Birmingham and Solihull Mental Health NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Inadequate**
Are services well-led?	**Requires Improvement**

Our findings

Acute wards for adults of working age and psychiatric intensive care units

Requires Improvement ➔➔

We carried out an unannounced inspection of Meadowcroft Psychiatric Intensive Care Unit as we received information giving us concerns about the safety and quality of the services.

The Care Quality Commission were contacted by a whistle blower who raised concerns in relation to restrictive practice on the ward; specifically an over reliance on seclusion due to a lack of skilled nursing care, a lack of keys, poor environmental safety and breaches of security, staffing and staff skill mix, communication and recording of risk, cultural tensions on the ward between staff and a lack of support and responsiveness from leaders.

This was a focused inspection and looked at the specific concerns raised and therefore we did not inspect all five domains or all key lines of enquiry.

Following inspection, we contacted the trust to share our immediate concerns and asked them to prepare a response to provide urgent assurance. The trust provided assurance that all staff would have an alarm, keys and fob and access to the anti-barricade door key so that they could work safely on the ward. In addition, they provided support to the ward with a programme of quality improvement to address our other immediate concerns and they rectified immediate environmental changes.

Our rating of the service stayed the same. We rated them as requires improvement because:

The ward had seen an increased level of patient risk and need since the COVID-19 pandemic and described a challenging work environment.

Risk was not always managed well. For example, staff did not record that they had completed checks of the ward environment. Patients continued to smoke following changes that had been made to smoking restrictions during the COVID-19 pandemic, despite the trust being smoke-free. Patients should not have had access to lighters but there here had been an incident where a patient had accessed a lighter, secreted it and had managed to take this into the seclusion room and had set fire to the mattress. Risk assessments were not completed for patients who were secluded in their bedrooms when there was unsupervised bathroom use or when searches were completed. There were not enough ward keys and fobs for all staff and during inspection staff could not locate the anti-barricade door key.

There were problems with the ward environment including areas of damage that needed repairing which made the ward environment unsafe. Staff told us there were sometimes delays for repairs. The ward was not clean and tidy in all areas and staff did not always follow infection control policy in relation to the COVID-19 pandemic.

The ward had seen an increase in acuity and staff used bedrooms to seclude patients when the seclusion room was in use. We had concerns about the bedroom environment not being suitable for the purpose of seclusion due to the robustness of the environment, blind spots and the fact that the bathroom area could not be observed from outside the room. In addition, staff did not always complete seclusion reviews in line with the Mental Health Act Code of Practice.

There was ineffective governance on the ward. We found gaps in governance in several areas which affected the management of risk, recording of activity, clinical supervision, safeguarding processes and learning from incidents. The

Our findings

service required extra staff to support increasing patients' needs and risk on the ward. As a result, there was high use of bank staff but there were not always enough staff, in particular registered nurses. We were made aware of two occasions where there had not been enough staff to complete restrictive interventions with patients due to staffing. However, the trust worked hard to try and ensure there were enough staff on shift.

However:

Leaders had the skills, knowledge and experience to perform their roles and were visible for patients and staff and overall staff felt respected and valued.

The trust had recently introduced safety huddles for the ward and there was a clear way for information from these local meetings to be shared with senior leaders.

The mandatory training programme was comprehensive. Overall staff training compliance was on average at 95%, there were some areas where compliance was lower, but it affected a small number of staff only.

How we carried out the inspection

Before the inspection visit, we reviewed information that we held about the location and asked another organisation for information. The inspection was unannounced. During the inspection visit, the inspection team; interviewed the ward manager and a senior manager,

spoke with 13 members of staff including the doctor, registered nurses, student nurses and unregistered nurses,

spoke with five people who were patients in the service,

observed patients' care, observed a ward handover and looked at the ward environment

reviewed two patients' care and treatment records,

looked at other documentation and records related to peoples' care and overall governance of the service**.**

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

What people who use the service say

We spoke with five patients about their experience of the ward, their feedback was positive overall but they did say that they could not always access staff when they needed them as there were not always enough staff and this made it difficult to access support or belongings that were kept in the ward office.

Is the service safe?

Inadequate 

Our findings

Our rating of safe went down. We rated it as inadequate.

Safe and clean care environments

Not all areas of the ward were safe and well maintained

Safety of the ward layout

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. There had been recent ligature reduction work completed by the trust to reduce ligature risks.

Staff had not had easy access to alarms before our inspection but this had improved shortly before our inspection. Staff told us previously they had not had enough alarms to use on the ward. Staff explained that not all staff returned their alarm at the end of each shift and therefore there was a shortage of alarms. However, there was no effective system in place to ensure alarms were returned. At the time of our inspection there were enough staff alarms, as there had been new alarms ordered by the ward manager. We checked that staff had alarms. We saw two historical incidents had been reported by staff where staff did not have access to an alarm and therefore there was a delay in locating one, during one of these incidents staff were assaulted.

