The Regulation and Quality Improvement Authority

Inspection Report

11 March 2026

South West Acute Hospital, Radiology Department

Address: 124 Irvinestown Road, Enniskillen, BT74 6DN
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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: Western Health and Social Care Trust (WHSCT)	**Department Inspected:** South West Area Hospital (SWAH) radiology department
Name of Employer: Dr Brendan Lavery Medical Director WHSCT	**Radiology Services Manager (RSM):** Ms Seana Nolan

Brief description of how the service operates:

The SWAH radiology department provides a seven-day a week service between 08:30am and 16:30pm, with out-of-hours cover for CT and plain film from 16:30pm to 09:00am. Imaging services are provided for both adults and paediatrics, although paediatric activity is low and integrated within standard workflow. The service provides general radiography, computed tomography (CT), fluoroscopy and dual energy X-ray absorptiometry (DXA). A C-arm image intensifier is used in theatre very occasionally.

Before the inspection Ms Nolan, RSM, and her team were asked to complete a self-assessment form (SAF). The submitted SAF confirmed that the SWAH radiology department has carried out 40747 general radiography examinations, 311 general fluoroscopy procedures, 14837 CT scans, 2040 DXA scans and 321 dental examinations in the last year.

The department is staffed by 33.1 whole time equivalent (WTE) radiographers and two WTE plain film reporting radiographers. There are 4.85 WTE consultant radiologists providing on-site and on-call cover. Contracted third-party provider consultant radiologists undertake clinical evaluation only out-of-hours. There is always a substantive consultant radiologist on call as support.

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).

2.0 Inspection summary

On 11 March 2026, 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 SWAH 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 and commissioning of new services.
- Justification and authorisation process including the 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 IR(ME)R (Northern Ireland) 2018.

Previous areas for improvement (if applicable) will also be 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 03 November 2021		
Action required to ensure compliance with The Ionising Radiation (Medical Exposure) Regulations (Northern Ireland) 2018		**Validation of compliance**
Area for Improvement 1 **Regulation 8(4)(a)(i)** **Stated: First time**	The Employer shall ensure that near misses are recorded on Datix and managed in accordance with incident management systems.	**Met**
	Action taken as confirmed during the inspection: Near misses are recorded on Datix and managed in accordance with incident management systems. This area for improvement has been assessed as met.	
Area for Improvement 2 **Regulation: 6** **Stated: First time**	The Employer shall ensure that the interim arrangements in the absence of a clinical director of radiology are reflected in the Radiology Protection Policy and the Employer's Procedures.	**Met**

	Action taken as confirmed during the inspection: The Radiology Protection Policy and the Employer's Procedures (EPs) were updated to reflect the management arrangements for radiology. The matter is further discussed in section 5.2.1 of this report. This area for improvement has been assessed as met.	
Area for Improvement 3 **Regulation: 8(3)** **Stated: First time**	The Employer shall conduct robust and meaningful trend analysis of radiology incidents and near misses which should be used to drive quality improvement.	**Met**
	Action taken as confirmed during the inspection: Trend analysis of radiology incidents and near misses is carried out. The matter is further discussed in section 5.2.1 of this report. This area for improvement has been assessed as met.	
Area for improvement 4 **Regulation: 6(5)** **Stated: First time**	The Employer shall ensure clarity on the entitlement process for the wholly private medical practitioners in relation to the duty holder role of referrer, to include how they access i-Refer and ensure this is reflected in the relevant EPs.	**Met**
	Action taken as confirmed during the inspection: Management confirmed a new entitlement form for solely private medical practitioners has been created. A letter of entitlement will be sent to the referrer, detailing how they access iRefer. Employer's procedures were updated to reflect this process. This area for improvement has been assessed as met.	

Area for improvement 5 **Regulation 6 Schedule 2(1)(b)** **Stated: First time**	The Employer shall develop EP B to include more detail on the entitlement process for referrers.	**Met**
	Action taken as confirmed during the inspection: EP B has been updated. This area for improvement has been assessed as met.	
Area for improvement 6 **Regulation 2** **Stated: First time**	The Employer shall ensure consistent use of IR(ME)R terminology within all documents required under IR(ME)R.	**Met**
	Action taken as confirmed during the inspection: Improvement was noted in relation to consistent use of IR(ME)R terminology within all documents required under IR(ME)R. Whilst this area for improvement has been assessed as met, there was some confusion noted in relation to justification and authorisation process terminology. This is outlined as a separate matter in section 5.2.2 of this report.	
Area for improvement 7 **Regulation 10(5)** **Stated: First time**	The Employer shall amend EP C to include more detail on the referral process; specifying the arrangements for prioritising, cancelling or managing incomplete referrals.	**Met**
	Action taken as confirmed during the inspection: EP C has been amended and outlines a detailed referral process. This area for improvement has been assessed as met.	

