff, helpful and considerate."*

Health promotion
There were bilingual (English and Welsh) posters displayed that provided information to patients about having an X-ray and a nuclear medicine procedure, also to advise staff if they may be pregnant or breastfeeding. Relevant information was made available to patients about the associated risks and benefits of the intended exposure.

We saw health promotion material displayed in the waiting areas within the nuclear medicine department. This included information on the benefits of adopting a healthy lifestyle.

Dignified and respectful care
There were suitable arrangements in place to promote patient privacy and we noted staff made efforts to promote patents' privacy and dignity, such as locked doors. We found all staff treated patients with courtesy, respect, and kindness.

All respondents who answered this question agreed that:

- Staff treated them with dignity and respect
- Measures were taken to protect their privacy
- They were able to speak to staff about their procedure without being overheard by other patients
- Staff listened to them.

When asked whether patients' privacy and dignity were maintained, all the staff who answered the question in the questionnaire agreed.

Patient information and consent
All respondents who completed a HIW questionnaire told us they were given information related to their examination or scan. In addition, all respondents who answered the question in the HIW patient questionnaire also told us they had been given written information on who to contact for advice following their examination or scan.

All respondents who answered the question in the HIW patient questionnaire told us they had been involved as much as they wanted to be in decisions about their examination or scan. Similarly, all respondents who completed a HIW patient questionnaire told us staff had explained what they were doing, had listened to them and answered their questions.

Communicating effectively
The Welsh language was well promoted within the department. We saw bilingual posters in both Welsh and English with information for patients clearly displayed within the department. We saw clear signage in place to direct visitors to the department and a photo board was displayed for patients to be able to identify staff members who may be caring for them. We saw appointment letters and the next steps for the patient documentation, which were in Welsh and English.

Staff we spoke with described some of the arrangements in place to help people with hearing difficulties and those whose first language was not English. There was a hearing loop available in the main reception. All staff that we spoke with were aware of how to access translation services.

People's rights
We found staff working in the Nuclear Medicine Department working in a way that protected and promoted patient rights. The arrangements in place to make the service accessible to patients, such as wheelchair access was described. The department was accessible with wide doors, clear corridors and spacious treatment rooms all with level access.

There were several health board inclusion groups. Staff we spoke with said that everyone would be treated fairly, with no discrimination, in accordance with health board values.

Staff were working in a way that protected and promoted patient rights. We were told that equality and diversity training for all staff was mandatory. All staff we spoke with confirmed they had completed this course online. Staff we spoke with

had a good awareness of their responsibilities in protecting and promoting patients' rights when attending the department. They were able to confirm the arrangements in place to promote equality and diversity in the organisation.

Most staff (86%) that answered the HIW survey said they had fair and equal access to workplace opportunities and that the workplace was supportive of equality and diversity.

Delivery of Safe and Effective Care

Compliance with The Ionising Radiation (Medical Exposure) Regulations 2017

Employer's duties: establishment of general procedures, protocols and quality assurance programmes

Procedures and protocols
The employer had established written procedures and protocols as required under IR(ME)R 2017 for the Nuclear Medicine Department. There was also an Ionising Radiation Protection Policy (IRPP). Staff we spoke with were aware of where to find the written employer's procedures relevant to their practice. They thought that the procedures were clear and easy to understand, they said that they would be informed of any changes to procedures verbally or by email.

Procedures we viewed showed some quality control measures and document control. However, throughout the inspection there were some inconsistencies and duplication noted on some employer's procedures. Some procedure documentation reviewed, relating to nuclear medicine, did not have consistent review and indexing systems in place. During the inspection, it was confirmed that all nuclear medicine related procedures and protocols were in the process of being uploaded to an online portal to ensure that effective sharing and quality assurance for all documents can take place in line with IR(ME)R 2017 requirements.

Referral guidelines
HIW reviewed documentation and procedures in relation to referrals and referral guidelines. Staff we spoke with described these guidelines. We confirmed with staff members within the department that referrers' practice accurately reflected the written employer's procedures. The pre-inspection information indicated that the referral process used European Commission referral guidelines for imaging for nuclear medicine referrals. The relevant employer procedure (EP3- Procedure for referral and referral criteria) did not reference these guidelines.

The employer must ensure that, if the European Commission referral guidelines for nuclear medicine are followed, that they are referenced in the employer procedure and made available to referrers.

