Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Health Information and Quality Authority

Report of the assessment of compliance with medical exposure to ionising radiation regulations

Name of Medical Radiological Installation:	St Finbarr's Hospital
Undertaking Name:	Health Service Executive
Address of Ionising Radiation Installation:	Douglas Rd, Ballinlough, Cork
Type of inspection:	Announced
Date of inspection:	27 May 2025
Medical Radiological Installation Service ID:	OSV-0007953
Fieldwork ID:	MON-0040055

About the medical radiological installation (the following information was provided by the undertaking):

St. Finbarr's Hospital is a health campus, comprising of five long stay wards, three rehabilitation wards and also provides social and primary care services.

St Finbarr's Hospital X-ray department consists of a plain film X-ray room, DXA unit and mobile X-ray service. The department is located on the ground floor of the administration building.

The X-ray department comes under the clinical governance of radiology in Cork University Hospital (CUH) with consultant radiologist, radiography services manager (RSM), radiation protection officer (RPO), radiography and medical physics support being provided from radiology in CUH.

The department serves the on-campus in-patient wards, the assessment and treatment unit, ICPOP and public health department located at the hospital.

The X-ray department performed 817 patient exams in 2024 and has one whole time equivalent radiographer on-site providing X-ray cover Monday to Friday. There are no emergency admissions to St Finbarr's Hospital and consequently no out-of-hours radiography services on campus. CUH provides emergency cover overnight and at weekends.

How we inspect

This inspection was carried out to assess compliance with the European Union (Basic Safety Standards for Protection against Dangers Arising from Medical Exposure to Ionising Radiation) Regulations 2018, as amended. The regulations set the minimum standards for the protection of service users exposed to ionising radiation for clinical or research purposes. These regulations must be met by each undertaking carrying out such practices. To prepare for this inspection, the inspector[1] reviewed all information about this medical radiological installation[2]. This includes any previous inspection findings, information submitted by the undertaking, undertaking representative or designated manager to HIQA[3] and any unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- talk with staff and management to find out how they plan, deliver and monitor the services that are provided to service users
- speak with service users[4] to find out their experience of the service
- observe practice to see if it reflects what people tell us
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

About the inspection report

In order to summarise our inspection findings and to describe how well a service is complying with regulations, we group and report on the regulations under two dimensions:

[1] Inspector refers to an Authorised Person appointed by HIQA under Regulation 24 of S.I. No. 256 of 2018 for the purpose of ensuring compliance with the regulations.
[2] A medical radiological installation means a facility where medical radiological procedures are performed.
[3] HIQA refers to the Health Information and Quality Authority as defined in Section 2 of S.I. No. 256 of 2018.
[4] Service users include patients, asymptomatic individuals, carers and comforters and volunteers in medical or biomedical research.

1. Governance and management arrangements for medical exposures:

This section describes HIQA's findings on compliance with regulations relating to the oversight and management of the medical radiological installation and how effective it is in ensuring the quality and safe conduct of medical exposures. It outlines how the undertaking ensures that people who work in the medical radiological installation have appropriate education and training and carry out medical exposures safely and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Safe delivery of medical exposures:

This section describes the technical arrangements in place to ensure that medical exposures to ionising radiation are carried out safely. It examines how the undertaking provides the systems and processes so service users only undergo medical exposures to ionising radiation where the potential benefits outweigh any potential risks and such exposures are kept as low as reasonably possible in order to meet the objectives of the medical exposure. It includes information about the care and supports available to service users and the maintenance of equipment used when performing medical radiological procedures.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 27 May 2025	09:30hrs to 12:50hrs	Kay Sugrue	Lead
Tuesday 27 May 2025	09:30hrs to 12:50hrs	Noelle Neville	Support

Governance and management arrangements for medical exposures

Inspectors completed an inspection at St Finbarr's Hospital on 27 May 2025. As part of this inspection, inspectors reviewed documentation provided, including a sample of medical exposure records, spoke with the management team and staff and visited the general X-ray room and DXA unit. Inspectors were informed that the Health Service Executive (HSE) was the undertaking for the radiology facility at St Finbarr's Hospital.