Area for improvement 8 **Regulation 11(5)** **Stated: First time**	The Employer shall update the authorisation guidelines to ensure that they clearly identify a current entitled practitioner on the front cover and ensure this entitled practitioner has fully reviewed and signed the authorisation guidelines.	**Met**
	Action taken as confirmed during the inspection: Authorisation guidelines clearly identify the entitled practitioner and are signed by this individual. This area for improvement has been assessed as met.	
Area for improvement 9 **Regulation 11(3)(b)** **Stated: First time**	The Employer must ensure • the justification of carers and comforters (C&C) exposures for all modalities is identified within authorisation guidelines, if radiographers are to act as operators for authorising these exposures • consider entitling the radiographers as practitioners for this form of justification • the justification process of C&C exposures must be fully outlined in EP V	**Met**
	Action taken as confirmed during the inspection: Radiographers have been entitled to act as practitioners for carers and comforters. EP V fully reflects this position. This area for improvement has been assessed as met.	
Area for improvement 10 **Regulation 6 Schedule 2(1)(m)** **Stated: First time**	The Employer shall include further detail in EP N of Suspected Physical Abuse in the context of non-medical imaging.	**Not Met**
	Action taken as confirmed during the inspection: EP N still outlines suspected physical abuse as non-medical imaging. The matter is further discussed in section 5.2.5 of this report. This area for improvement has been assessed as not met and is stated for a second time.	

Area for improvement 11 **Regulation 15(3)** **Stated: First time**	The Employer must ensure • clear oversight by senior management of the level B quality control (QC) testing of radiology equipment, in particular details of any non-compliance with the frequency of testing of radiology equipment as specified within IPEM. • consideration must be given to recording this matter on the Trust's risk register	**Met**
	Action taken as confirmed during the inspection: There is clear oversight by senior management of the level B quality control (QC) testing of radiology equipment, in particular details of any non-compliance with the frequency of testing of radiology equipment as specified within IPEM. The RMPS based in the BHSCT have issued an agreed regional risk-based approach to this matter. The Trust has recorded this as a risk on the Trust risk register. This area for improvement has been assessed as met.	
Area for improvement 12 **Regulation 6(3)** **Stated: First time**	The Employer shall ensure third-party providers are entitled and entitlement records outline a clear scope of practice.	**Met**
	Action taken as confirmed during the inspection: Third party providers are entitled and entitlement records outline a clear scope of practice. This area for improvement has been assessed as met.	

Area for improvement 13 **Regulation 6 Schedule 2(1) (b)** **Stated: First time**	The Employer shall describe in EP B the arrangements concerning how they delegate the task of entitlement and the entitlement arrangements for MPEs.	**Met**
	Action taken as confirmed during the inspection: EP B outlines the arrangements concerning how they delegate the task of entitlement and the entitlement arrangements for MPEs. This area for improvement has been assessed as met.	

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. At the time of inspection the role of IR(ME)R Employer in the WHSCT was held by the Medical Director. Management confirmed that the service is undergoing a period of transition, and the organisation is preparing for a change of Employer, as the current Medical Director is due to leave next month. It is unclear whether this role will transfer to the WHSCT Chief Executive or to the Assistant Medical Director. It was advised that when there is confirmation of the arrangements for the Employer's role, clear lines of accountability must be incorporated into the revised Radiation Safety Policy. The need for formalised IR(ME)R training for the incoming Employer was also emphasised to ensure they fully understand their duties and responsibilities. Any change of Employer must be formally communicated to RQIA. Management gave assurances on this matter.

The WHSCT Radiation Safety Policy was due for review in September 2023, with a draft update available during the inspection; it was advised that the updated policy sets out the organisational structures, lines of accountability and governance structures. A detailed radiology quality manual which has been approved in February 2026 was in place. It was found to be a well written document setting out management roles and responsibilities. The RSM and the Lead for Clinical Governance (LCG) are recently appointed and both are based on the Altnagelvin Hospital site. Their roles and responsibilities were outlined with some changes to previous governance arrangements noted. The lead for clinical governance holds overall responsibility for governance and incident management. The RSM must ensure the service complies with IR(ME)R. An assistant radiology services manager (ARSM) is based in SWAH and covers both SWAH and the Omagh Hospital. A new lead MPE role for WHSCT has recently been assigned.