On reviewing a sample of referral forms and the corresponding radiology information system (RadIS), we noted some inconsistencies. The referrer details and information on the referral form was not always accurately replicated on

Radis. We also saw that the authorisation of the exposure is not always noted in the correct place on the form. Confirmation was received that indicated that referral forms are audited for IR(ME)R compliance. However, given the inconsistencies noted on the review of a sample of referral forms, this audit process needed reviewing.

The employer must

- **Review and strengthen the referral form audit process in employer procedure 3** - Procedure for referral and referral criteria

- **Review process of recording referrer on electronic system to accurately reflect the referrer**

- **Review the process for the completion of other information on referral forms such as authorisation in a consistent manner.**

Diagnostic reference levels
HIW reviewed a suitable written employer's procedure in place for the use and review of diagnostic reference levels (DRLs).

We confirmed that local DRLs had been established for some tests. These were equal to or below national DRLs for the nuclear medicine administration and the hybrid CT.

Within the department we saw that both national and local DRLs were displayed for reference for the hybrid CT. Best practice would be to display one DRL in use for each procedure rather than both the local and national to reduce the risk of potential error. The use of each set of DRL's was not clear in the employers procedure.

The employers procedure should be updated to clarify the purpose of both set of DRL's that are being displayed and how they are to be used.

Medical research
Whilst there was a written employer's procedure in place for research, senior department staff confirmed that the Nuclear Medicine Department does not participate in research involving medical exposures.

Entitlement
HIW reviewed the employer's written procedure in place to identify individuals entitled to act as a referrer, practitioner or operator.

Documentation confirmed that the Chief Executive (the employer) was designated as the employer with overall responsibility for compliance with duties required by IR(ME)R 2017 regulations. They had delegated the task of entitlement to appropriate persons and details were confirmed during the inspection process.

We viewed the IR(ME)R training records and entitlements of five staff members. Records confirmed that entitlement is signed off annually at individual staff performance appraisal and development review. Some irregularities were noted with the process for competency assessment where two members of staff signed each other off which was not appropriate.

The employer needs to ensure that training records of the staff should be updated to ensure that staff competences were assessed by an appropriate individual who has been delegated the task by the employer.

We confirmed the employer and practitioners held valid licences to undertake the intended exposures involving the administration of radioactive substances. We saw that processes were in place to ensure that these licences were checked and updated regularly.

Patient identification
We noted a written employer's procedure in place relating to the identification of individuals to be exposed to ionising radiation. Staff we spoke with were able to describe the procedure to correctly identify individuals. Additionally, they were aware of the procedure to correctly identify individuals who may not be able to identify themselves.

Individuals of childbearing potential (pregnancy enquiries)
Posters were clearly displayed in the waiting areas advising patients who were or might be pregnant or breastfeeding to inform staff prior to them having their examination or scan. This information was displayed in both Welsh and English and suitable pictograms were also used. The appointment letters asked patients to contact the department if there was a chance of pregnancy or if they were breastfeeding. Staff confirmed that children and young people having their investigation or scan would come straight into the injection room in the department from the ward, rather than use the waiting room. During the first day of our visit, there was no poster on display in relation to pregnancy in this area. This was rectified during the inspection and a poster was displayed in the injection room and this would ensure that all young people, attending directly from the ward, would be able to see the poster prior to receiving the exposure.

We reviewed some inconsistencies in the making of pregnancy enquiries noted between the forms used (referral and patient history), policy and the relevant

employer's procedure. Forms seen and staff confirmed that pregnancy confirmation was a yes / no question for patients. The process was not clearly defined if a patient answered maybe to include the process for pregnancy testing.

The employer must review processes and training of staff in relation to making pregnancy enquiries checking to ensure that current process, employer's procedure and all forms are consistent and clearly detail the procedure used.

Benefits and risks
Staff we spoke with explained the process for providing the individual to be exposed (or their representative) with adequate information on benefits of having the exposure and the risks associated with the radiation dose. This information would be discussed during the pre-procedure explanation prior to the administration and a leaflet would be provided afterwards.

We viewed the written employer's procedure and the nuclear medicine procedure for providing written instructions and information to each patient or the patient's representative. The written patient information that we saw was unclear around the radiation risks of the procedure and provided two different values.

