The Regulation and Quality Improvement Authority

Inspection Report

22 October 2025

Ards Hospital
Radiology Department

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Telephone: 028 9055 0494

Information on legislation and standards underpinning inspections can be found on our website https://www.rqia.org.uk/ and The Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2018 known as IR(ME)R

1.0 Service information

Organisation/Registered Provider: South Eastern Health and Social Care Trust (SEHSCT)	**Department Inspected:** Ards Hospital Radiology Department
Name of Employer: Mrs Roisin Coulter Chief Executive (SEHSCT)	**Radiology Services Manager (RSM)** Ms Jayne Hutchinson

Brief description of how the service operates:

The Ards Hospital radiology department provides an adult and limited paediatric general radiology imaging service. The service operates Monday to Friday from 08:50am to 5:00pm. No imaging services are provided outside of these hours.

The department is equipped with two plain film rooms, installed as retrofit units in 2009 and 2013, both of which were upgraded to digital radiography (DR) in 2020. A mobile X-ray unit was also installed in 2020, although demand for mobile imaging is minimal, with only two mobile examinations carried out over the past year.

Before the inspection Ms Jayne Hutchison (RSM), and her team were asked to complete a self-assessment form (SAF). The submitted SAF confirmed that Ards Hospital radiology department has carried out 11,155 general radiography images in the last year.

Consultant radiologist support is provided remotely from other Trust sites on a rotational basis. Staffing within the department consists of 2.33 whole-time equivalent (WTE) radiographers, supplemented by additional rotational staffing cover from the Ulster Hospital site and a part-time Assistant Practitioner (AP) who also works as an operator within a limited scope of practice.

The team is supported by a Medical Physics Expert (MPE) contracted from Regional Medical Physics Service (RMPS) based in the Belfast Health and Social Care Trust (BHSCT).

Referrals are received predominantly from GPs, including those linked to ward-based GP services. Additional referrals are made by physiotherapists, advanced practice nurses working within orthopaedic clinics and podiatrists acting as non-medical referrers from outpatient clinics.

It is noted that a breast screening department is located on the Ards Hospital site. However, the RSM confirmed that this service is managed by the Belfast Health and Social Services Trust and is separate from the local X-ray department's operations.

2.0 Inspection summary

On 22 October 2025, warranted Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspectors from the Regulation and Quality Improvement Authority (RQIA), with advice being provided by the United Kingdom Health Security Agency (UKHSA) staff, carried out an IR(ME)R inspection of Ards Hospital radiology department, as part of RQIA's IR(ME)R inspection programme.

For the 2025/26 inspection year the inspections will focus on the following key themes:

- IR(ME)R governance, including arrangements for compliance with IR(ME)R services provided outside of the main department, communication with other departments, commissioning of new services
- Justification and authorisation process including use of authorisation guidelines where appropriate
- Management of equipment performance
- Patient identification including pause and check
- Nuclear medicine therapies and radiotherapy - the study of risk
- Radiotherapy – focus on the breast pathway
- Any other areas identified through the review of the submitted SAF and supporting documentation

The purpose of our focus is to minimise risk to service users and staff, whilst being assured that ionising radiation services are being provided in keeping with the IR(ME)R (Northern Ireland) 2018 regulations.

Previous areas for improvement were also reviewed.

The service was notified of the inspection date and time; and requested to complete and submit a SAF and include supporting documentation to be reviewed in advance of the inspection. The site inspection process included:

- Discussion with management and staff
- Examination of relevant radiology documentation
- Review of the department and facilities
- Review of patient records to ensure compliance with IR(ME)R
- Discussion with patients/representatives (where appropriate)

IR(ME)R is intended to protect individuals undergoing exposure to ionising radiation as follows:

- Patients as part of their own medical diagnosis or treatment
- Individuals as part of health screening programmes
- Patients or other persons voluntarily participating in medical or biomedical, diagnostic or therapeutic, research programmes
- Carers and comforters
- Asymptomatic individuals
- Individuals undergoing non-medical imaging using medical radiological equipment

3.0 How we inspect

RQIA is responsible for monitoring, inspecting and enforcement of IR(ME)R. The inspection process includes the gathering and review of information we hold about the service, examination of a variety of relevant written procedures, protocols and records, and discussion with relevant staff. RQIA inspection reports reflect on how a service was performing at the time of inspection, highlighting both good practice and any areas for improvement.

The information obtained is then considered before a decision is made on whether the service is operating in accordance with the relevant legislation and professional standards. Examples of good practice are acknowledged and any areas for improvement are discussed with the relevant staff in charge and detailed in the quality improvement plan (QIP).

As already stated, prior to the inspection, the service was requested to complete a SAF and provide RQIA with all relevant supporting information including written policies and procedures. This information was shared with UKHSA prior to the inspection and was used to direct discussions with key members of staff working within the radiology department and provide guidance for the inspection process.

It is the responsibility of the Employer to ensure compliance with legislation, standards and best practice, and to address any deficits identified during our inspections.