Radiology governance structures are split into Northern and Southern sectors of the Trust. There is a Clinical Lead Radiologist for WHSCT, supported by associate leads for each sector.

The governance framework includes quarterly Clinical Governance meetings and Radiation Protection Subgroup (RPSG) meetings. A Radiation Protection Working Group (RPWG) is also in place and is described as fulfilling the equivalent function of a Radiation Protection Committee. Although multi-disciplinary attendance is good, the terms of reference do not establish a quorum, and it remains unclear which committees hold which responsibilities or how they formally report to each other. The terms of reference are required to be reviewed to ensure an effective and IR(ME)R-compliant governance structure. An area of improvement has been identified to establish a clear governance framework around RPSG and RSWG and define terms of reference for both.

An annual Clinical Governance Report is produced, including IR(ME)R matters, although it is unclear whether this is shared with the Employer. It was advised to consider sharing this valuable report with the Employer.

It was good to note that the radiology service has well established image optimisation teams (IOT) for each modality which are multi-disciplinary groups that meet on a six monthly basis. 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 radiology services provided outside of the radiology department**.** There is informal communication on a daily basis. Daily safety huddles or briefs are conducted infrequently and are not formalised. It was advised to consider establishing formal daily or at least weekly safety briefs. Monthly team meetings occur, which are largely modality-specific, with minutes stored on QPulse. QPulse also distributes updates and read-receipts, which are monitored by the site lead. There is a central point 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.

Radiologists hold monthly meetings and routine communication occurs via messaging platforms. Radiology Events and Learning Meetings (REALM) take place six times per year and include trust-wide peer review (which includes third-party provider Medica radiologists). Audit meetings are also held, with presentations commonly delivered by radiographers and radiologists. The Clinical Lead Radiologist escalates issues directly to the Divisional Clinical Director, who then reports to the Employer.

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 and consultant radiologists was reviewed and found to be in line with duty holder roles.

There is a limited paediatric plain film imaging service and limited CT for trauma service. It was advised to have processes in place for refresher training for paediatric imaging due to the limited workload. Management gave assurances on this matter.

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. It was confirmed that entitlement is reviewed at annual appraisal and adjusted accordingly if a staff member's scope of practice had changed.

Individual entitlement records for a consultant radiologist, a radiographer and a non-medical referrer (NMR) were reviewed. The group entitlement record for MPEs and third-party provider (Medica) were also reviewed. It was noted that entitlement records were overall well completed.

As stated previously, Medica radiologists are group entitled, with individual names held on a central database. The processes for oversight and review of this database were limited. An area of improvement has been identified to formalise the review and oversight processes of this database as well as the formalised entitlement arrangements of third-party providers.

A QPulse database lists all NMRs and is updated as required. NMRs complete IR(ME)R awareness training face-to-face, as well as an e-learning module before entitlement. Each duty holder receives a letter confirming their individual scope of practice. All entitlement is issued on an individual basis; no group entitlements are in place for NMRs. It was noted that an NMR had been entitled as an operator, however there was no specific operator task outlined. Management confirmed the entitled operator role was only in relation to clinical evaluation. An area of improvement has been identified to ensure entitlement records relating to operators include operator functions specific to the individual operator's scope of practice.

Referrers from outside WHSCT submit referrals, in particular from cancer specialties. However, management was unsure whether these individuals are formally entitled by WHSCT and whether they are fully aware of their scope of practice. It was clarified that entitlement by another Trust is not sufficient; WHSCT must ensure these referrers are appropriately entitled before referrals can be accepted. An area of improvement has been identified to ensure there is evidence of entitlement of referrers from outside of WHSCT performed by the SWAH Employer before referrals can be accepted. This must also include a defined scope of practice.

For third-party operators (Medica), WHSCT reviews CVs and registration details before adding individuals to the 'reporting panel'. Management confirmed these individuals are group-entitled, with specific names held on the panel. An area of improvement has been identified to establish a more formal process to verify training and competency prior to WHSCT entitlement and incorporating this into Employers Procedure (EP) B.

Review of EP B noted that it lacked clarity on how the task of entitlement is delegated by the Medical Director, particularly in respect of third-party operators. It was clarified that the Medical Director entitles all medical and dental referrers except radiologists, who are entitled by the Clinical Lead Radiologist. Clarity on how this process will be managed and reviewed once the current employer steps down was also advised.

Management confirmed that EPs Appendix 2 relates to radiographers acting as referrers, who are currently entitled to refer for a small number of plain film examinations under a defined scope of practice. As EP B and Appendix 2 are unclear, an area of improvement has been identified to review EP B to ensure there is clarity on entitlement arrangements for medical staff, and to review the use of terminology outlined in order to aid clarity in Appendix 2.