The employer must review and update the radiation risk information provided to patients around equivalent doses of radiation exposure.

Clinical evaluation
A written employer's procedure was in place for carrying out and recording a clinical evaluation of each medical exposure within the department. This procedure was reviewed against a sample of records on site which confirmed that appropriate clinical evaluation had taken place in a timely manner.

Non-medical imaging exposures
Whilst there was a written employer's procedure in place for referral and management of non-medical exposures, we were told that these rarely occurred in nuclear medicine.

Employer's duties - clinical audit
There was a robust clinical audit programme described and there were good examples of clinical audits conducted by the Nuclear Medicine Department. The lead practitioner was heavily involved in this process which was positive to note. Clinical staff were actively encouraged to take part in audits and to share learning through staff updates and meetings. However, the examples of reports provided did not seem to include evidence of how practice was changed, actions required, who was responsible for the actions and how the completion of the actions was

verified. These were all of the requirements of an audit report as set out in the relevant employer's procedure.

The employer is required to provide HIW with details of the action taken to clearly show the outcome of clinical audits, the actions to be taken, the person responsible for the actions and the date for completion for all audits completed.

IRMER audit

There was a robust IR(ME)R audit programme and there were good examples of IR(ME)R audits completed. Examples included IR(ME)R request form audits and reviews of compliance with DRL's.

Employer's duties - accidental or unintended exposures

There was a written employer's procedure in place for the reporting, recording, investigating and the analysis of significant accidental or unintended exposures involving radiation for the Nuclear Medicine Department. **It was noted that this procedure would benefit from a review to reflect current guidance on the reporting criteria for significant accidental and unintended exposures.**

Most staff who answered said their organisation encouraged them to report errors, near misses or incidents (11/14) and felt staff who were involved were treated fairly (10/13). Most who answered said they would feel secure raising concerns about unsafe clinical practice (9/12) but fewer are confident their concerns would be addressed (4/8).

Some comments we received about reporting incidents and concerns are below:

> *"There is an environment for sweeping concerns raised under the carpet and being defensive about work instead of seeing it as an opportunity to learn and improve. Concerns raised about safety of practise, compliance with IRMER regulations and the law and staff competence have all been met with disdain. Little or no action or measures have been taken to change..."*
>
> *"…Staff are not encouraged to report near misses. There is a culture of not admitting mistakes or insecurities, which leads to staff undertaking work outside of their scope of practice and not seeking out advice. NM is treated as a poor relative in radiology and the usefulness of the technique is not realised to its full potential."*

The employer should review the feedback received from staff in relation to the reporting of incidents and address concerns.

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

The sample of referral forms we examined showed referrals to the Nuclear Medicine Department had been made in accordance with the established referral guidelines. We saw the forms included sufficient clinical details and noted some inconsistencies in the completion of the forms as previously indicated.

We were provided with examples of audits that showed suitable arrangements were in place to monitor staff compliance with the written employer's procedures used in the Nuclear Medicine Department.

Justification of individual exposures
We were told that exposures performed at the Nuclear Medicine Department were justified and authorised by entitled practitioners working at the Nuclear Medicine Department.

There was a written employer's procedure in place for the justification and authorisation of exposures at the Nuclear Medicine Department. Details of the justification of exposures for carers and comforters' was included in a separate procedure.

Referral documentation examined followed the employer's procedure.

Optimisation
Suitable arrangements were described in relation to how practitioners and operators ensure exposures performed at the Nuclear Medicine Department were as low as reasonably practicable (ALARP). These arrangements included how practitioners and operators paid particular attention in relation to individuals in whom pregnancy could not be excluded and individuals who were breastfeeding.

Paediatrics
Senior staff described suitable arrangements for the optimisation of exposures to children in line with ARSAC guidance. These included reducing DRLs, scaling down adult administered activity according to a child's weight and operators adjusting clinical protocols accordingly.

Carers or comforters
There was a suitable written employer's procedure in place to establish dose constraints and guidance for the exposure to carers or comforters at the Nuclear Medicine Department. This clearly set out the dose constraints for all nuclear medicine examinations.

Expert advice
We confirmed the employer had appointed and entitled MPEs to provide advice on radiation protection matters and compliance with IR(ME)R 2017.

