The Regulation and Quality Improvement Authority

Inspection Report

03 May 2023

Altnagelvin Area Hospital Diagnostic and Interventional Radiology Department

Address: Glenshane Road, Londonderry, BT47 6SB
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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:** Altnagelvin Area Hospital (AAH) Diagnostic and Interventional Radiology Department
Name of Employer: Dr Brendan Lavery, Medical Director (WHSCT)	**Radiology Services Manager (RSM):** Ms Tracey McIvor
Clinical Lead for Radiology (Northern Sector WHSCT): Dr Niall MacKenzie	**Medical Physics Expert:** Ms Julie Smyth

Brief description of how the service operates:

The AAH diagnostic and interventional radiology department provides a 24 hour seven days a week radiology service to adult and paediatric patients within the WHSCT catchment area. The AAH diagnostic radiology department is based in two areas on the main hospital site, one within the main hospital, and a smaller radiology department (which is separate to the radiotherapy service) in the North West Cancer Centre (NWCC), both sites are operational and are managed together as one department.

Before the inspection Ms McIvor (RSM) and her team were asked to complete a self-assessment form (SAF). The submitted SAF confirmed that each year, the AAH radiology department provides 92,122 general radiography exams, 23,502 computed tomography (CT) scans, 2274 dental exams, 2444 dual x-ray absorptiometry (DXA) scans, 2455 theatre fluoroscopy exams, 917 fluoroscopy exams in room 7 and 287 general fluoroscopy exams in room 8 in the main radiology department. A limited interventional radiology service was outlined to include 157 ureteric stents, 160 peripherally inserted central catheter (PICC) line insertion, 55 tunnelled dialysis line, 11 Hickman line insertion, 7 percutaneous transhepatic cholangiogram (PTC) and 12 testicular embolization procedures.

It is proposed that a 'hub and spoke' interventional radiology service will be developed in the coming months with an interventional radiologist from the Belfast Health and Social Care Trust (BHSCT) providing a weekly interventional radiology service in AAH radiology department. The RSM outlined the planning arrangements and the due diligence exercise that will take place prior to the commencement of this service. Advice was provided with regards to entitlement arrangements.

The department is staffed by 94.2 whole time equivalent (WTE) permanent radiographers including 5.8 WTE plain film reporting radiographers and 1.8 WTE fluoroscopy reporting radiographers; 16.8 WTE consultant radiologists; 3 WTE specialist registrars (trainees); 2.4 WTE assistant practitioners and 10 WTE radiographer assistants.

The WHSCT have two clinical leads for radiology, one for the southern sector and one for the northern sector. The clinical lead position for the northern sector is Dr MacKenzie who is currently covering as the IR(ME)R practitioner for the whole WHSCT service. The clinical lead position in the southern sector is vacant. However, management confirmed they hope to appoint a clinical lead for the southern sector when staffing has stabilised.

The team is supported by a Medical Physics Expert (MPE) contracted from Regional Medical Physics Service (RMPS) based in the BHSCT.

2.0 Inspection summary

On 3 May 2023, 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 AAH diagnostic and interventional radiology department, as part of RQIA's IR(ME)R inspection programme.

For the 2023/24 inspection year the inspections will focus on four key themes:

- Entitlement of staff focusing particularly on those duty holders outside of the radiology department and inter Trust duty holders
- Clinical evaluation including arrangements for peer review
- Clinical audit including robust interpretation of findings and action plans
- Patient identification including pause and check
- Any other areas identified through the review of the submitted self-assessment form 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 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?

A previous inspection had not been undertaken of the AAH diagnostic and interventional radiology department under the current IR(ME)R legislation.

5.2 Inspection findings

5.2.1 Does the service adhere to legislation in relation to the entitlement of duty holders including assessing training and competency?