It was established consultant surgeons carry out clinical evaluation of theatre fluoroscopy procedures. On discussion, the duty holder roles for the IR(ME)R pathway in relation to the theatre fluoroscopy service was not evidenced. An area of improvement has been made to ensure there is evidence of entitled duty holders including referrer, practitioner and operator roles for the function of clinical evaluation surrounding the provision of theatre fluoroscopy services.

Clinical Audit

IR(ME)R states 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. Management confirmed that audit is managed via the Radiology Quality Management System (QMS). A radiology audit group is in place and meets annually to agree the Trust wide audit schedule. A schedule of audits is drawn up to include clinical audits and IR(ME)R compliance audits, to ensure the WHSCT Radiology EPs are in place and being followed.

Audits are carried out by the multi-disciplinary team using an agreed audit template. Strong examples of clinical audit were reviewed, including a lateral hip imaging quality audit. However, on discussion, in relation to the findings of an audit relating to the stroke pathway clinical evaluation compliance, management provided additional information on robust action taken. This had not been fully outlined in the record of the audit. An area of improvement has been identified to ensure that any communications and actions resulting from audits are formalised; clear documentation regarding outcomes and any follow-up on compliance is detailed to ensure that this process is more robust.

The clinical lead radiologist is responsible for ensuring that clinical audit related to medical radiological practices, procedures and results are examined against agreed standards.

The outcomes and learning from audits are shared via QPulse or through “lunch and learn” sessions. Management confirmed audit pro formas are approved by the clinical lead radiologist and quality lead before dissemination.

The Trust governance team maintains oversight of all clinical audits. Clinical audit findings are shared via the previously described Trust governance structures and overall accountability lies with the Employer.

An IR(ME)R audit programme which is part of the overall audit programme is carried out. It was good to note a range of IR(ME)R compliance audits were in place. Upon review of examples of IR(ME)R compliance audits, it was noted the findings were outlined clearly, however there were limited action plans in place even when compliance was less than 100%. Management were reminded that IR(ME)R audit compliance rates must be set at 100%. Robust action plans must be in place where findings highlight non-compliance with IR(ME)R and thereafter followed up. The inspection team highlighted other IR(ME)R compliance audits which should be included in the IR(ME)R audit schedule.

An area of improvement has been identified as follows:

- to separate IR(ME)R audit schedules from clinical audit schedules for ease of oversight and to ensure that there is no confusion over what constitutes an IR(ME)R compliance audit
- ensure there is a robust action plan and follow-up in place for non-compliance findings, including a responsible person and appropriate time-frame
- consider including justification of Carer and Comforter exposures and DXA clinical evaluation as part of the IR(ME)R audit schedule

Urgent findings from audits are shared with the RSM and escalated as required. Any issues arising from audit, which require the Employer to be aware of, are reported via the governance structures outlined previously or directly to the Employer, if deemed high risk.

Incident and near miss management

There are clear arrangements in place to report, record, investigate and learn from radiology incidents or near misses in the radiology department. If an incident or near miss occurs, the radiographer completes a Datix form which details a description of the incident/near miss, dose to the patient and other relevant details. The RSM would be informed and share with relevant senior management. The MPE would be informed with the appropriate details to support the dose risk assessment and provide advice.

The management and staff clearly outlined action to be taken if it suspected significant accidental or unintended exposure (SAUE) has occurred, which was fully reflected in relevant EPs. SAUEs are escalated and a dose report is requested from the MPE.
The ARSM will investigate the SAUE and a radiation incident form completed. The RSM will nominate a senior officer (usually ARSM) to report to and liaise with RQIA in relation to SAUEs. It was noted that the quality of information outlined in notifications of SAUEs was on occasions lacking in detail and outcomes focused on a duty holder error approach and not a systems-based approach.

Incidents are discussed at the RPSG and learning is shared at the monthly team meetings. The Trust does not currently conduct Radiation Incident Governance Group (RIGG) type meetings, however a rapid review group is in place weekly where ‘flagged’ incidents can be discussed.