Staff we spoke with said they could access expert advice and had never had an issue when they could not contact the MPE. It was positive to note the involvement of the MPEs, who were clearly engaged with the department despite not being on site on a daily basis. There was good communication between the MPEs and the nuclear medicine staff. There were some concerns raised around the involvement of MPEs at a late stage of procurement of equipment in the past. Senior staff for the department confirmed that their intention was to involve MPEs more fully from the start going forwards.

The employer should ensure that nuclear medicine MPEs are actively engaged and involved with the service to ensure effective developments and improvements are made. This should include, but not limited to, the procurement of all nuclear medicine equipment, including that for use in surgery.

The involvement extended to MPE audits of the service which were notable, albeit on a two-year cycle. There were no concerns given by the MPEs into the operation of the Nuclear Medicine Department.

Equipment: general duties of the employer
We saw that there was new equipment that had been recently commissioned in the department however this contained some repetition and duplication. There was a QA programme for the Nuclear Medicine Department in respect of the equipment used in the department. Suitable arrangements were described for the acceptance testing of new equipment, performance testing at regular intervals and performance testing following equipment maintenance. Equipment QA issues were reported to the Health Board Radiation Safety Committee.

The employer should review and update the nuclear medicine QA procedures, eliminate the duplication between the QA handbook and the other nuclear medicine QA procedures and consolidate these as appropriate.

A suitable process was also described for identifying, reporting and escalating equipment faults to senior staff so that appropriate action could be taken. This included removing equipment from service. Up-to-date equipment inventories for equipment at the Nuclear Medicine Department were available and provided for the inspection.

Staff described the procedures used for QA as advised by the MPE.

Safe

Managing risk and health and safety

During a tour of the department, the environment appeared well maintained and in a good state of repair, the nuclear medicine area was newly refurbished with new equipment. It offered a bright, clean, clear and welcoming environment for patients. We did not identify any obvious hazards to the health and safety of patients and other individuals visiting the department. However, we did note that the carpet in the reception office of the department was in a poor state of repair and had holes in with tape to make it secure. This may represent a trip hazard for staff working within the department.

The health board should review the reception office environment and address any health and safety hazards to ensure that the risks to staff working in the department are minimised.

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

Infection prevention and control (IPC) and decontamination

We found suitable IPC and decontamination arrangements were in place. All areas accessible by patients were visibly clean and free of clutter. The equipment was also visibly clean and staff described suitable cleaning and decontamination procedures.

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

All patients who completed the questionnaire said that, in their opinion, the department was clean and, in their opinion, IPC measures were being followed.

All staff respondents to the questionnaire thought there were appropriate IPC procedures in place, that appropriate PPE was supplied and used, and that the environment allowed for effective infection control. All bar one member of staff agreed there was an effective cleaning schedule in place.

There was clear evidence that staff had completed IPC training. Staff we spoke with were aware of their responsibilities in relation to IPC and decontamination.

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. They were also able to describe the actions they would take if they had a safeguarding concern.

We checked a sample of five staff records and these showed that the appropriate level of safeguarding training had been completed.

Effective

Record management

We reviewed a sample of referral records for five patients. The sample we reviewed had a clear layout and had been completed in full although some discrepancies were noted.

They showed evidence of the relevant written employer's procedures, such as patient identification checks and confirmation of pregnancy, being followed by duty holders. They also showed evidence of exposures having been authorised, and hence justified.

Quality of Management and Leadership

Staff Feedback

HIW issued an online questionnaire to obtain staff views on services carried out by Morriston Hospital and their experience of working there. The questionnaire complemented the HIW inspection in June 2024. In total, we received 14 responses from staff.

Responses from staff were generally positive, with some negative comments left throughout the survey. All who answered were satisfied with the quality of care and support they give to patients. However, fewer agreed that they would be happy with the standard of care provided by their hospital for themselves or for friends and family (9/14). Just over half of respondents recommended their organisation as a place to work (8/14).