At the time of this inspection, the radiology service at St Finbarr's Hospital was resourced by radiography staff from the Cork University Hospital (CUH). The arrangements in place ensured that medical exposures were only carried out on the basis of referrals received from recognised referrers, as per Regulation 4. Similarly, only those entitled to act as practitioners, under Regulation 5, took clinical responsibility for medical exposures in this service. Inspectors found from the evidence gathered that MPE continuity arrangements were in place to provide the necessary advice in relation to medical radiological practices in this service, thereby, complying with Regulation 19(9). Inspectors noted while the majority of responsibilities set out under Regulation 20 were met, there was scope to improve MPE contribution towards optimisation and in relation to the regular review of local diagnostic reference levels (DRLs).

Inspectors reviewed the radiology governance arrangements at St Finbarr's Hospital and found that there was a hospital radiation safety committee (RSC) in place that met twice a year**.** Staff informed inspectors that matters relating to the radiation protection of service users were overseen locally by the RSC and issues that arose were also discussed at the Cork University Hospital (CUH) radiation protection unit (RPU). Inspectors were informed that the designated manager reported to the regional executive officer via the management framework for older persons services which differed from the reporting structure described by staff in relation to the oversight of the radiation protection of service users. From the review of documentation and discussions with staff, inspectors found it difficult to ascertain where the overarching responsibility for radiation protection lay and consequently identified that improvements were required to ensure that reporting pathways up to the undertaking, the HSE, were clear to all staff working at the facility. Staff described the status of governance arrangements as "in flux," while multiple services co-located on the grounds of the hospital, transitioned into the new Integrated Healthcare Area (IHA) within the HSE South West health region.

In addition, inspectors identified that document quality management systems also needed attention. For example, most of the available guidance documentation originated from CUH and were not specific to St Finbarr's Hospital, while some were in draft form, others had poor version control history recorded or had not been regularly updated.

Based on the above findings from this inspection, the undertaking must take action to clearly define the radiology governance structures for this facility while also improving supporting documentation for medical radiological practices for the benefit of staff delivering medical exposures and for service users attending for X-ray there.

Regulation 4: Referrers

Inspectors were satisfied that medical radiological procedures were only carried out at St Finbarr's Hospital on the basis of referrals from persons recognised in Regulation 4. A list of approved referrers for this service was available to staff in the control area of the X-ray room.

Judgment: Compliant

Regulation 5: Practitioners

Inspectors were informed that radiographers were recognised as practitioners for medical exposures conducted in this facility, thereby, meeting the requirements of Regulation 5.

Judgment: Compliant

Regulation 6: Undertaking

A radiation safety committee (RSC) was in place at St Finbarr's Hospital and met twice a year. The RSC meetings held in 2024 were chaired by a clinical projects facilitator for older person services who was also the designated manager for this facility. Representatives from Cork University Hospital (CUH) also attended, including, the radiography services manager (RSM), a medical physics expert (MPE) and the radiation protection officer. Membership of this committee was multidisciplinary, however, inspectors were informed that a review of the membership was required to ensure that all attendees at this forum were appropriate and relevant to the radiology service. Additionally, inspectors were also informed that sub-committees of the RSC detailed in the committee's terms of reference did not exist and therefore the terms of reference should be updated accordingly to reflect the current arrangements.

This facility is co-located with several different HSE service types which have separate management structures in place. Management staff informed inspectors that the establishment of governance arrangements for the Integrated Healthcare

Area (IHA) had been delayed and were due to be finalised by September of this year. As a consequence, this led to uncertainty and ambiguity among staff as to where the current oversight for radiation protection lay. Inspectors were informed that the designated manager reported to the regional executive officer via the management framework for older persons services, however, matters relating to radiation protection were overseen locally by the RSC. Inspectors were informed that issues arising were further discussed at the Cork University Hospital (CUH) radiation protection unit (RPU). Given the current complex arrangements in place, and the discussions with staff during this inspection, it was unclear to staff, management and inspectors where ultimate responsibility for the radiation protection of service users lay. This has a potential to impact on the radiology service at St Finbarr's Hospital, the supports and resources available to staff, and ultimately, the radiation protection of service users, should the deficiencies outlined in radiology governance be allowed to continue. As a priority, the undertaking (the HSE) must establish radiology governance arrangements that provide appropriate oversight of the radiation protection of service users and clarity for all staff involved in the delivery of medical exposures at this facility.