An area of improvement has been identified as follows:

- ensure a robust investigation process of incidents/near misses with a systems-based approach
- ensure SAUE notifications are robustly completed for submission to RQIA
- initiate a more robust process for reviewing individual incidents and oversight of immediate actions related to incidents in a shorter time-frame than quarterly review at RPSG meetings
- ensure any changes to management of incidents is reflected in the relevant EP Q

Management outlined that on a six-monthly basis, incidents are reviewed by classification and graphical visualisation enables a trend analysis to be performed and this is shared with staff on QPulse and team meetings. Review of the trend analysis reports noted that they provided some valuable findings and actions. However, it was a limited high-level statistical approach with a focus on duty holder error. On discussion, management confirmed that a more systems-based approach to trend analysis was being developed. It was noted that reviews such as the trend analysis and oversight of the management of incidents were not fully outlined in the EP Q. An area of improvement has been identified to develop a more robust systems-based approach to trend analysis of incidents and near misses and ensure these arrangements are fully reflected in EP Q.

Analysis of incidents, trends and near misses, causes and potential risks are identified and reviewed at the bi-monthly clinical governance meeting and quarterly RPSG. Follow-up and review of any identified actions is monitored at clinical governance meetings which then feeds into a risk management sub-committee which is chaired by the Medical Director (Employer).

Learning themes will be shared and communicated to all relevant stakeholders within, and if required, external to the organisation. It was positive to note a poster on a near–miss incident overview for 2025 had been devised which outlined near miss reporting, key findings, reasons identified and action to improve safety.

EP R clinically significant accidental or unintended exposures (CSAUE) was in place. The decision-making process for a CSAUE and informing relevant stakeholders was clearly outlined by management however was not fully reflected in the EP R - CSAUE. An area of improvement has been identified on this matter.

Risk register

The arrangements for ensuring the Trust risk register reflects risks associated with non-compliance with IR(ME)R was reviewed. Management outlined clear information to ensure that the Trusts risk registers are examined, updated and mitigated to ensure all identified IR(ME)R risks are appropriately captured and that specific actions to reduce the risks are identified and that appropriate systems of assurance are in place. The RSM is responsible for the quarterly review and update of risks associated with IR(ME)R held on the risk register. The Employer would be made aware of any additions to the risk register through the previously described governance structures.

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

It was confirmed that RPWG review and ratify draft EPs and protocols. The Employer signs off the Employer's Procedures. The QPulse system is in place for all electronic documents which staff can access.

The governance team lead is responsible for ensuring newly ratified documents are uploaded to QPulse 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. Radiation Clinical Governance group would ratify any implementation of new services where IR(ME)R is applicable. Responsibility lies with the governance team and RSM for the introduction of radiology services.

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.

Review of the submitted SAF, supporting documentation and discussion with key staff during the inspection evidenced that there are good governance arrangements with respect to the SWAH radiology service and these arrangements are regularly reviewed and, if necessary, improvements are made. It is hoped the areas of 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 were examined in relation to the justification and authorisation of exposures. It is not always possible for a practitioner to review every imaging referral, therefore 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.

It was confirmed that within the SWAH, justification and authorisation can be carried out by practitioners or radiographers acting as operators authorising exposures using authorisation guidelines. The practitioner for exposures undertaken using each set of authorisation guidelines was clearly identifiable.

The service uses authorisation guidelines for all modalities. However, the reason for adopting authorisation guidelines in DXA and fluoroscopy when entitled practitioners are directly involved in the delivery of the service was discussed. Three DXA radiographers act as practitioners by justifying and authorising DXA scans; and are trained and entitled to do so. Similarly for fluoroscopy, radiologists are entitled as practitioners to justify and authorise the examination. They are present for the examination and perform the examination as entitled operators. The necessity for authorisation guidelines for both these modalities was unclear.

An area of improvement has been identified to review the use of authorisation guidelines for DXA and fluoroscopy services.

As stated previously in section 5.2.1 of this report, the justification and authorisation process for the use of ionising radiation in theatre was unclear and an area of improvement has been made in this regard.

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 this net benefit can be clearly identified. In SWAH radiographers have been entitled to act as practitioners for exposures to carers and comforters.

Completed carer and comforter (patient support) forms are signed by the carer and comforter and the practitioner justifying and authorising the carer and comforter exposure. These are then scanned onto PACS on the examination record.

It was noted that in a number of EPs the terminology used in relation to the justification and authorisation process needs to be reviewed to ensure complete clarity on the process.
An area of improvement has been identified in this regard.

The Stroke Lysis Pathway

The stroke lysis pathway was examined in relation to the referral process, the justification and authorisation process for all radiology exposures associated with this pathway and clinical evaluation of these exposures, which are often time sensitive.

Referral guidelines utilised within the stroke lysis pathway were discussed. Management confirmed the referral guidelines for the stroke lysis pathway is in the form of a flowchart. However, this flowchart does not include dose information as is required for referral guidelines. Referrers request all three scan types simultaneously as an ‘imaging package’, and operators determine, by reference to authorisation guidelines, whether the additional perfusion scan is required.