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 and continuing professional development for radiographers was reviewed and it was noted that there were inconsistencies in the completion of induction and training records. Some did not have co-signatures of the mentor or line manager with regards to completion of various components of the induction programme. In some cases, the individual had signed their own training records or indeed they were not completed at all. Staff spoken with confirmed they had received induction and training in line with their scope of practice. Following the inspection additional staff training and competency records were submitted to RQIA. These evidenced that equipment training and competency had been undertaken by radiographers and the training programmes were robust. However, to ensure a consistent approach to completion of induction programmes and ongoing training and competency records, an area for improvement has been identified to ensure all induction and training/competence records are robustly completed by the relevant stakeholders and that these records are subject to periodic auditing.

The entitlement process must be underpinned by evidence of training and competency for practitioner and operator duty holders. There was little evidence available of training and competence for duty holders outside of the radiology department, for example orthopaedic surgeons, urologists, nephrologists and anaesthetists. An area of improvement has been identified to ensure practitioner and operator duty holders including those outside of the radiology department have evidence of undertaking training and assessment of competency in line with their scope of practice.

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. Consultant radiologists 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, radiographers and non-medical referrers(NMRs) were reviewed. Overall these individual records were found to be mostly well completed. However, the radiologists entitlement did not specifically reflect the operator tasks undertaken by the radiologists such as clinical evaluation. An area of improvement has been identified to ensure consultant radiologists entitlement records reflect operator tasks such as clinical evaluation.

The arrangements for entitlement of NMR were very robust and it was good to evidence that they are subject to regular review. Group entitlement records were reviewed for MPEs, these were found to clearly evidence the entitlement of this group of staff.

The entitlement of staff outside the radiology department such as those who may act as a duty holder in theatres was discussed. As previously stated, orthopaedic surgeons, urologists and nephrologists and anaesthetists had been entitled and the entitlement records for orthopaedic surgeons were reviewed. Through discussion it became clear the entitlement records did not reflect the duty holder roles as outlined for these groups of staff and did not reflect a clear individual scope of practice.

An area for improvement has been identified to review the entitlement arrangements for such staff as orthopaedic surgeons, urologists, nephrologists and anaesthetists to ensure it is in line with their duty holders roles, that entitlement records accurately reflect this and outline a clear individual scope of practice.

A named advanced nurse practitioner entitlement record was reviewed and it was noted that this individual had been entitled as a NMR which was fully reflected in the record. However, they were also carrying out clinical evaluation which is an operator task. The entitlement record did not fully reflect the duty holder role of operator. An area of improvement has been identified to ensure the named advanced nurse practitioner is entitled as an operator and the entitlement record fully reflects this duty holder role.

It was confirmed that a third party independent company, Medica, have been entitled as operators under group entitlement to clinically evaluate some exposures for the WHSCT. The entitlement records did not fully reflect clear detail on duty holder roles and there was no evidence of competency sign off in the entitlement record. An area of improvement has been identified to review the entitlement arrangements for Medica staff and ensure there is evidence of competency sign off.

It was confirmed artificial intelligence (AI) services HeartFlow and RAPID AI are to be introduced across the Northern Ireland (NI) region to support assessment of specific cardiac conditions and patient stroke conditions respectively. These services are further discussed in section 5.2.2 of this report. The entitlement arrangements for such services were examined. The WHSCT had sought to entitle the RAPID AI Ltd company. The service is the detailed analysis of CT scan images by a computer algorithm and AI and not by a person. Under IR(ME)R clinical evaluation is an operator duty holder role and an operator is currently defined as *'any person' entitled to carry out practical aspects of an exposure* it would not therefore be appropriate to entitle the company RAPID AI Ltd. It was determined that the analysis generated by the RAPID AI service would be sent to specific stroke clinicians providing additional information to inform clinical decision making for individual patients. As such these clinicians should be trained and entitled as operators. These arrangements would also be reflected for the HeartFlow service. An area of improvement has been made to identify and entitle relevant cardiologists and stroke clinicians who are trained to clinically evaluate the data and images from relevant AI software programmes used to support the clinical decision making process.