In relation to the allocation of responsibilities, it was evident from a sample of medical exposure records viewed that appropriate individuals, as per the regulations, were allocated responsibility for referrals, clinical responsibility and justification of individual medical exposures. Similarly, continuity for MPE services, advice and involvement were also assured from established arrangements in place. However, inspectors noted that not all roles and responsibilities had been allocated to meet the requirements of Regulation 6(3). For example, inspectors were not provided with evidence in relation to the allocation of the roles and responsibilities for ensuring compliance with Regulation 7, the justification of practices and Regulation 13(4) for the responsibility for carrying out clinical audits in accordance with national procedures.

In addition, improvements were required regarding the management of documentation in relation to the radiation protection of service users and medical radiological practices at this facility. Inspectors found that most of the policies and guidance documents provided to inspectors did not specify if the scope of these documents were applicable to St Finbarr's Hospital radiological facility. The quality management of local policies and guidance material also needed to improve to ensure policy and processes were subject to regular review and revision to align with best practice and regulatory requirements and provide greater assurance of appropriate oversight and approval for use by management.

Judgment: Not Compliant

Regulation 10: Responsibilities

Medical radiological procedures at St Finbarr's Hospital took place under the clinical responsibility of a practitioner, as per Regulation 10(1). Inspectors were satisfied

that the justification of individual medical exposures involved the practitioner and referrer, and the optimisation process involved the practitioner and MPE, as required under this regulation.

Judgment: Compliant

Regulation 19: Recognition of medical physics experts

Inspectors met staff from the medical physics department in CUH. Medical Physics Experts (MPEs) from this department provided specialist advice for medical radiological practices at St Finbarr's Hospital and the continuity arrangements in place were sufficient to comply with the requirements of this regulation.

Judgment: Compliant

Regulation 20: Responsibilities of medical physics experts

Records and documentation reviewed by inspectors demonstrated that MPEs provided specialist advice at St Finbarr's Hospital, as required. An MPE attended the facility's RSC meetings, gave advice on medical radiological equipment, contributed to the definition of the quality assurance (QA) programme and carried out annual QA testing. This included acceptance testing which was evident in records viewed by inspectors for new equipment commissioned for use in 2020. Inspectors were informed that there were limited MPE resources which were shared across multiple facilities in the southwest of the country, therefore, annual QA of equipment and post service testing was an area of responsibility prioritised at St Finbarr's hospital.

There was evidence to show MPE involvement in the establishment and review of local DRLs in 2023, however, inspectors found there was scope for improvement in MPE involvement in dosimetry and optimisation in relation to the regular review of local DRLs and protocols. Inspectors noted that the electronic dose management system available to MPEs at CUH was not available for dose data collection at St Finbarr's Hospital. Consequently this data had to be manually collected by radiology staff at the hospital. The undertaking should ensure that data collection is progressed to facilitate MPEs to contribute to optimisation as per Regulation 20(2)(c)(i). In addition, greater assurance was required to ensure that online training courses in relevant aspects of radiation protection are available to practitioners at St Finbarr's Hospital.

Inspectors were assured that MPEs at this facility liaised with radiation protection advisors (RPAs) assigned to the hospital, therefore satisfying the requirements of Regulation 20(3).

Judgment: Substantially Compliant

Regulation 21: Involvement of medical physics experts in medical radiological practices

Inspectors found from the review of documentation and discussions with staff that medical radiological practices at this facility were associated with a low level of radiological risk. Predominantly, MPEs focussed on ensuring medical radiological equipment was fit for continued clinical use to help ensure the delivery of safe medical exposures for service users attending for X-rays there. However, as outlined in Regulation 20, inspectors noted that there was scope for improvement such as MPE involvement in other aspects of radiation protection, for example, the regular review of DRLs at the hospital, and in contributing to the training of staff in relevant aspects of radiation protection.