An area of improvement has been identified to clarify the referral guidelines used for the imaging required within the stroke lysis pathway and amend EPs as appropriate.

It was good to note that a bespoke training programme has been developed for stroke physicians, covering both registrars and consultants. Following training, stroke physicians are entitled to act as both referrers and operators for clinical evaluation only. Authorisation Guidelines devised by consultant radiologists acting as practitioners are used by entitled operators to authorise scans within this pathway.

Review of the submitted SAF, supporting documentation and discussion with key staff during the inspection evidenced that the justification and authorisation process is well understood by staff and largely fully implemented in accordance to the employer's procedures. The areas of improvement will assist on this matter. The inspection team acknowledge the commitment of staff in this regard.

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 did not fully reflect all information required under IR(ME)R. An area of improvement has been identified in this regard.

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 daily and monthly quality control (QC) checks of the radiology equipment including that which is operated outside of the main radiology department, are carried out by appropriately trained and entitled operators.

As part of the service level contract between WHSCT 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 SWAH site, level B testing is carried out on a reduced frequency schedule, reflecting an agreed risk-based approach which is ongoing.

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

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 comprehensive and a clear framework for staff to follow.

EP J describes dose recording but does not detail any further processes for assessment or involved personnel. An area of improvement has been identified in this regard.

A robust equipment QA audit programme is in place. It was noted 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 is in place. The areas for improvement will enhance these arrangements. The inspection team acknowledge the 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. Employers Procedure A - 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 referral on RIS. The patient must be asked to state their name, address and date of birth rather than confirm these details. 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 and staff had received refresher training on Pause and Check.

For other scenarios, for example, 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.

Staff explained the process for discrepancies in the patient ID. Staff 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 have 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

Non-medical imaging

Management confirmed that non-medical imaging is not undertaken at this site. Suspected Physical Abuse (SPA) imaging is performed; however, the service had not previously recognised that SPA is not classed as non-medical imaging and an area of improvement had been made on the previous inspection as outlined in section 5.1 of this report. The matter was again clarified during the inspection and the previous area of improvement 'the Employer shall include further detail in EP N of Suspected Physical Abuse in the context of non-medical imaging' is stated for a second time.

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 surveys for groups of patients.

It was good to note a detailed EP K in relation to DRLs was in place. A discussion on the site's use and understanding of DRLs took place. 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. A recent restructure of the Image Optimisation Teams (IOTs), as well as aforementioned changes to management roles and MPE oversight, has resulted in a delay of dose audits and DRL reviews being conducted. It was confirmed the lead MPE is in the process of overhauling all dose audits and DRL processes for this site. The lead MPE confirmed that they deemed it preferable not to adopt the National DRLs that came in to place in 2025, and rather wait for the dose audits to be completed and ratified so that these can be adopted. However, the timescales for this work to be completed were unclear.

Management were requested to submit to RQIA a detailed action plan with timescales on the proposed action to be taken in relation to DRLs within one week.

RQIA received a detailed action plan with timescales and additional documentary evidence relating to dose audits and establishing of DRLs. An area of improvement has been identified to fully implement the action plan for DRLs

It was confirmed that there were no DXA DRLs in place. An area of improvement has been identified to establish and implement DRLs for DXA scans.

Employer's Procedures

WHSCT Employers Procedures were in place which had been signed by the Employer as approved in February 2026. Overall, they were found to be mainly well written and outlined clear frameworks for duty holders to follow.

However, the following was noted:

- EP D pregnancy enquiries included statements that were not consistent and lacked detail when determining which individuals to make enquiries of.
- EP G clinical evaluation was well written however did not include sufficient detail on arrangements for clinical evaluation of imaging carried out in theatre.

An area of improvement has been made to amend EP D pregnancy enquiries and EP G clinical evaluation to ensure they provide sufficient consistent information for duty holders to follow.

6.0 Conclusion

One area for improvement relating to further development of Employers Procedure N has been stated for a second time.

