

Title of Document:	IR(ME)R PROCEDURE (K)	
	To ensure that the probability and magnitude of accidental or unintended exposure to individuals from radiological practices are reduced so far as reasonably practicable	
Directorate:	RADIOLOGY DIRECTORATE	

Document type & number:	IRMER 11
Approval committee:	DIRECTORATE GOVERNANCE MEETING
Approval date:	14.05.2025
Issue date following approval/review/	20.05.2025
amendment :	
Review date:	14.05.2028
Version number:	V4
Key amendments:	Date:
Information added around patient dose	May 2025
audits and LDRLs plus corrective actions	
following radiation incidents.	May 2025
Full review with narrative and actions	
added to better reflect the ne IR(ME)R	
regulations 2024 Amended .Change in	
wording to reflect the 2024 regulation 7	
changes	
Individuals involved in developing /	
reviewing / amending this document:	
(titles only)	
Radiation Protection Supervisor	Match 2025
Radiation Protection Advisor	May 2025
General Lead Radiographer	May 2025
Key staff responsibilities	Post:
Responsible for ensuring that the SOP is	Radiology Clinical Services Manager
followed on all sites.	
Responsible for the day to day	Lead Superintendent Radiographers for each site
implementation of the SOP, and for	
Preventative maintenance and repair:	
To comply with this procedure and all	All IR(ME)R Operators
related procedures,	
Ensure Equipment fault and incident	
reporting in completed and ensure	
adequately trained on equipment	
operation	OA radiographer / Madical Physics Type at /MADT\
Quality Assurance	QA radiographer / Medical Physics Expert (MPE)
To complete or delegate completion of	RPS
the IRMER procedure audits	

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In-line with regulation 6 schedule 2 requirements within IRMER 2024 (Amendment) Regulations, the purpose of this procedure is to limit the likelihood and extent of accidental or unintended exposure of patients.

This procedure explains the processes we follow to limit the above and covers all medical exposures within Diagnostic X-ray, Nuclear Medicine, Cardiology and Interventional Radiology, exposures to which these regulations Apply

The employer must establish a system for—

(a)recording analyses of events involving or potentially involving accidental or unintended exposures proportionate to the radiological risk posed by the practice; and

(b) the taking of any appropriate action in relation to such analyses.".

## **Practice:**

- Ensure we have the correct patient, the identity of the patient is checked prior to any radiation exposure, following IRMER procedure (A)
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   PROCEDURES + carer-comfort form\IRMER PROCEDURE (A) PATIENT ID.pdf
- To ensure were appropriate, that enquiries are made of individuals of childbearing age if they are pregnant or breastfeeding, according to the IRMER procedure (C).
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   PROCEDURES + carer-comfort form\IRMER PROCEDURE (C) PREGNANCY AND
   BREASTFEEDING ENQUIRIES.pdf
- 3. Equipment, where appropriate, is subject to a regular preventative maintenance programme.
- 4. Equipment is subject to a Quality Assurance (QA) programme:
  - commissioning tests before it is first used for clinical purposes.
  - Testing at regular intervals and after any major maintenance.
  - Representative patient dose assessments patient dose audits and Local Diagnostic Reference Levels (LDRL) reviews are undertaken by your MPE.
     Examinations will be optimised where averages significantly exceed DRL's.

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(MPE REPORTS)\IRS PATIENT DOSE AUDIT\Countywide\Countywide Dose Audit

2024\CAS-03155-N6B3D5.pdf

- 5. Regular QA and audits (including monthly reject analysis) of procedures undertaken by RPS but this may be delegated to an alternative appropriate member of staff.
- 6. Equipment that exhibits faults is likely to cause patient dose overexposure is taken out of use until repaired. Equipment faults are reported to Site Superintendent and logged onto the countywide fault log spreadsheet.
  M:\Acute\Radiology\Radiology\Radiology Team Share Point\EQUIPMENT BREAKDOWN AND HANDOVER\COUNTYWIDE EQUIPMENT FAULT LOG
- 7. A formal procedure is followed for hand-over of equipment for maintenance or repair. Following the breakdown procedure and using a standardized AXREM forms:

  M:\Acute\Radiology\Radiology\Team Share Point\EQUIPMENT BREAKDOWN
- All operators undergo appropriate in-house training on the operation of equipment or tasks. With associated competency records: <u>M:\Acute\Radiology\Directorate\3.TRAINING</u>
- 9. All incidents are reported and investigated following the Worcestershire Acute Hospitals NHS Trust Incident Reporting Policy. (Datix)

https://nhs.sharepoint.com/sites/RWP\_Clinical\_Governance\_Hub/SitePages/Datix-aspx?promotedState=0

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10. All radiation incidents are recorded on a County widespread sheet. Root cause can be identified

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11. All incidents are submitted to Datix and assigned to a member of the Radiology team to investigate. Shared learning opportunities are created and sent Countywide. The Site Superintendent radiographer (or delegated member of staff) will perform a Formal one to one discussion and request a reflective piece of work be created. All documentation relating to the incident will be attached to the DATIX incident for clarity.

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- 12. Following the formal One to one with the site Superintendent Radiographer, a recurring theme may be identified and actions put in place proportional to the incident. All Actions will be recorded with in the Datix system. A typical action could be a period of supervised practice.
- 13. Incidents are discussed at Radiology Directorate Governance Meetings. A monthly report from DATIX is discussed. feedback is provided to staff on the monthly Quality Governance (QG)Updates where themes are itemized. Reading compliance for the QG updates is monitored on DAVE acknowledgement platform which will be audited.

NHS Trust

## **QUALITY GOVERNANCE UPDATE FEBRUARY 2025**

If you are reading this on your phone, tablet or PC at home, you will not be able to acknowledge the link at the end and you will not be able to read it in full as you are not able to open any embedded documents relevant to your role or open the links to approved new documents.



## INCIDENT REPORTING & LEARNING

- Total incidents = 55
   Radiation incidents = 6

  | Incidents January 2025.docx
- 14. Where appropriate and identified corrective actions such as staff retraining or updating procedures will be carried out.
- 15. All radiation incidents are tabled separately and also reviewed at the Radiation Protection Committee utilizing the Annual RPC report created by our medical Physics Providers.
- 16. Ratified Minutes of bi yearly Radiation Protection Committee meetings are available to staff on Team Share Point. Radiation incidents are reviewed by modality, duty holder and root cause. The reports also compare incident levels to the previous year.
- 17. All unintended radiation incidents must be reported following the radiation incident flow chart (appendix A).

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## Appendix A:

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