Judgment: Substantially Compliant

Safe Delivery of Medical Exposures

Inspectors viewed the systems and processes in place to assess the safe delivery of medical exposures at St Finbarr's Hospital and found compliance with Regulations 8, while action was required by the undertaking to address the gaps in compliance identified in relation to Regulations 11, 13, 14 and 17.

From a review of records of completed medical radiological procedures, inspectors were satisfied that each medical exposure record viewed was appropriately referred by a recognised referrer and the clinical information provided was sufficient to inform the process of justification by a practitioner, as per the regulations.

Areas that required improvement were in relation to the regular review of facility DRLs which must be completed in line with local policy and HIQA guidance. The undertaking must also implement clinical audit in accordance with national procedures published by HIQA in 2023, to ensure compliance with Regulation 13. Additional action was also required to ensure that the inventory of medical radiological equipment and associated QA programme is specific to St Finbarr's Hospital to comply with Regulation 14(10). Furthermore, inspectors found that the systems in place to identify and manage potential radiation incidents and good catches could be strengthened to improve reporting levels within the radiological service at the hospital.

Regulation 8: Justification of medical exposures

Inspectors were satisfied that all referrals reviewed were in writing, stated the reason for the request and were accompanied by sufficient medical data to facilitate the practitioner in the justification of each medical exposure. Justification in advance of each medical radiological procedure was documented by the radiographer on the radiology information system using the patient identification and justification tick box. Information about the benefits and risks associated with the radiation dose from medical exposures was available to service users by means of posters displayed on walls in the X-ray waiting areas of the hospital.

The evidence viewed demonstrated compliance with the requirements of this regulation.

Judgment: Compliant

Regulation 11: Diagnostic reference levels

Inspectors were informed that the document named *Policy and Procedure on Dose Reference Levels in Radiology- Cork University Hospital Group* was applied at St Finbarr's Hospital. Inspectors noted that version control and review dates were not evident and the scope for application of this policy in St Finbarr's Hospital was not specified. In accordance with this policy, dose audits and facility DRLs were to be reviewed annually by the radiation protection officer (RPO), in consultation with the MPE. Inspectors found that the most recent dose audit and review of facility DRLs for general and portable X-ray procedures had been completed in 2023 which was not in line with local policy or HIQA guidance and therefore was not compliant with the regulations.

However, inspectors noted one example of good practice where staff had carried out a review of a small sample of cervical spine procedures following the above 2023 data collection period, where dose levels were found to be above national DRLs. New adjusted protocols were implemented which were based on preferred settings used by staff in other CUH facilities with similar equipment, and in consultation with medical physics. An image quality review of these procedures was also carried out to ensure that the adjusted settings applied provided sufficient diagnostic quality. A review of doses from cervical spine procedures in 2024 demonstrated reduced dose levels were below national DRLs and represented a good example of optimisation.

The undertaking must ensure that facility DRLs are completed annually in line with local policy and HIQA guidance and continue to follow the example of good corrective measures taken above as required.

Judgment: Not Compliant

Regulation 13: Procedures

Inspectors saw evidence to demonstrate that written protocols were in place for standard medical radiological procedures in both general X-ray and DXA scanning services which met the requirements of Regulation 13(1). An area of improvement was identified by the inspectors in relation to the process for review and approval of protocols to be applied at the hospital, which needed to be strengthened as detailed under Regulation 6.

Inspectors were satisfied that information relating to the patient exposure was evident in each of the reports of the medical radiological procedure reports viewed, as per Regulation 13(2). In addition, referral guidelines for medical imaging were available to staff delivering medical exposures at this facility.

A notable gap in compliance with this regulation was found in relation to the implementation of clinical audit for medical radiological procedures which had not been implemented in this service in accordance with national procedures. For example, inspectors found that a clinical audit strategy and clinical audit programme was not evident at the time of this inspection. Consequently, despite compliance found with the above sub-regulations, this finding impacted compliance with Regulation 13(4) and overall compliance with this regulation. This was due to the lack of a systematic approach to measure the effectiveness of the service provided and a means to effectively identify areas to improve the quality and outcomes for service users undergoing medical exposures at this facility.