4.0 What people told us about the service

As this was a busy radiology department, patients were awaiting or immediately recovering from radiology diagnostic procedures, it was deemed inappropriate to seek to speak to these patients on the day of the inspection.

5.0 The inspection

5.1 What has this service done to meet any areas for improvement identified at or since the last inspection?

Areas for improvement from the last inspection on 22 October 2020		
Action required to ensure compliance with The Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2018		**Validation of compliance**
Area for Improvement 1 **Regulation:** 6 Schedule 2.1(f) **Stated:** First time	The Employer shall review and amend Employer's Procedure F to accurately reflect operational practice, the arrangements for reviewing Diagnostic Reference Levels (DRLs) and devising local DRLs. This Employer's Procedure should then be fully implemented.	**Met**

	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Review of the Employer's Procedures noted that they had been updated to reflect previous areas of improvement.	
Area for Improvement 2 **Regulation:** 6(5)(c) **Stated:** First time	The Employer shall formalise the use of DRLs as national or local. Meaningful DRLs ratified by the Radiation Safety Committee should be displayed within the department.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Management confirmed following the inspection that national and local DRLs had been identified and were ratified by the Radiation Safety Committee. However, further detail on matters arising in relation to DRLs is provided in section 5.2.5	
Area for Improvement 3 **Regulation:** 6(5)(c) & Schedule 2.1 (f) **Stated:** First time	The Employer shall ensure the work to establish local DRLs is progressed and that they are fully ratified in accordance with Employer's Procedure F.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Management confirmed following the inspection the work to establish local DRLs progressed and that they had been fully ratified in accordance with Employer's Procedure F. However, further detail on matters arising in relation to DRLs is provided in section 5.2.5	
Area for improvement 4 **Regulation:** 6(2) **Stated:** First time	The Employer shall ensure that IR(ME)R compliance audit reports should be formalised and include more detailed information on the findings of the audits and include an action plan where appropriate to address any deficits noted.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. The IR(ME)R compliance audit reports were formalised and included more information on findings and an action plan. Further detail on IR(ME)R compliance audits is provided in section 5.2.1.	

Area for improvement 5 **Regulation:** 7 **Stated:** First time	The Employer shall review and amend Employer's Procedure I to include the information outlined in Section 6.1 of the self-assessment form, any changes made to the audit process and improve and expand the detail around the QA for written procedures and equipment.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Review of the Employer's Procedures noted that they had been updated to reflect previous areas of improvement.	
Area for improvement 6 **Regulation:** 8 **Stated:** First time	The Employer shall ensure that Employer's Procedures J and K are both reviewed and amended as detailed in the report. Employer's Procedure J should describe the systems and processes in place to reduce the probability and magnitude of accidental or unintended exposures. Consideration should be given to devising one Employer's Procedure K, with specific clinically significant accidental or unintended exposures (CSAUE) and significant accidental or unintended exposures (SAUE) sections.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Review of the Employer's Procedures noted that they had been updated to reflect previous areas of improvement. Further detail is provided in section 5.2.1 of this report.	
Area for Improvement 7 **Regulation:** 8(3) **Stated:** First time	The Employer shall establish a meaningful system for trend analysis of accidental or unintended exposures which should include reference to any identified patterns and any action taken as a result of the analysis.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further details on this matter is outlined in section 5.2.1. of this report.	
Area for Improvement 8 **Regulation:** 6 Schedule 2.1(b) **Stated:** First time	The Employer shall review entitlement arrangements for duty holders and ensure that Employer's Procedure A is amended to fully reflect these arrangements and include who is entitled to justify carers and comforters exposures.	**Met**

	The Employer's Procedure must be implemented and strictly adhered to.	
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Review of the Employer's Procedures noted that they had been updated to reflect previous areas of improvement. Further detail on justification and authorisation is provided in section 5.2.2.	
Area for Improvement 9 **Regulation:** 6 Schedule 2.1(b) **Stated:** First time	The Employer shall ensure that individual entitlement is in place for all grades of radiographers.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail on entitlement is provided in section 5.2.1.	
Area for improvement 10 **Regulation:** 6 Schedule 2.1(b) **Stated:** First time	The Employer shall ensure that third party provider's staff are entitled under SEHSCT Employer's Procedures and this must include evidence of how assurance is obtained that they are suitably qualified, trained and competent to carry out their duty holder role.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Further detail on entitlement is provided in section 5.2.1.	
Area for improvement 11 **Regulation** 6 Schedule 2.1(b) **Stated:** First time	The Employer shall ensure that entitlement arrangements for Medical Physics Experts (MPEs) are reviewed, clarified and consolidated in practice. Employers Procedure A should be updated accordingly to reflect this.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. There are clear entitlement arrangements in place for MPEs. Further detail on entitlement is provided in section 5.2.1.	
Area for improvement 12 **Regulation** 6 Schedule 2.1(b) **Stated:** First time	The Employer shall ensure that there are formal entitlement arrangements for general practitioners (GP) as referrers including how they are provided with referral criteria. The SEHSCT should maintain an updated GP referrers list.	**Met**