There were 21 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 SWAH 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	21

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 1(l) (m)** **Stated: Second time** **To be completed by: 11 May 2026**	The Employer must include further detail in EP N of Suspected Physical Abuse in the context of non-medical imaging. Ref 5.1 and 5.2.5
	Response by Employer detailing the actions taken: EP Procedure N updated to reflect advice regarding SPA
Area for improvement 2 **Ref: Regulation 6** **Stated: First time** **To be completed by: 11 May 2026**	The Employer must establish a clear framework around the Radiation Protection Subgroup (RPSG) and the Radiation Protection Working Group (RPWG) and define terms of reference for both. Ref 5.2.1
	Response by Employer detailing the actions taken: Reviewed Terms of Reference (TOR) for Radiation Protection Sub Group (RPSG) and Radiation Protection Working Group (RPWG), for ratification at June 2026 meeting,
Area for improvement 3 **Ref: Regulation 6 Schedule 2(1)(b)** **Stated: First time** **To be completed by: 11 May 2026**	The Employer must formalise the review and oversight processes of the entitled duty holder database as well as the formalised entitlement arrangements of third-party providers. Ref 5.2.1
	Response by Employer detailing the actions taken: Review of Entitlement Database to be added to bimonthly meeting Agenda with third party provider, Entitlement Document and Emplyers Procedure also shared.

Area for improvement 4 **Ref: Regulation 6 Schedule 2(1)(b)** **Stated: First time** **To be completed by: 11 May 2026**	The Employer must ensure entitlement records relating to operators include operator functions specific to the individual operator's scope of practice. Ref 5.2.1
	Response by Employer detailing the actions taken: All entitlement documentation has been reviewed and changes to ensure all duty holders functions clearly defined
Area for improvement 5 **Ref: Regulation 6 Schedule 2(1)(b)** **Stated: First time** **To be completed by: 11 May 2026**	The Employer must ensure there is evidence of entitlement of referrers from outside of WHSCT including a defined scope of practice. Ref 5.2.1
	Response by Employer detailing the actions taken: Process in place to ensure all referrers outside WHSCT are entitled within their scope of practice
Area for improvement 6 **Ref: Regulation 6 Schedule 2(1)(b) Regulation 17(4)** **Stated: First time** **To be completed by: 11 May 2026**	The Employer must establish a more formal process to verify training and competency prior to WHSCT entitlement and incorporate this into Employers Procedure B. Ref 5.2.1
	Response by Employer detailing the actions taken: Protocol developed, Procedure B and H have been reviewd and amended.
Area for improvement 7 **Ref: Regulation 6 Schedule 2(1)(b)** **Stated: First time** **To be completed by: 11 May2026**	The Employer must review Employers Procedure B to ensure there is clarity on entitlement arrangements for medical staff and review the use of terminology outlined to aid clarity in Appendix 2. Ref 5.2.1
	Response by Employer detailing the actions taken: Procedure B reviewed and updated.

Area for improvement 8 **Ref: Regulation 6 Schedule 2(1)(b)** **Stated: First time** **To be completed by: 11 May 2026**	The Employer must ensure there is evidence of entitled duty holders for the provision of theatre fluoroscopy services, including referrer, practitioner and operator roles. Ref 5.2.1
	Response by Employer detailing the actions taken: All staff performing theatre fluoroscopy have been entitled as per their scope of practice.
Area for improvement 9 **Ref: Regulation 7** **Stated: First time** **To be completed by: 11 May 2026**	The Employer must ensure that any communications and actions resulting from audits are formalised; clear documentation regarding outcomes and any follow-up on compliance is detailed to ensure that this process is more robust. Ref 5.2.1
	Response by Employer detailing the actions taken: Three monthly review of Trustwide Audits by Lead Radiographer of completed Audits and any actions outstanding, this is discussed at Clinical Governance and/or RPSG.
Area for improvement 10 **Ref: Regulation 6** **Stated: First time** **To be completed by: 11 May 2026**	The Employer must ensure the following: • to separate IR(ME)R audit schedules from clinical audit schedules for ease of oversight and to ensure that there is no confusion over what constitutes an IR(ME)R compliance audit • ensure there is a robust action plan and follow-up in place for non-compliance findings • consider including audits to cover the justification of Carers and Comforters and DXA clinical evaluation in the IR(ME)R audit schedule. Ref 5.2.1
	Response by Employer detailing the actions taken: IR(ME)R audit schedule has been seperated from Clinical Audit schedule. IR(ME)R audit findings will be added to Radiation Incident Governance Group (RIGG) Agenda and any non compliances actioned. Audits covering the justification of Carers and Comforters and DXA clinical evaluation will be discussed at next Audit meeting in June 2026