Judgment: Not Compliant

Regulation 14: Equipment

A medical radiological inventory of equipment was provided to inspectors and verified during the inspection. Inspectors noted that medical radiological equipment from other facilities was included in both the inventory and the QA programme for St Finbarr's Hospital and this should be rectified.

Documentation including records of acceptance testing and quality assurance by an MPE were reviewed by inspectors. In addition, records of regular performance testing carried out by radiography staff and service engineers were evident and demonstrated that medical radiological equipment in use in this facility was maintained in line with regulatory requirements.

Inspectors were informed that the DXA unit was end of life and a replacement scanner was due to be installed in the coming months.

Judgment: Substantially Compliant

Regulation 17: Accidental and unintended exposures and significant events

The hospital had a document named *Guide to Radiation Incident Reporting in SFH,* which was dated June 2020 and did not have a version control history indicating the next review date or who had approved this document for use. Inspectors were informed that there had been no radiation incidents or near misses reported in the last two years. From discussions with staff, inspectors noted that while there was a process in place to manage radiation incidents should they occur, there was scope to improve the reporting of potential incidents and good catches to help minimise the risk of an accidental or unintended exposure happening in the future.

Judgment: Substantially Compliant

Appendix 1 – Summary table of regulations considered in this report

This inspection was carried out to assess compliance with the European Union (Basic Safety Standards for Protection against Dangers Arising from Medical Exposure to Ionising Radiation) Regulations 2018, as amended. The regulations considered on this inspection were:

Regulation Title	Judgment
Governance and management arrangements for medical exposures	
Regulation 4: Referrers	Compliant
Regulation 5: Practitioners	Compliant
Regulation 6: Undertaking	Not Compliant
Regulation 10: Responsibilities	Compliant
Regulation 19: Recognition of medical physics experts	Compliant
Regulation 20: Responsibilities of medical physics experts	Substantially Compliant
Regulation 21: Involvement of medical physics experts in medical radiological practices	Substantially Compliant
Safe Delivery of Medical Exposures	
Regulation 8: Justification of medical exposures	Compliant
Regulation 11: Diagnostic reference levels	Not Compliant
Regulation 13: Procedures	Not Compliant
Regulation 14: Equipment	Substantially Compliant
Regulation 17: Accidental and unintended exposures and significant events	Substantially Compliant

Compliance Plan for St Finbarr's Hospital OSV-0007953

Inspection ID: MON-0040055

Date of inspection: 27/05/2025

Introduction and instruction
This document sets out the regulations where it has been assessed that the undertaking is not compliant with the European Union (Basic Safety Standards for Protection against Dangers Arising from Medical Exposure to Ionising Radiation) Regulations 2018, as amended.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the undertaking must take action on to comply. In this section the undertaking must consider the overall regulation when responding and not just the individual non compliances as listed in section 2.

Section 2 is the list of all regulations where it has been assessed the undertaking is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of service users.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the undertaking or other person has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the undertaking or other person has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance — or where the non-compliance poses a significant risk to the safety, health and welfare of service users — will be risk rated red (high risk) and the inspector will identify the date by which the undertaking must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of service users, it is risk rated orange (moderate risk) and the undertaking must take action *within a reasonable timeframe to* come into compliance.

Section 1

The undertaking is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the medical radiological installation back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the undertaking's responsibility to ensure they implement the actions within the timeframe.