	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. A formal group entitlement arrangement is in place for GPs as referrers and signed by the medical director. Referrers are provided with information on referral criteria via email.	
Area for Improvement 13 **Regulation** 6 Schedule 2.1(b) **Stated:** First time	The Employer shall ensure that Employer's Procedure R for Non-Medical Referrers(NMR) includes the arrangements for entitlement under SEHSCT Employer's Procedures for NMRs from other trusts, taking into account evidence from their host Trust of entitlement, scope of practice, training and competencies.	**Met**
	Action taken as confirmed during the inspection: This area for improvement has been assessed as met. Review of the Employer's Procedures noted that they had been updated to reflect previous areas of improvement.	

5.2 Inspection findings

5.2.1 Are there appropriate IR(ME)R governance arrangements in place to ensure compliance with the legislation?

Organisational Structures and Governance Committees

The overall responsibility for ensuring compliance with IR(ME)R lies with the Employer. The role of the IR(ME)R Employer in the SEHSCT is held by the Chief Executive. The SEHSCT Ionising Radiation Safety Policy approved in October 2025 sets out the organisational structures, lines of accountability and governance structures.

The task of implementing IR(ME)R has been delegated to the Medical Director who acts as the Chair of the Radiation Safety Sub-Committee (RSSC) and is responsible to the Chief Executive for the implementation of the Employer's duties under the IR(ME)R. The RSSC meets twice a year. Review of minutes confirmed a robust approach to radiology governance.

The radiology governance lead produces a quarterly governance report. The governance lead emails team leads requesting the required information for the report. This report includes IR(ME)R audit results, radiation incidents and shared learning. It was noted to be well written and contained valuable information. The quarterly report is shared with the radiology team. In addition the quarterly governance report is provided to the Employer by the Assistant Director.

It was good to note that the service has established an image optimisation team (IOT) which is a multi-disciplinary group. IOT meetings are scheduled to take place every three to four months, and include attendance from site leads, modality leads, the RSM and the MPE.

However, due to staffing challenges this programme has not been followed (as noted by the IOT meeting dates). Management confirmed that the frequency of IOT meetings will resume to every three to four months following the stabilisation of staffing and management arrangements. A standing agenda is in place for the IOT, which includes audits, updates to policies and protocols as well as DRLs. It was advised that IOT meeting actions and outcomes should be considered to be included in meeting minutes. Management gave assurances on this matter.

The Clinical Director for Radiology is accountable to the Trust Medical Director who is part of the executive management team. Monthly business meetings are conducted between the radiologists and co-ordinated by the Clinical Director. An agenda is set, with standing items, which includes governance, audits and quality reports.

All meetings were found to be well attended with robust scrutiny being applied to the matters discussed. As with the IOT meetings, it was advised to clearly record the actions and outcomes of governance meetings in the minutes. The Trust SharePoint acts as the quality management system (QMS), where meeting minutes are stored for staff to look at retrospectively. Clear escalation processes were described by management and staff should a serious issue arise.

Communication

Management and staff confirmed there was good communication within the radiology department and with other Trust radiology departments. Where possible, there is a morning huddle in the Ards Hospital radiology department which is led by the site lead. Six weekly staff meetings are utilised for communication within the team. Minutes are disseminated to staff, updates are shared via email and the opportunity to add items to the agenda are also put forward. There is a central point on SharePoint in the staff area for access to procedures and other relevant information. The team can also contact each other via e-mail and WhatsApp platforms. Radiographers confirmed communication was good and they felt well supported in their role.

Updates to standard operating procedures or any new documents are disseminated amongst staff via team brief and a shared drive. All staff have access to shared drives, which also hosts audit results, PowerPoint and educational material.

Entitlement

Entitlement is the term used to describe the process of endorsement by an appropriate and specified individual within an organisation. They must have the knowledge and experience to authorise on behalf of the Employer, that a duty holder or group of duty holders, have been adequately trained and deemed competent in their specific IR(ME)R duty holder roles.

Evidence of induction, training, competency and continuing professional development for radiographers, an assistant practitioner and consultant radiologists was reviewed and found to be in line with duty holder roles. However, equipment training records reviewed on site noted some signatures were missing and it was advised to ensure that all training and entitlement documentation is signed by the relevant competency assessor and by those entitling.

Systems are in place to check the professional qualifications and registration of all employees with their appropriate professional bodies. It was confirmed comprehensive systems were in place to provide annual appraisals for all grades of staff and individual development needs are identified as part of this process. The consultant radiologists and other consultant staff have their appraisals undertaken by an approved medical appraiser.

t was confirmed that entitlement is reviewed at annual appraisal and adjusted accordingly if a staff member's scope of practice had changed. Discussion and review of Employers Procedure (EP) A, entitlement, noted that there was lack of clarity in relation to how all IR(ME)R duty holders are informed of their scope of entitlement with a number of discrepancies noted in EP A. An area for improvement has been identified to ensure EP A clearly outlines how all IR(ME)R duty holders are informed of their scope of entitlement.