Employers Procedures (EP) B on entitlement, sets out the arrangements for entitlement and provides a sound framework for the entitlement process. It was good to note that a number of amendments had been completed following a recent IR(ME)R inspection of another WHSCT radiology department. It was advised to keep this EP updated in line with changes to entitlement arrangements as a result of this inspection.

It was confirmed that Republic of Ireland (ROI) referrers have group entitlement. They refer for nuclear medicine procedures only and for a restricted scope of practice. Management confirmed that staff always check ROI medical registration is in place before booking these examinations. It was confirmed that there is a nuclear medicine department on the AAH site.

Justification and Authorisation

The duty holder roles of operator and practitioner was examined in relation to the justification and authorisation of exposures.

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. 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. 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. 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.

It was confirmed that within the AAH radiology department the radiographers act as operators and authorise exposures using authorisation guidelines. A range of authorisation guidelines were reviewed and they were found to have sufficient detail to act as authorisation guidelines and the identity of the practitioner for exposures undertaken using the authorisation guidelines was evident from the guidelines. It was confirmed that radiographers have been entitled to act as practitioners for carers and comforter's exposures. The justification and authorisation process was found to be clear on the roles of the operator and practitioner and staff displayed a very good understanding of their roles and responsibilities. It was confirmed that a nephrologist acts as a practitioner for exposures carried out for specific renal studies. However, it was not possible to evidence where justification of these exposures is recorded. An area of improvement has been identified to ensure there is evidence of justification of all exposures including specific renal studies.

Review of the submitted SAF, supporting documentation and discussion with key staff during the inspection evidenced overall clear and robust entitlement arrangements are in place. However, entitlement of some staff groups outside of the radiology department requires to be strengthened. Management and staff were receptive to advice on the entitlement process. The inspection team acknowledge the commitment of staff in this regard.

5.2.2 Does the service have appropriate arrangements for the clinical evaluation of medical exposures including peer review?

Clinical Evaluation

The employer must ensure that a clinical evaluation of the outcome is recorded for each exposure. Clinical evaluation involves the assessment of an image and the documentation by the suitably trained and entitled operators. Clinical evaluation is most commonly considered to be a documented radiology report, which is usually recorded on Radiology Information System (RIS). Other methods of clinical evaluation include written records in patient notes. It is considered that evaluation is the final step in the justification process. A clinical evaluation is not required for individuals who are exposed while being a carer or comforter.

It was confirmed that radiologists including specialist trainees provide clinical evaluation in the form of a written report available on (RIS). There are a number trained and entitled radiographers providing clinical evaluation in line with their scope of practice. As stated previously some advanced nurse practitioners in the Emergency Department clinically evaluate images and treat on the basis of what they see.

In theatres the performing surgeon clinically evaluates images undertaken as part of the operation/procedure and records this in the patient's notes. Clinical evaluation of DXA scans is carried out by entitled DXA radiographers. A DXA clinical evaluation formal report was reviewed and it was good to note it provided technical data and also clinical information such as diagnosis of osteopenia or osteoporosis.

The Regional Imaging Board for NI have been working on a regional reporting approach for some specialised clinical evaluation due to a lack of appropriately trained radiologists. It was confirmed that the regional reporting approach has been implemented in the WHSCT with double reporting for suspected physical abuse (SPA) imaging. Only three radiologists in NI can perform SPA evaluation so they share the workload of this double reporting across NI. The governance arrangements for regional clinical evaluation services is through the individual radiologist's host Trust's.

The timeframe for providing clinical evaluation was discussed, management outlined the following:

- Urgent/red flag report within 48 hrs
- 75% of all exposure clinically evaluated within 14 days
- 100% of exposures within 28 days

It was confirmed Altnagelvin radiology department generally adheres to these standards. There is an audit trail in the RIS which identifies which exposures have not yet been reported and these are followed up on by management. As stated there are instances where clinical evaluation is recorded directly in the patient's clinical notes which is also subject to audit.