Compliance plan undertaking response:

Regulation Heading	**Judgment**
Regulation 6: Undertaking	Not Compliant
Outline how you are going to come into compliance with Regulation 6: Undertaking: Authority in relation to the undertaking has been delegated from HSE Corporate to the National Radiation Protection Office HSE, to HSE South West via Regional Executive Officer (REO) South West, to the Clinical Projects Facilitator (Older Persons Services) who is the Designated Manager of the SFH Radiology facility and chair of the SFH Radiation Safety Committee (RSC). The SFH RSC has a reporting role through the chair to Older Persons Services (OPS) Quality and Patient Safety (QPS) committee which reports into the Regional QPS Structure and to the REO for the RHA. The Undertaking will provide evidence of allocation of responsibility for the protection of patients from medical exposure by clearly written policies and guidance documentation. [S] – SFH Policies and guidance documents will be amended to clarify their scope of applicability to the SFH radiological facility. [M] – Policy (development and review) is a standing item on the SFH RSC agenda. [R] – The RPO function in SFH is now delivered by the CUH RPU. Policy is also a standing item on the CUH RPU agenda. [A] – CUH policies can be amended to derive equivalent SFH policies. [T] – Progression of policies will be monitored by the CUH RPU (meets two monthly) and the SFH RSC (meets six monthly).	
Regulation 20: Responsibilities of medical physics experts	Substantially Compliant
Outline how you are going to come into compliance with Regulation 20: Responsibilities of medical physics experts:	

Medical Physics Expert responsibilities in SFH are owned by CUH Radiology Physics, who also support CUH and other HSE services in the South/SouthWest Region. Radiology. A recruitment process to fill vacant posts in Radiology Physics is on-going and applications for new posts have been submitted for approval.

There is scope for improvement of MPE involvement in dosimetry and optimisation in relation to the regular review of local DRLs by,
[S] - Radiology Physics fulfils its commitment to Regulation 20 by contributing to the derivation and use of DRLs in SFH
[M] – DRL review is a standing item on the agendas of the SFH RSC and the CUH RPU.
[A] – Radiology Physics prioritises DRL reviews using patient dose data which is collected by the onsite radiographer and made available to Radiology Physics staff for analysis.
[R] – SFH DRLs is the responsibility of the CUH RPU who work in close liaison with the onsite radiographer in SFH.
[T] – SFH DRL review is monitored by the CUH RPU (meets two monthly) and the SFH RSC (meets six monthly).

There is scope for improvement of MPE involvement in the training of practitioners by,
[S] – Radiology Physics fulfils its commitment to Regulation 20 by contributing to the training of practitioners and other staff in relevant aspects of radiation protection.
[M] – Staff training is a standing item on the agenda of the SFH RSC.
[A] - Radiology Physics have already produced several online training videos for CUH which will be made available to SFH staff. SFH staff will also be made aware of training material on HSELanD and freely available from other hospitals/organisations.
[R] – Online training videos produced for CUH staff can be readily made available for SFH staff.
[T] – Progression of staff training is monitored by the SFH RSC (meets twice yearly).

Regulation 21: Involvement of medical physics experts in medical radiological practices	Substantially Compliant

Outline how you are going to come into compliance with Regulation 21: Involvement of medical physics experts in medical radiological practices:
Please see the response to Regulation 20 as regards the fulfilment of MPE responsibilities in SFH by CUH Radiology Physics.

Please see the response to Regulation 20 as regards the scope for improvement of MPE involvement in dosimetry and optimisation in relation to the regular review of local DRLs in SFH.

Please see the response to Regulation 20 as regards the scope for improvement of MPE involvement in the training of practitioners

Regulation 11: Diagnostic reference levels	Not Compliant

Outline how you are going to come into compliance with Regulation 11: Diagnostic reference levels:
Please see the response to Regulation 20 as regards the fulfilment of MPE responsibilities in SFH by CUH Radiology Physics.

Please see the response to Regulation 20 as regards the scope for improvement of MPE involvement in dosimetry and optimisation in relation to the regular review of local DRLs in SFH.

Regulation 13: Procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 13: Procedures:
X-Ray and DXA procedures will be reviewed, updated and approved by 31st Aug 2025.

[S] – SFH Policies and guidance documents will be amended to clarify their scope of applicability to the SFH radiological facility.
[M] – The development and management of Policy documentation is a standing item on the RSC agenda and so will be monitored by the SFH RSC.
[R]- SFH is now under the CUH RPU, SFH policies development and review will be a standing item at CUH's RPU
[A] – There are several existing CUH policies which can be amended to derive equivalent SFH policies.
[T]-The progression of SFH policies will be monitored by the CUH RPU, which meets every two months, and the SFH RSC, which meets every six months.