Individual entitlement records for consultant radiologists, radiographers, an assistant practitioner and NMRs were reviewed. The group entitlement record for MPEs was also reviewed. It was noted that entitlement records were overall well completed.

There are robust oversight arrangements for entitlement of radiology staff and staff outside of radiology such as non-medical referrers (NMRs). It was good to note that a NMR entitlement audit is regularly carried out, which was found to be very detailed and clearly laid out on a standard template with an action plan and outcomes detailed.

Clinical Audit

IR(ME)R tells us that clinical audit means the systematic examination or review of medical radiological procedures which seek to improve the quality and outcome of patient care through a structured review.

Medical radiological practices, procedures, and results are examined against agreed standards for good medical radiological procedures, with practices modified where indicated and the new standards applied where necessary.

It was evident the radiology service has an underpinning culture of quality improvement. Management and staff demonstrated an inclusive, enthusiastic and proactive approach to patient centred service improvement.

A clinical audit plan is developed collaboratively, incorporating input from consultant radiologists and other radiology department staff. This approach ensures that audit topics are multi-disciplinary and aligned with service priorities.

Shared learning from clinical audits are regularly presented during the site's 'Lunch and Learn' sessions, promoting engagement and continuous professional development across the team. Outcomes from clinical audits are also summarised within the quarterly governance report, collated by the Governance Training & Service Improvement Lead. This report is distributed to the consultant radiologists through the Consultants' Business Meeting and is also stored on SharePoint for ongoing access and reference.

A number of clinical audits were reviewed and overall most were noted to be well completed, with clear objectives, findings, robust evaluation and outcomes allowing for effective shared learning. However an audit relating to suspected physical abuse (SPA) in children did not follow this detailed approach within the documented audit report. An area of improvement has been identified to consider establishing a standardised template to ensure that all audits include sufficient detail to support a robust evaluation and effective shared learning.

In addition, a recurrent IR(ME)R audit programme is carried out. The content and the methodology of the IR(ME)R audit programme was discussed. It was noted that the audit programme focused on a limited number of areas of IR(ME)R compliance and largely relied on retrospective review of records to confirm compliance.

The audits reviewed highlighted that Ards Hospital radiology department complied with IR(ME)R on the areas audited. However, there were examples of non-compliance noted across a number of other Trust sites. It was acknowledged that a more robust approach to IR(ME)R audit was required and an area of improvement has been identified on this matter.

Management confirmed that audit results and expected compliance is shared with staff at staff team meetings. Staff are also sent an email to remind them of their duty holder role in respect of each specific audit. This is copied to Senior Management Team (SMT). Audit results are uploaded to the department's Quality Management System (QMS) and a link is included in the Quarterly Governance Report. Where a change in practice has been identified this will be communicated in the same email to the relevant duty holders.

It was good to note a bi-annual IR(ME)R compliance report is presented to the Radiology Safety Subcommittee and shared with staff.

Incident and near miss management

There are clear arrangements in place to report, record, investigate and learn from radiology incidents or near misses within the radiology department. The management and staff clearly outlined action be taken if a suspected significant accidental or unintended exposure (SAUE) occurred. This was fully reflected in relevant employer's procedures.

A recently established Radiology Incident Review Group meets regularly to review radiology incidents and near misses. Management confirmed this has been a very positive development and has strengthened the governance and oversight of incidents and near misses.

A quarterly analysis of incidents by type, theme and area is conducted by the Governance Training and Service Improvement Lead. This report is shared with the RSM, Assistant Director and Clinical Director of Radiology, Trust/Team Site Leads and all clinical staff. It is also circulated internally and externally to all referrers. This report is presented to the Radiology Safety Sub-Committee, and a shared learning report is circulated alongside the quarterly incident and near miss analysis and disseminated to all internal and external duty holders.

Staff confirmed they were kept informed of incidents, near misses and are made aware of any learning and changes to practice. EP K reporting, investigating and learning from radiological errors is in place.

The decision making process for clinically significant accidental and unintended exposures (CSAUE) and informing relevant stakeholders was clearly outlined by management, however it was noted that this approach was not reflected within the EP L - CSAUE. An area for improvement has been identified on this matter

Overall there are robust incident and near miss management arrangements in place.

Risk register

The arrangements for ensuring the Trust's risk register reflects risks associated with non-compliance with IR(ME)R was reviewed. The management outlined clear information to ensure that the Trust's risk registers are regularly examined, updated and that appropriate mitigations are implemented.

This ensures that all identified IR(ME)R risks are appropriately captured and that specific actions to reduce these risks are identified, and appropriate systems of assurance are in place. The RSM is responsible for the review and updating the IR(ME)R related risks on the risk register. Any additions to the risk register would be communicated to the Employer through the previously described governance structures.