We received several comments on the service, some are shown below:

> *"The investment made by our trust in my department has allowed us to provide an up-to-date service that provides a safe and efficient service that benefits both service users and staff."*

> *"Staff working together to help each other and do their best for their patients is the thing that is keeping the service going. Many of us are going above and beyond to make up for shortfalls in staffing numbers and skill mix and increasing demand and targets, we are exhausted. We want our patients to have a safe and caring experience above all so we continue to do that to our best ability."*

> *"We are missing an experienced level of staff, it does feel like staff are trained, they leave, and we are back to square one. Not enough experienced staff to rotate through. Difficult to have time to scan patients and complete admin, as well as booking appointments etc. It is a pleasant and exciting room to work in but the lack of admin support makes it difficult on times."*

Governance and accountability framework

The Chief Executive had overall responsibility for the implementation of IR(ME)R with tasks, not responsibility, delegated through the management structure. The key responsibilities under IR(ME)R for the Chief Executive and duty holders were provided in the IRPP which showed clear lines of reporting and accountability.

Whilst we saw that the use of i-passport, a cloud based system to support the management and quality assurance of policies and procedures as positive, we noted that this system was new to the department and will take time to embed. During the inspection, we saw repetition in some documents and information referred to that was in many different folders in different places.

The department would benefit from making efficiency improvements by reviewing and consolidating documents and information where appropriate.

Workforce planning, training and organisational development
We were provided with details of the numbers and skill mix of staff working at, or on behalf of, the Nuclear Medicine Department. Staffing consisted of Consultant Radiologists, Radiographers, MPEs and Clinical Scientists.

Some staff that we spoke with told us of specific challenges related to the administrative tasks that they had completed in relation to patient appointment bookings. Senior staff confirmed an intention to centralise appointment bookings for the department within the health board. Very few staff (3/12) that answered the HIW survey felt there are enough staff for them to do their job properly. Although most staff (11/13) told us that they were able to meet the conflicting demands on their time at work.

> *"Not enough staff to run department effectively. Need admin staff to organised booking patients like Singleton does and also need admin staff or orderly to help with processing forms like singleton does..."*

The employer must review staffing provision and allocation of administrative tasks with a view to increasing efficiencies.

All respondents who answered felt they had appropriate training to undertake their role. Records reviewed indicated 90% compliance with mandatory training requirements. In relation to staff training records for IR(ME)R 2017 requirement, the records that we reviewed included obsolete documents and we would recommend that these are removed.

When asked what other training they would find useful, staff comments included:

> *"New scanner in, not enough dedicated time or exposure to different scans to be signed off completely."*

Citizen engagement and feedback

There were posters and information displayed on how patients can feed back on their experiences. This included information related to ‘Putting Things Right’ as well as a “You Said We Did” board.

4. Next steps

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

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

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

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

Appendix B - Immediate improvement plan

Service: Nuclear Medicine Department, Morriston Hospital, Swansea Bay University Health Board

Date of inspection: 11 - 12 June 2023

The table below includes any immediate non-compliance 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.

Risk/finding/issue	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
No immediate assurance issues were identified during this inspection					

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

Service representative:

Name (print):

Job role:

Date:

Appendix C - Improvement plan

Service: **Nuclear Medicine Department, Morriston Hospital, Swansea Bay University Health Board**

Date of inspection: **11 - 12 June 2024**

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.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	**The reception office carpet was worn and taped and could represent a trip hazard**	**The employer should review the reception office environment and address any health and safety hazards to ensure that the risks to staff working in the department are minimised**		Replacement of damaged carpet.	Morriston Radiology Site Lead / Estates Dept.	**Completed** - *New Carpet installed July 24.*
2.	**Recent commissioning of new equipment involved MPEs at a late stage in the process**	**The employer should ensure that nuclear medicine MPEs are actively engaged and involved with the service to ensure effective developments and improvements are made.**	The Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R 2017) regulation 14 (1)	Develop equipment procurement SOP using RCR guidance and IR(ME)R Regulations 2017, to ensure all key stakeholders including MPEs are actively engaged at the outset of any	Morriston Radiology Site Lead, Principle Clinical Scientist - NM, Consultant Clinical Scientist - CT,	**30 April 2025**