St.Finbarr's hospital Radiology department will now be incorporated into the CUH radiology audit group. St.Finbarr's Hospital Radiology will be also included in the clinical audit strategy and the clinical audit programme of CUH. Audits for SFH will be identified and performed.

Regulation 14: Equipment	Substantially Compliant

Outline how you are going to come into compliance with Regulation 14: Equipment: In future only information associated with the OSV of the inspection site will be provided to HIQA.	
Regulation 17: Accidental and unintended exposures and significant events	Substantially Compliant
Outline how you are going to come into compliance with Regulation 17: Accidental and unintended exposures and significant events: [S]- A near miss incidents excel sheet has been developed and is located in the Radiation Safety shared folder. [M]- Any near misses will be recorded in the excel sheet by the radiographer on site. The near misses / incidents will be included in the Agenda for the CUH RPU (This item is a standing item on the RSC) [A] – Policy for the reporting of incidences is currently being updated. [R] – Trending of near misses will be documented and all incidents will be investigated. [T]- Near misses, accidental and unintended exposures will be monitored by the CUH RPU, which meets every two months, and the SFH RSC, which meets every six months.	

Section 2:

Regulations to be complied with

The undertaking and designated manager must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the undertaking and designated manager must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the undertaking must include a date (DD Month YY) of when they will be compliant.

The undertaking has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 6(3)	An undertaking shall provide for a clear allocation of responsibilities for the protection of patients, asymptomatic individuals, carers and comforters, and volunteers in medical or biomedical research from medical exposure to ionising radiation, and shall provide evidence of such allocation to the Authority on request, in such form and manner as may be prescribed by the Authority from time to time.	Not Compliant	Orange	18/07/2025
Regulation 11(5)	An undertaking shall ensure that diagnostic reference levels for radiodiagnostic examinations, and where appropriate for interventional	Not Compliant	Orange	31/08/2025

	radiology procedures, are established, regularly reviewed and used, having regard to the national diagnostic reference levels established under paragraph (1) where available.			
Regulation 13(4)	An undertaking shall ensure that clinical audits are carried out in accordance with national procedures established by the Authority.	Not Compliant	Orange	31/12/2025
Regulation 14(10)	An undertaking shall provide to the Authority, on request, an up-to-date inventory of medical radiological equipment for each radiological installation, in such form and manner as may be prescribed by the Authority from time to time.	Substantially Compliant	Yellow	15/07/2025
Regulation 17(1)(a)	An undertaking shall ensure that all reasonable measures are taken to minimise the probability and magnitude of accidental or unintended exposures of individuals subject to medical exposure,	Substantially Compliant	Yellow	31/08/2025

Regulation 20(2)(a)	An undertaking shall ensure that, depending on the medical radiological practice, the medical physics expert referred to in paragraph (1) takes responsibility for dosimetry, including physical measurements for evaluation of the dose delivered to the patient and other individuals subject to medical exposure,	Substantially Compliant	Yellow	30/11/2025
Regulation 20(2)(c)	An undertaking shall ensure that, depending on the medical radiological practice, the medical physics expert referred to in paragraph (1) contributes, in particular, to the following: (i) optimisation of the radiation protection of patients and other individuals subject to medical exposure, including the application and use of diagnostic reference levels; (ii) the definition and performance of quality assurance of the medical radiological equipment; (iii) acceptance	Substantially Compliant	Yellow	30/11/2025

	testing of medical radiological equipment; (iv) the preparation of technical specifications for medical radiological equipment and installation design; (v) the surveillance of the medical radiological installations; (vi) the analysis of events involving, or potentially involving, accidental or unintended medical exposures; (vii) the selection of equipment required to perform radiation protection measurements; and (viii) the training of practitioners and other staff in relevant aspects of radiation protection.			
Regulation 21(1)	An undertaking shall ensure that, in medical radiological practices, a medical physics expert is appropriately involved, the level of involvement being commensurate with the radiological risk	Substantially Compliant	Yellow	30/11/2025

	posed by the practice.			