The ratification process for Employers Procedures (EPs) and other IR(ME)R documentation

It was confirmed that RSSC review and ratify draft EPs and protocols. The governance team lead is responsible for ensuring newly ratified documents are uploaded to the SharePoint with the older versions archived. Staff are informed of the new documents via email and at team brief. There are a limited number of hard copy procedures which are subject to a clear tracking system to ensure the most up to date version is in place.

The introduction of a new radiology service

Management outlined the process to be followed when a new radiology service is introduced. New techniques and technologies group would ratify any implementation of new services where IR(ME)R is applicable. Responsibility lies with the governance team and the IR(ME)R lead for the introduction of radiology services. Medical Physics Experts will provide advice on the selection, procurement and commission of new services including: radiation protection testing, performance of equipment, quality assurance and control testing, and where required advice on optimisation of equipment/examination protocols. The MPE also undertakes acceptance testing of equipment and provides guidance on the installation design and technical specification of equipment as required. New services are a standing agenda item for all IOT meetings.

The governance arrangements for the new service will be fully reviewed including ensuring compliance with IR(ME)R. Once a new service is introduced it will be subject to audit. Management confirmed there were no plans to introduce new radiology services to the Ards Hospital site.

Review of the submitted SAF, supporting documentation and discussion with key staff during the inspection evidenced that there are robust governance arrangements with respect to the Ards Hospital radiology service and these arrangements are regularly reviewed and, if necessary, improvements are made. It is hoped the areas for improvement made will enhance governance systems. The inspection team acknowledge the commitment of staff in this regard.

5.2.2 Does the service adhere to legislation in relation to the justification and authorisation of ionising radiation procedures?

Justification is the intellectual activity of weighing up the expected benefits of an exposure against the possible detriment of the associated radiation dose, and is the primary role of the practitioner. Authorisation is a process separate to justification and is the documentation confirming that the intellectual activity of justification has taken place.

The duty holder roles of operator and practitioner was examined in relation to the justification and authorisation of exposures. It is not always possible for a practitioner to review every imaging referral, so regulations allow for an appropriately entitled operator to authorise an exposure following written authorisation guidelines issued by a named practitioner.

Authorisation guidelines must be clearly written using precise statements that are unambiguous in order to allow the operator to confirm whether the referral can be authorised. The practitioner is responsible for the justification of any exposure that is authorised by an operator following the authorisation guidelines. The operator is responsible for the authorisation and following the authorisation guidelines accurately.

Well written authorisation guidelines with a clearly identifiable practitioner are used to authorise exposures by entitled operators in Ards Hospital radiology department. However, discussions with staff and a review of records highlighted some discrepancies in how this process is actioned in practice. There was confusion over the vetting, protocolling, appointing of referrals, as well as the authorisation process itself.

The EP B on justification and authorisation notes that vetting, protocolling, and prioritisation of referrals are separate processes from authorisation. However, discussions with staff and a review of records indicated that these processes were amalgamated and often carried out remotely making it difficult to confirm who has acted as the operator authorising the exposures under authorisation guidelines.

An area of improvement has been identified to ensure the justification and authorisation process as outlined in EP B is fully understood and adhered to by practitioners and operators.

The duty holder role of the Assistant Practitioner(AP) was discussed, and it was confirmed that the AP is not entitled to act as an operator to authorise exposures. A review of records noted that exposures undertaken by the AP are authorised by a radiographer acting as an entitled operator. In light of the confirmation that the AP does not authorise exposures, it was confusing as to the purpose of a document titled 'Assistant Practitioner General Imaging Authorisation Guidelines (Adults) V1.1 SEP25-28'. Management agreed to review the purpose of these specific authorisation guidelines for APs.

An area of improvement has been identified to ensure there is complete clarity on the duty holder role of the AP and the purpose of the document titled 'Assistant Practitioner General Imaging Authorisation Guidelines (Adults) V1.1 SEP25-28'

Exposures to carers and comforters require individual justification. Justification of the exposure of carers and comforters who knowingly and willingly provide help and support should consider both the direct benefit to the health of the individual undergoing the medical exposure as well as the indirect benefit to the carer or comforter. The exposure of a carer or comforter should only be permitted when the benefit can be clearly identified. In Ards Hospital radiographers have been entitled to act as operators to authorise exposures to carers and comforters as outlined in authorisation guidelines.

Completed carer and comforter (patient support) forms are signed by both the carer and comforter and operator authorising the carer and comforter exposure. These forms are then scanned onto the Picture and Archiving and Communication System (PACS) examination record.

Review of the submitted SAF, supporting documentation, and discussions with key staff during the inspection evidenced that the justification and authorisation process was not fully understood by staff and, as a result not fully implemented in accordance to the employer's procedures. The identified areas for improvement relating to justification and authorisation should assist in strengthening understanding and compliance with these requirements.

The inspection team acknowledges the ongoing commitment of staff in relation to the continuous improvement within this area.