'EP G' is in place for the clinical evaluation for medical exposures which outlines a documented clinical evaluation is produced for all medical exposures. Discussions with management and staff confirmed a clear understanding of the clinical evaluation for medical exposures.

Artificial Intelligence (AI)

As AI systems are beginning to make their way into clinical radiology practice, it is crucial to ensure that their use is compliant with IR(ME)R and safe clinical practice. The AI systems being trialled in NI provide images using data from CT scans. The resulting data and images are clinically evaluated by clinicians who have been trained and entitled as operators and used to support decision making processes for ongoing treatment of patients to improve patient care.

As stated previously two projects using AI software, HeartFlow and Rapid AI, are being piloted across the NI region. The pilot studies are regionally funded to support efficient and effective cardiology and stroke services. The data and images produced provide additional clinical information to support clinical decision making, for example, which patients should be transferred to interventional services at BHSCT and which are best treated locally. A full impact analysis of the trial will be undertaken. It was confirmed the lead for HeartFlow is a cardiologist and the lead for RAPID AI is a clinician in the stroke team. It was advised to explore whether the studies are deemed as research and therefore subject to the requirements of IR(ME)R on research. Management confirmed they would follow this up with the co-ordinating team.

It was confirmed that CT scan images sent to the AI software will have been clinically evaluated by trained and entitled operators.

When the data and image analysis is used to support clinical decision making then, those reviewing the AI analysis should be entitled as operators for clinical evaluation and a record of the evaluation made.

Management confirmed that the AI trial is subject to detailed scrutiny at each phase to ensure participating staff are suitably qualified and trained to perform the practical aspects of these exposures. For example, radiographers at AAH radiology department require training in performing CT perfusion scanning and radiologists require training in the clinical evaluation of CT perfusion scans. It was good to note that management clearly recognised staff will require time and support from manufacturer applications specialists to set up CT perfusion protocols, MPE involvement to ensure dose optimisation and training for radiographers performing this new technique. Assurances were provided by management, this would be instigated and completed prior to WHSCT proceeding to phase 2 of the Rapid AI trial.

Peer Review

Peer review in radiology means an assessment of the accuracy of a written report (clinical evaluation) issued by another radiologist/radiographer (entitled operator).

It was good to note that in general radiography reporting radiographers are required to perform regular peer review on each other's clinical evaluation with support from their radiologist mentors all of which is subject to regular audit.

For newly recruited radiologists there is a two week induction involving working alongside another radiologist mentor followed by spot checks on report standards performed, with peer review included at multi-disciplinary team (MDT) meetings.

The implementation of the recently issued regional guidance on peer review was discussed. The guidance outlines the process of setting targets for high risk categories. AAH suggested one to two per cent of reporting to be subject to peer review in higher risk areas for example CT. Regionally the pilot of peer review is awaiting feedback and results. The lead radiologist highlighted that regional peer review must not impact on clinical work. The WHSCT is considering the guidance and how best to implement peer review of clinical evaluation in their practice.

It was confirmed that radiologists hold two monthly learning (discrepancy) meetings which now includes learning and peer review of images. These meetings also include locum radiologists.

Review of the submitted SAF, supporting documentation and discussion with key staff during the inspection evidenced that the AAH radiology department have robust arrangements with respect to clinical evaluation and are enthusiastic to ensure these arrangements are regularly reviewed and if necessary improvements are made. The inspection team acknowledge the commitment of staff in this regard.

5.2.3 Does the service adhere to legislation with regard to clinical audit including robust interpretation of findings and action plans?

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, whereby medical radiological practices, procedures, and results are examined against agreed standards for good medical radiological procedures, with modification of practices, where indicated and the application of new standards if necessary.