		This should include, but is not limited to the procurement of all nuclear medicine equipment including that for use in surgery		equipment procurement. SOP to be shared at Medical Exposure Group Meeting.	Head of Radiation Physics	
3.	**Some inconsistencies and duplication of information was seen in some Employer Procedures.**	**The employer must ensure that all documentation including written protocols, procedures and policies are part of a QA programme for documentation and include the required level of detail as set out within the employer's procedure for document control.**	IR(ME)R 2017 regulation 6 (1) (a) Schedule 2 (1)(d) and 6 (5)(b)	Review all documentation on i-passport to include the required level of detail as set out within the employer's procedure for document control.	Interim Quality Lead	**31 December 2024**
	Some procedure documentation reviewed related to nuclear medicine did not have consistent review and indexing systems in place	**The employer should review and update the nuclear medicine QA procedures eliminate the duplication between the QA handbook and the other nuclear medicine QA procedures and consolidate these as**	IR(ME)R 2017 regulation 15 (1) (a)	Duplicated QA procedures have been reviewed and removed from i-passport and consolidated into the QA handbook.	Interim Quality Lead, Radiology Nuclear Medicine Modality Lead, Principle Clinical Scientist	**Completed** - *Evidenced in i-passport Aug 24*

		appropriate.				
4.	**The pre-inspection information indicated that the referral process used European Commission referral guidelines for imaging for nuclear medicine referrals. The relevant employer procedure (3) did not reference these guidelines.**	**The employer must ensure that, if the European Commission referral guidelines for nuclear medicine are followed, that they are referenced in the employer procedure and made available to referrers.**	IR(ME)R 2017 regulation 6 (5) (a)	The use of European Commission referral guidelines was noted in error during completion of the SAQ, A review of all Key stakeholders confirmed the Nuclear Medicine service only uses i-refer.	Interim Quality Lead, Morriston Site Lead, Principle Clinical Scientist	**Completed** - *Evidenced in EP-3*
5.	**We found further details needed to be recorded around the process of clinical audit.**	**The employer for the Nuclear Medicine Department is required to provide HIW with details of the action taken to clearly show the outcome of clinical audits, the actions to be taken, the person responsible for the actions and the date for completion for all audits**	IR(ME)R 2017 regulation 7	Audit Template to be amended to include: action to be taken; date for completion and responsible person. Updated audit template to be shared with staff and noted in Radiology Governance Meeting.	Morriston Site Lead	**31 December 2024**

		completed.				
6.	**On reviewing a sample of referral forms and the corresponding Radis system and we noted some inconsistencies. The referrer details and information on the referral form was not always accurately replicated on Radis. We also saw that the authorisation is not always noted in the correct place.**	**The employer must: -** **Review and strengthen the referral form audit process in employer procedure 3 - Procedure for referral and referral criteria** **Review process of recording the referrer on electronic system to accurately reflect the referrer.**	IR(ME)R 2017 regulation 6 (2)	EP-3 to be reviewed and updated to include the current audit processes for referral form and Radis completion. Updated version to be noted in Radiology Clinical Governance Meeting. Meeting to be scheduled with MPEs, Clinical Director (CD), Radiology Services Manager (RSM), RIS & PACS Managers, to discuss the options to accurately reflect the referrer in RadIS.	Interim Quality lead, Morriston Site Lead – RadIS Manager Head of Radiation Physics, Radiology Site Leads, Interim Quality lead, Radiology Services Manager, Radiology Clinical Director – RadIS Manager	**30 April 2025** **31 October 2024**

		Review the process for the completion of other information on referral forms such as authorisation in a consistent manner		Develop business case for funding admin support for referrer monitoring & compliance.	Morriston Site Lead Radiology Services Manager, Radiology Interim Assistant Directorate Manager	**31 May 2025**
				Clinical Director to highlight need for authorisation signature box compliance at Radiology Education Meeting.	Radiology Clinical Director, Radiology Clinical Lead	**31 October 2024**
				IR(ME)R audits for all modalities to include authorisation signature box compliance. Updated documentation to be noted in Clinical Governance Meeting.	Site Leads and Modality Lead Radiographers	**30 November 2024**
7.	**We reviewed some inconsistencies in pregnancy enquiries**	**The employer must review processes and training of staff in relation**	IR(ME)R 2017 regulation 11 (1)(f) and IR(ME)R	The policy, forms and EP-6 to be reviewed and updated to include the	Interim Quality lead, Site Lead Radiographers,	**30 April 2025**