5.2.3 Does the service adhere to legislation with regard to equipment QA?

The Employer must keep an up-to date inventory of all medical radiological equipment including ancillary devices that can directly control or influence the exposure. It was noted that the equipment inventory largely reflected information required under IR(ME)R. However, not all required details such as the year of manufacture of the radiology equipment had been outlined on the equipment inventory. An area for improvement has been identified on this matter.

Management and staff confirmed there is an appropriate amount of equipment available for the workload of the radiology department.

There is a formal, written equipment quality assurance (QA) programme in place. It was confirmed that the MPE had been involved in devising the equipment QA procedures. It was confirmed that monthly quality control (QC) checks of the radiology equipment are carried out by appropriately trained and entitled operators.

As part of the service level contract between SEHSCT and Regional Medical Physics a programme for expert QC (Level B) is undertaken using recommended QC test methods and at a frequency advised by the IPEM 91 report, where resources permit. It was confirmed that for the Ards Hospital radiology department, level B testing is carried out on a reduced frequency schedule, reflecting an agreed risk-based approach which is ongoing but is up to date.

A review of the updated overarching QA schedule evidenced that the routine QC checks were performed with no gaps in testing.

Equipment QA audits are carried out by the PACS team, with overall oversight of Quality Control (QC) compliance maintained by the RSM. Quality Assurance Coordinators (QACs) receive formal training and sign-off from the MPE, after which they are responsible for training the Quality Assurance Radiographers (QARs) who conduct routine equipment QC testing.

A monthly QA proforma is completed and discussed to record equipment downtime, faults and any related operational issues. These findings are also summarised and reported within the quarterly quality report to support trend analysis and service improvement.

It was confirmed that the imaging equipment within Ards Hospital radiology department cannot be accessed remotely by servicing engineers.

The QA folders were reviewed on site and it was confirmed that the routine QC checks were performed with no gaps in testing. It was noted that the QA Standard Operating Procedure (SOP) was outside of it's review date (January 2025). Management confirmed their awareness of this and identified this as an outstanding action. This had been discussed with the modality leads at a recent meeting. The SOP requires minor amendments to ensure alignment with current practice and to accurately reflect recent procedural updates, which the management confirmed is currently underway.

Management and staff described the action taken for dealing with defective or faulty equipment. This robust process was fully outlined in EP I– Equipment QA, which was found to be a comprehensive and a clear framework for staff to follow.

It was good to note there is clear governance and oversight of the equipment QA programme. Staff and management demonstrated understanding of their roles and responsibilities in relation to equipment QC.

Review of the submitted SAF, supporting documentation and discussion with key staff during the inspection evidenced a clear and robust equipment QA programme in place. The inspection team acknowledges the ongoing commitment of staff in this regard.

5.2.4 Does the service adhere to legislation with regard to patient identification including pause and check?

IR(ME)R requires the Employer to establish a procedure to identify correctly the individual to be exposed to ionising radiation. The procedure should specify how and when an individual is to be identified. EP C - patient identification, is in place and provides a clear comprehensive framework for staff to follow. Correct identification (ID) of the patient or individual to be exposed is an operator task and must be undertaken prior to any exposure.

Management and staff confirmed that it is the responsibility of the operator to ensure the correct patient is being examined against the referral. Whilst multiple staff may be involved with the patient, the responsibility for correct ID lies with the operator who carries out the medical exposure.

Staff confirmed that the operator must always check the patient's name, address and date of birth on the Radiology Information System (RIS), by requesting that the patient states these details, rather than simply confirming them. They outlined the following questions:

- What is your name?
- What is your address?
- What is your date of birth?

It was confirmed that supplementary safety checks are also carried out such as:

- Why are you here?
- Have you been X-rayed or scanned recently?

Staff confirmed that the professional guidance on Pause and Check is used and promoted in the radiology department. It was good to note that Pause and Check notices were displayed in the department.

For other scenarios, for example such as patients who lack capacity and children, a clear patient ID process was outlined for each situation.

The patient ID check is recorded on RIS by the operator and validated with their personal password prior to exposing the patient to ionising radiation. Review of a random sample of patient records confirmed that patient ID had been recorded as checked for all those reviewed.

A patient ID audit is carried out as part of the rolling programme of IR(ME)R audits. There was a 100% compliance level noted for the Ards Hospital site.

Staff explained the process for handling patient ID discrepancies, as outlined in work instructions:

Process for requesting amendments on RIS when incorrect patient demographics (name, date of birth or address) are identified'. They confirmed patient demographics must not be changed directly on RIS. It was very clear from responses that the exposure would not be undertaken if the patient ID could not be confirmed.

There is evidence to show that incidents involving referral of the wrong patient are among the largest percentage of all diagnostic errors notified to IR(ME)R regulators. The radiology department has robust systems in place to report, record, investigate and learn from incidents and near misses. Patient ID processes have been strengthened using learning from patient ID incidents and near misses, such as the implementation of Pause and Check; further staff training, raising awareness of their responsibilities and liaising with other departments to promote safe practice.