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

There are systems in place to undertake clinical audits of CT and general radiology. Audit is managed via the radiology quality management system (QMS). The service achieved Quality Standard for Imaging (QSI) accreditation and part of the process requires that an agreed audit schedule is established. The audit information is managed via the Q pulse part of the QMS and creates alerts to the responsible officers to ensure that the required audits are performed and documented as per the schedule. There is an annual audit programme in place which is carried out by the radiographers. The audit programme is planned with the involvement of the radiology team who provide suggestions to the assistant radiology service managers (ARSMs) on topics for audit taking into account such areas as review of incidents. It was good to note a high level of involvement of all grades of radiology staff in carrying out audit. A rolling programme of core audits is carried out which includes compliance with IR(ME)R audits. The clinical audit programme for radiologists is agreed as part of the individual radiologists annual appraisal, each must carry out at least one audit per year in line with revalidation requirements. However, the lead radiologist confirmed as a result of a recent QSI visit the clinical audit programme for radiologists is more structured and a rolling programme of audits is to be established.

Evidence of audits were provided which included:

- Fluoroscopy (cardiac cath) dose recording audit
- Lateral knee positioning audit
- NG tube positioning technique and time to report audit
- Dental dose audit
- Quality control of equipment compliance audit
- PICC line position audit

These were found to include a good audit methodology with a clear template outlining results, actions, named responsible person and re-audit timeframes when required.

The findings of the audit are outlined and specific actions to address any issues in place. Staff described how audits had led to positive changes in practice and demonstrated a knowledge on the importance of audit. It was noted that the time frame for the re-auditing where issues had been identified did not reflect appropriate re- audit timeframes to ensure issues were addressed with some scheduled for a year later.

An area of improvement has been identified to review the timing of re-auditing when significant findings have been identified through clinical audit to ensure issues are addressed in a timely manner.

It was confirmed that audit findings are shared with staff through monthly meetings, team briefings in their departments, PowerPoint presentations, lunch time audit presentations and audit findings posters where noted to be displayed in the department. This robust approach to sharing audits findings and involving staff is to be commended.

Management described the clear governance arrangements for ensuring the audit programme is established, implemented, acted upon and used to drive improvement. All demonstrated a sound understanding of the roles and responsibilities associated with clinical audit. It was confirmed this includes sharing radiology audits with the Trust audit office for external scrutiny.

Review of the submitted SAF, supporting documentation and discussion with key staff during the inspection evidenced clear and robust clinical audit arrangements are in place. Management and staff were receptive to advice on the clinical audit process. 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. EP 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 request made. Whilst many people may be involved with the patient the responsibility for correct ID lies with the operator who carries out the medical exposure. Staff described the patient ID process, the operator must always check the patient's name, address and date of birth on the referral. 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 being x-rayed/scanned?
- 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. Pause and check notices were observed to be displayed in the department and staff demonstrated a clear understanding of the importance of the use of Pause and Check.

Staff described the patient ID process when more than one operator is involved. For other scenarios such as patients who lack capacity, the unconscious patient and patients in theatre, 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 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 core audits. There was a very high compliance level noted.

Staff explained the process for discrepancies in the patient ID, this included; check if known as any other name, check with carer/relative, check on picture archiving communication system (PACS), make a record of the changes required, and send a request to PACS team to change the demographics. There is a section in RIS for incorrect demographics. However, 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 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

Employers Procedures (EPs)
There were comprehensive detailed EPs in place which had been approved in April 2023 by the Employer. It was good to note that they had been updated following a recent IR(ME)R inspection to another WHSCT radiology department.

EP C making a referral was reviewed, overall it was found to be well written however it did not include sufficient detail on the management of a referral such as:

- How to appoint a referral
- Process for incomplete referrals
- Process for cancelling referral and safe timely return to referrer
- Process for patients who did not attend (DNA)

EP D making pregnancy enquiries, was reviewed and found to be very comprehensive. However, it requires to further reflect the professional guidance on inclusivity and provide procedures for staff to follow in this respect.

An area of improvement was identified to amend EP C and EP D as outlined above.