Area for improvement 11 **Ref: Regulation 8** **Stated: First time** **To be completed by:11 May 2026**	The Employer must ensure the following: • ensure a robust investigation process of incidents/near misses with a systems-based approach • ensure significant accidental or unintended exposure(SAUE) notifications are robustly completed for submission to RQIA • initiate a more robust process for reviewing individual incidents and oversight of immediate actions related to incidents in a shorter time-frame than quarterly review at RPSG meetings • ensure any changes to management of incidents is reflected in the relevant EP Q Ref 5.2.1
	Response by Employer detailing the actions taken: RIGG meeting to be held monthly, TOR have been drafted, for ratification at RPSG. All radiation incidents will be reviewed Review of SAUE notifications to be reviewed by Lead Radiographer or RSM prior to submission to RQIA to ensure clarity. EP Q has been reviewed.
Area for improvement 12 **Ref: Regulation 8(3)** **Stated: First time** **To be completed by:** **11 May 2026**	The Employer must develop a more robust systems-based approach to trend analysis of incidents and near misses and ensure these arrangements are fully reflected in Employers Procedure Q. Ref 5.2.1
	Response by Employer detailing the actions taken: All incident reviews will follow a systems based approach to identify any trends. A quarterly report will be shared at relevant Trust groups including Clinical Governance, RPSG and RPWG. Procedure Q has been reviewed to reflect these changes.
Area for improvement 13 **Ref: Regulation 6 Schedule 2(1)(l) Regulation 8(1)** **Stated: First time** **To be completed by:** **11 June 2026**	The Employer must ensure Employers Procedure R –clinically significant accidental or unintended exposures (CSAUE) fully reflects the decision-making process for a CSAUE and informing relevant stakeholders. Ref 5.2.1
	Response by Employer detailing the actions taken: Procedure will be reviewed and updated to reflect decision making process.

Area for improvement 14 **Ref: Regulation 11(5)** **Stated: First time** **To be completed by:** **11 May 2026**	The Employer must review the use of authorisation guidelines for DXA and fluoroscopy services. Ref 5.2.2
	Response by Employer detailing the actions taken: Authorisation Guidelines for these services have been reviewed and removed .
Area for improvement 15 **Ref: Regulation 11** **Stated: First time** **To be completed by:** **11 May 2026**	The Employer must ensure the terminology used in EPs in relation to the justification and authorisation process is in keeping with IR(ME)R to ensure complete clarity on the process. Ref 5.2.2
	Response by Employer detailing the actions taken: EPs reviewed throughout to ensure correct terminology is used.
Area for improvement 16 **Ref: Regulation 6(5)(a)** **Stated: First time** **To be completed by:** **11 May 2026**	The Employer must clarify the referral guidelines used for the imaging required within the stroke lysis pathway and amend Employers Provedures as appropriate. Ref 5.2.2
	Response by Employer detailing the actions taken: Stroke Lysis Imaging Referral Pathway has been added to Procedure F.
Area for improvement 17 **Ref: Regulation 15(2)** **Stated: First time** **To be completed by:** **11 May 2026**	The Employer must ensure that the equipment inventory fully reflects all information required under IR(ME)R. Ref 5.2.3
	Response by Employer detailing the actions taken: Equipment Inventory has been reviewed and updated.
Area for improvement 18 **Ref: Regulation 6 Schedule 2(1)(e)** **Stated: First time** **To be completed by:** **11 June 2026**	The Employer must ensure EP J describes dose recording and details processes for dose assessment and involved personnel. Ref 5.2.3
	Response by Employer detailing the actions taken: EP J to be reviewed and further detail added.

Area for improvement 19 **Ref: Regulation 6(5)(c) Schedule 2(1)(f)** **Stated: First time** **To be completed by: 11 May 2026**	The Employer must fully implement the action plan for diagnostic reference levels. Ref 5.2.5
	Response by Employer detailing the actions taken: Following Action Plan devised and agreed with MPE and shared following inspections dose data has been collected trust wide from all modalities, timescales on track for completion.
Area for improvement 20 **Ref: Regulation 6(5)(c) Schedule 2(1)(f)** **Stated: First time** **To be completed by: 11 June 2026**	The Employer must establish and implement diagnostics reference levels for DXA examinations. Ref 5.2.5
	Response by Employer detailing the actions taken: Following Action Plan devised and agreed with MPE and shared following inspections DXA dose data trustwide has been collected timescales on track for completion.
Area for improvement 21 **Ref: Regulation 6 Schedule 2(1)(c) &(j)** **Stated: First time** **To be completed by: 11 June 2026**	The Employer must amend Employers Procedure D pregnancy enquiries and Employers Procedure G clinical evaluation to ensure they provide sufficient consistent information for duty holders to follow. Ref 5.2.5
	Response by Employer detailing the actions taken: EP D and G will be reviewed and ammended for accuracy and clarity.

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