Review of the submitted SAF, supporting documentation and discussion with key staff during the inspection evidenced clear and robust patient identification processes are in place. The inspection team acknowledge the commitment of staff in this regard.

5.2.5 Additional areas reviewed - other areas identified through the review of the submitted self-assessment form and supporting documentation

Diagnostic Reference Levels (DRLs)

Diagnostic reference levels (DRLs) are defined as radiation dose levels, or for Nuclear Medicine the administered activity, for typical diagnostic examinations for groups of standard size adults and paediatrics for broadly defined types of equipment.

They are not expected to be exceeded when good and normal practice regarding diagnostic and technical performance is applied. DRLs should be used with professional judgement and all operators must be familiar with and be trained in their appropriate use.

DRLs are used as a guide to help promote improvements in radiation protection practice and can help identify issues relating to equipment or practice by highlighting unusually high radiation doses.

DRLs do not apply to individual patient exposures and any assessment against the DRL should be based on the results of patient dose survey for groups of patients.

It was good to note a detailed EP F in relation to DRLs was in place. A discussion on the site's use and understanding of DRLs also took place. It was good to note that that the Trust have developed local DRLs for CT examinations, although not relevant to this site. It was however, noted that results from previous dose audits had not been used to review and, where appropriate, update local DRLs. It was confirmed the DRLs in place for adult general radiography were adopted from the national DRLs in 2023. Since then, the national DRLs have been updated in 2025, however this update was not reflected in the DRLs adopted by the trust. The rationale for continuing with the use of 2023 DRL values in light of the updates to national DRLs was unclear.

The MPE confirmed that discussions had taken place regarding the current DRLs in place and the matter had been raised at the most recent IOT meeting. Management were aware that the current DRLs in place were not in line with the most up-to-date national DRLs as issued in 2025.

There were no displayed paediatric DRLs in the radiology department. An area for improvement has been identified to ensure the Trust develops an action plan as a priority to progress the review, and where appropriate, implementation of national DRLs as issued in July 2025 and ensure paediatric DRLs are displayed and utilised in the radiology department.

Pregnancy checks

IR(ME)R provides a framework designed to protect individuals from the harmful effects of ionising radiation. This includes the radiation protection of the foetus and those individuals who are breastfeeding. IR(ME)R includes the requirement to make enquiries of individuals of child bearing potential, and this should accurately reflect the diversity of the gender spectrum in the population.

On review of patient records, it was confirmed that a new inclusive pregnancy policy has recently been implemented. Staff are now required to perform a pregnancy enquiry in all individuals within the ages of 11 and 55 years. The pregnancy enquiry proforma is completed by the operator and scanned on to the system by an administrator.

For patients who are registered on the NIPACs system as female, the appropriate information from the pregnancy enquiry is transferred onto the Exam Window of NIPACS in the “LMP date” drop down box in order to confirm the name of the operator completing this check. This is detailed within EP D - pregnancy enquiries, which states ‘The appropriate information from the form must also be transferred onto the Exam Window of NIPACS in the “LMP date” drop down box’. However, individuals who are registered as male within the NIPACs system do not have the LMP drop down box option. As a result, the required information cannot be transferred to this section, and the operator responsible for completing this task cannot always be identified.

An area for improvement has been identified to review the recording of a pregnancy enquiry on NIPACs in relation to the site’s inclusive pregnancy policy and Employer’s Procedure D, to ensure that the operator carrying out the enquiry is identifiable for all exposures and that the enquiry outcome is documented to ensure compliance with EP D for pregnancy enquiries.

6.0 Conclusion

There were nine areas of improvement identified as a result of this inspection. These are fully outlined in the appended QIP.

The management team and staff are to be commended for their ongoing commitment and enthusiasm to ensuring that the Ards Hospital radiology department is well managed and operating within the legislative framework; and maintaining optimal standards of practice for patients.

The inspection team would like to extend their gratitude to the management team and staff for their contribution to the inspection process.

7.0 Quality Improvement Plan/Areas for Improvement

Areas for improvement have been identified where action is required to ensure compliance with The Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2018 known as IR(ME)R and other published standards which promote current best practice to improve the quality of service experienced by patients.

Total number of areas for improvement	9

Areas for improvement identified during this inspection are detailed in the QIP. Details of the QIP were discussed with senior management as part of the inspection process. The timescales commence from the date of inspection.

It is the responsibility of the Employer to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

The QIP should be completed and detail the actions taken to address the areas for improvement identified. The Employer should confirm that these actions have been completed and return the completed QIP via BSU.Admin@rqia.org.uk for assessment by the inspector.