6.0 Conclusion

There were 10 areas of improvement identified as a result of this inspection. This is 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 AAH 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	10

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 area 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 17 (4) **Stated:** First time **To be completed by:**	The Employer must ensure all induction and training records are robustly completed by the appropriate staff and are subject to periodic auditing. Ref 5.2.1

3 August 2023	**Response by Employer detailing the actions taken**: Completed June 23 - quarterly audit thereafter for 12 months and then audit frequency will be reviewed.
Area for improvement 2 **Ref:** Regulation 17 **Stated:** First time **To be completed by:** 3 August 2023	The Employer must ensure practitioner and operator duty holders have evidence of undertaking training and assessment of competency in line with their scope of practice. Ref 5.2.1
	Response by Employer detailing the actions taken: Review underway and lots of work completed already - Will be completed by 3rd August 2023
Area for improvement 3 **Ref:** Regulation 6 Schedule 2 (1) (b) **Stated:** First time **To be completed by:** 3 August 2023	The Employer must ensure consultant radiologists entitlement records reflect operator tasks such as clinical evaluation. Ref 5.2.1
	Response by Employer detailing the actions taken: Will be completed by 3rd August 2023
Area for improvement 4 **Ref:** Regulation 6 Schedule 2.1 (b) **Stated:** First time **To be completed by:** 3 August 2023	The Employer must review the entitlement arrangements for such staff as orthopaedic surgeons, urologists and nephrologists to ensure it is in line with their duty holder roles, that entitlement records accurately reflect this and outline a clear individual scope of practice. Ref 5.2.1
	Response by Employer detailing the actions taken: Will have carried out review of requirements by 3rd August 2023
Area for improvement 5 **Ref:** Regulation 6 Schedule 2 .1 (b) **Stated:** First time **To be completed by:** 3 August 2023	The Employer must ensure the named advanced nurse practitioner is entitled as an operator for clinical evaluation and the entitlement record fully reflects this duty holder role. Ref 5.2.1

	Response by Employer detailing the actions taken: Will be completed by 3rd August 2023
Area for improvement 6 **Ref:** Regulation 6 Schedule 2 .1 (b) **Stated:** First time **To be completed by:** 3 August 2023	The Employer must review the entitlement arrangements for Medica duty holders to ensure they accurately reflect the scope of practice and include competency sign off. Ref 5.2.1
	Response by Employer detailing the actions taken: Will be completed by 3rd August 2023
Area for improvement 7 **Ref:** Regulation 6 Schedule 2.1(b) **Stated:** First time **To be completed by:** 3 August 2023	The Employer must entitle, as operators, relevant cardiologists and stroke clinicians who are clinically evaluating image analysis data from Artificial Intelligence (AI) software used to support clinical decision making. Ref 5.2.1
	Response by Employer detailing the actions taken: Will be completed by 3rd August 2023
Area for improvement 8 **Ref:** Regulation 11 (1) (b) **Stated:** First time **To be completed by:** 3 August 2023	The Employer must ensure justification by nephrologists for their specific renal exposures is recorded and the practitioner can be identified. Ref 5.2.1
	Response by Employer detailing the actions taken: Will be completed by 3rd August 2023
Area for improvement 9 **Ref:** Regulation 7 **Stated:** First time **To be completed by:** 3 June 2023	The Employer must review the timing of re-auditing when significant findings have been found through the audit process to ensure issues are addressed in a timely manner. Ref 5.2.3
	Response by Employer detailing the actions taken: Complete
Area for improvement 10 **Ref:** Regulation 6 Schedule 2 (1) (c) & (d) **Stated:** First time **To be completed by:** 3 August 2023	The Employer must amend Employer's Procedure C making a referral and Employer's Procedure D making pregnancy enquiries as outlined in section 5.2.5 of this report. Ref 5.2.5
	Response by Employer detailing the actions taken: Will be completed by 3rd August 2023 - contact made with Trust representatives re review of Trust Policy also

The Regulation and Quality Improvement Authority

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