	noted between the forms used, policy and the relevant employer's procedure.	**to** making pregnancy enquiries **to ensure that current process, EP and all forms are consistent and clearly detail the procedure used.**	2017 regulation 6 (1) (a) Schedule 2 (1)(c)	process for all individuals unsure of their pregnancy status. Updated documentation to be noted in Clinical Governance Meeting.	Radiology Services Manager, Radiology Clinical Director & MPEs	
8.	**The patient information that we saw was unclear around risks and equivalent doses of radiation exposure**	**The employer must review and update the radiation risk and benefit information provided to patients.**	IR(ME)R 2017 regulation 12 (6) and 12 (7)	The patient information letter has been updated to clearly reflect the radiation risk/benefit. This will be reviewed regularly and updated as required.	Interim Quality lead, Nuclear Medicine Modality Lead, Principle Clinical Scientist, Consultant Clinical Scientist	**Completed** - *Evidenced in RadIS & Patient Letters as of Aug 24*
9.	**Some staff comments indicated that they were not always confident that concerns around unsafe clinical practice would be addressed**	**The employer should review the feedback received from staff in relation to the reporting of incidents and address concerns**		Staff to be reminded that near misses, incidents and risks need to be reported/identified via Datix, where they are investigated and escalated as appropriate via the Radiology, Unit and Health Board Governance	Interim Quality lead, Site Lead Radiographers, Radiology Clinical Lead	**31 August 2024**

				processes.		
				Staff to be reminded of the available Health Board policies and services for raising individual concerns e.g. 'Raising Concerns Procedure', the Guardian service.	Interim Quality lead, Site Lead Radiographers & Radiology Clinical Lead	**31 August 2024**
				A Clinical Governance Report will be uploaded to i-passport and sent to all staff to ensure they have visibility and awareness of all activities relating to quality and clinical governance.	Interim Quality lead	**30 September 2024**
				Minutes of all Clinical Governance Meetings are currently available on Radiology SharePoint for visibility of how current near misses, risks and incidents are managed.	Interim Quality lead	**Completed-** *Evidenced in Radiology Sharepoint Site*

				Develop Strategic plan in collaboration with Singleton Nuclear Medicine service for joint Clinical Governance approach to ensure visibility of any potential concerns.	Morriston Site Lead, Radiology Services Manager, Head of Nuclear Medicine Singleton	**31 January 2025**
10.	**We saw repetition and some inconsistencies in some documents. Folders containing information were also in different locations**	**The department would benefit from making efficiency improvements by reviewing and consolidating documents and information where appropriate.**	IR(ME)R 2017 regulation 6 (1) and 6(2)	All documents to be reviewed; consolidated & added into the i-passport documentation system. A singular hardcopy will be held in the Modality Lead Radiographer's office for Business Continuity purposes.	Interim Quality lead, Morriston Site Lead, Nuclear Medicine Modality Lead	**30 April 2025**
11.	**Staff members told us that a large amount of their clinical time is taken up performing administrative tasks like processing forms**	**The employer must review staffing provision and allocation of administrative tasks with a view to increasing efficiencies.**		Develop a joint business case with Singleton Nuclear Medicine service to fund the administrative staff required for singular centralised booking.	Head of Nuclear Medicine Singleton, Morriston Site Lead, Radiology	**31 August 2025**

	and appointments				Services Manager	
12.	**Some irregularities were noted with the process for competency assessment where two members of staff signed each other off which was not appropriate.**	**The employer needs to ensure that training records of the staff should be updated to ensure that staff competences were assessed by an appropriate individual who has been delegated the task by the employer.**	IR(ME)R 2017 regulation 17 (1)	Training records have been updated following inspection feedback.	Morriston Site Lead	**Completed** - *Evidenced in Training record*
13.	**Best practice would be to display one DRL in use for each procedure rather than both the local and national to reduce the risk of potential error. The use of each set of DRL's was not clear in the employer's procedure.**	**The employer's procedure should be updated to clarify the purpose of both set of DRL's that are being displayed and how they are to be used.**	IR(ME)R 2017 regulation 6 (1) (a) Schedule 2 (1)(f)	Service has now adopted singular DRL's for use in CT imaging (only local DRL's are now displayed). The Employers Procedure (EP 10) will be reviewed and updated as applicable.	Nuclear Medicine Modality Lead, Morriston Site Lead, Consultant Clinical Scientist Interim Quality Lead; MPEs; Site Leads; Clinical Director; RSM	**Completed** **31 January 2025**

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): Sue Moore

Job role: Service Group Director (Morriston Hospital)

Date: 19th August 2024