Quality Improvement Plan	
Action required to ensure compliance with The Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2018	
Area for improvement 1 **Ref:** Regulation 6 Schedule 2.1(b) **Stated:** First time **To be completed by:** 20 January 2026	The Employer should ensure Employers Procedure A clearly outlines how all IR(ME)R duty holders are informed of their entitlement and scope of practice. **Ref 5.2.1**
	Response by Employer detailing the actions taken: Employers Procedures A has been updated to include a table that clearly outlines how all IR(ME)R duty holders are informed of their entitlement and scope of practice.
Area for improvement 2 **Ref:** Regulation 7 **Stated:** First time **To be completed by:** 20 January 2026	The Employer must consider establishing a standardised template to ensure that all clinical audits include sufficient detail to support a robust evaluation and effective shared learning. **Ref 5.2.1**
	Response by Employer detailing the actions taken: The Trust standarised Audit template has been shared with Audit Convenor and the Clinical Director on the 17 December 2025. A reminder to use the Trust template has been tabled for the Radiology Seniro Management Team and Conusltant Business meeting. The Employers Procedure N has been

	updated to include the requirement to complete the Trust standarised Audit template.
Area for improvement 3 **Ref:** Regulation 6(2) **Stated:** First time **To be completed by:** 20 January 2025	The Employer must ensure a more robust approach to IR(ME)R audit is applied. **Ref 5.2.1**
	Response by Employer detailing the actions taken: The IRMER rolling audit calander will be updated and will commence in 2026. IRMER audits will be considered for procedures that do not currently have an IRMER audit in place. The rolling audit calander has been added to the Employers Procedures.
Area for improvement 4 **Ref:** Regulation 8(1) Schedule 2.1(l) **Stated:** First time **To be completed by:** 20 January 2025	The Employer must update Employer Procedure L – clinically suspected significant accidental or unintended exposure (CSAUE) to reflect current practice as to the decision making process when a suspected significant accidental or unintended exposure (SAUE) is deemed clinically significant, and to specify where this information is recorded. **Ref 5.2.1**
	Response by Employer detailing the actions taken: The Employers Procedure L has been updated to reflect current practice as to the decision making process when a suspected signfiicant accidential or unitended exposure (SAUE) is deemed clinicall signficiant, and to specify where this information is recorded.
Area for improvement 5 **Ref:** Regulation 11 **Stated:** First time **To be completed by:** 20 January 2026	The Employer should ensure the justification and authorisation process as outlined in Employer Procedure B reflects current practice and is fully understood and adhered to by duty holders. **Ref 5.2.2**
	Response by Employer detailing the actions taken: The Employers Procedure B has been updated to reflect the current practice for Justification and Authorisation. Staff education and training event on the process for Justification and Authorisation for duty holders is planned for February 2026. A reminder email will be issued to duty holders.
Area for improvement 6 **Ref:** Regulation 10(1) Regulation 11(5) Schedule 2.1(b)	The Employer must ensure there is complete clarity on the duty holder role of the Assistant Practitioner and, the purpose of the document titled 'Assistant Practitioner General Imaging Authorisation Guidelines (Adults) V1.1 SEP25-28' is clearly defined.

Stated: First time **To be completed by:** 20 December 2025	**Ref 5.2.2** **Response by Employer detailing the actions taken**: The Assistant Practitioner Authorisations Guidelines (POL GEN 31) have been removed from circilation and an email has been sent out to staff as of 17 December 2025.
Area for improvement 7 **Ref:** Regulation 15(2) **Stated:** First time **To be completed by:** 20 January 2025	The Employer must ensure the equipment inventory is maintained in accordance to legislation. **Ref 5.2.3** **Response by Employer detailing the actions taken**: The Equipment Inventory will be updated by 20. January 2026.
Area for improvement 8 **Ref:** Regulation 6(5)(c) Schedule 2.1(f) **Stated:** First time **To be completed by:** 20 December 2025	The Employer must ensure the Trust develops an action plan as a priority to progress the review, and where appropriate, implementation of up-to-date Diagnostic Reference Levels (DRLs) and ensure paediatric DRLs are utilised and displayed in the radiology department. **Ref 5.2.5** **Response by Employer detailing the actions taken**: The Service has taken guidance's from the Medical Physics Expert (MPE) and the following action plan has been agreed: The Service will continue to gather local dose audit data on a rolling programme Dose data collection will be monitored through the Senior Management Team When the required number of dose data has been collected for the area, the Lead will send through the data to the MPE for review The MPE will review the data and provide feedback in relation to DRL and dose optimisation Dose optimisation measures will be implmented and the area will re audit as above The dose audits will be discussed at the Trust IOT with MPE in attendance (Planned for Janurary 2026) With the support of the MPE, the service will make a decision on whether to adopt the 2025 National DRL at the Radiology Safety Subcommittee in Janurary 2026.
Area for improvement 9 **Ref:** Regulation 6(8) Regulation 11(1)(f) Regulation 6 Schedule 2(1)(c) **Stated:** First time	The Employer should review the recording of a pregnancy enquiry on NIPACs to ensure the operator carrying out the enquiry is identifiable and the enquiry outcome is documented to ensure compliance with Employer Procedure D for pregnancy enquiries. **Ref 5.2.5**

To be completed by: 20 December 2025	**Response by Employer detailing the actions taken**: The Employers Procedures D has been updated to include the procedure for using the Radiation Safety Questionnaire for patients who are registered male at birth.

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