There were not enough keys and fobs for all staff and therefore they could not easily move throughout the ward. For example, staff who did not have keys could not enter the nursing office or a patient's bedroom and those without a fob could not open some of the doors that led to different patient areas on the ward. During our inspection we observed staff not having their own keys or fobs and swapping these between each other on the day of our inspection. The lack of keys and fobs meant that not all staff could move around the ward freely or safely. Patients were aware that staff did not always have keys, and staff gave us examples of not being able to move around the ward easily and safely when they needed to. Trust data demonstrated not all staff had keys and fobs at the time of our inspection. However, the trust took action to amend this immediately after our inspection and audited this for assurance.

Bank staff told us that they shared fobs with other staff members. These fobs included staff identification, which meant that staff sometimes displayed the identification belonging to another staff member. There were several staff who were not wearing identification at all. This was not in line with trust policy.

The ward had anti barricade doors which could be opened outwards by staff with a key in the event of an emergency and staff needed to enter a room. However, when we asked staff they were not able to tell us where this key was located. This meant that staff would not be able to respond quickly or appropriately in the event of an emergency, such as a patient barricading themselves in a room.

There were security issues within the environment. Nine of the twelve seats in the dining room were not attached to the chairs, this was unsafe, and these could potentially have been misused. We found a screw and lose metal bar underneath one of the chair pads. Staff told us that a patient had damaged the seats the previous day. This issue had been raised with the trust's estates team for urgent action, but there had been a delay in the seats being repaired. Other staff told us that there were issues with the lock on the nursing office door as it had been damaged the week before. Some staff were concerned about how secure the nursing office door was. We saw a bedroom door had been damaged around the lock by a patient who was is seclusion and there were still splinters around the handle. The trust told us that the ward was in a private finance initiative funded building and that this sometimes meant there were delays in repairs being completed.

Maintenance, cleanliness and infection control

Our findings

Ward areas were not all clean, well maintained, well-furnished or fit for purpose. The environment in the staff areas, including the manager's office and nursing office was untidy, unclean and disorganised. The courtyard area of the ward was not well cared for the bin was overflowing and there was debris on the floor. There was a mattress that had been previously set on fire that had been left in the outdoor seclusion area for a week and had not been disposed of.

Staff did not always follow infection control policy in relation to the COVID-19 pandemic. Staff did not always wear masks in line with trust policy and we did not see staff handwashing or using hand gel regularly. The sink at the ward entrance was not working and the sink in a room next to the nursing office was in a cluttered and unclean area where it was hard to access the sink due to various items on the floor. We saw three staff members wearing nail varnish and not all staff were bare below the elbow. This was not in line with trust policy.

Seclusion room

The seclusion room allowed clear observation and two-way communication. It had a toilet and a clock.

However, there was not always capacity for patients to be secluded in this environment. There had been an increase trust wide of patients being secluded in ward bedrooms. In the last three months there had been six occasions where bedrooms had been used for seclusion. The trust told us they had seen an increase in the level of patient's risk and need since the COVID-19 pandemic.

We looked at a bedroom that staff told us was often used for secluding patients. We had several concerns about the bedroom environment not being suitable for the purpose of seclusion. It was not possible for staff to see the whole room easily; we saw that there were blind spots and that it was not possible to monitor bathroom use for staff stood outside the door. The convex mirror we saw in one bedroom was small and positioned some way from the door which made it difficult to see blind spots. We also saw that there were parts of the structure of the room which patients could have used to hurt themselves. There had previously been an incident reported where a patient had been able to deliberately self-harm because of the unsuitability of the room structure.

There had been incidents where patients had been able to damage fixtures and fittings, as they were not as robust as the fixtures and fittings in the seclusion suite. This meant patients could be a risk to themselves or others. Staff told us the patient bedroom doors were not secure enough for the purpose of seclusion and we saw that incidents had taken place where patients had tried to break through these.

Staff told us when they secluded patients in bedrooms, they sometimes had to leave the door open to the bedroom to ensure a patient's safety or enter the bedroom area to monitor patients when they were using their bathrooms. This potentially placed staff and others at risk. The practice of secluding patients in their bedrooms meant that their privacy and dignity was compromised as other patients and staff could see into the bedroom.

Safe staffing

The service did not always have enough nursing staff, who knew the patients. However, most staff received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not always have enough nursing and support staff to keep patients safe. Staff told us there were not always enough staff on duty and that this put them under pressure. There were also several newly qualified nurses, who due to being newly qualified were less experienced. During our inspection, on the night shift, there were two registered nurses, one who was a newly qualified nurse and the other a member of bank staff.

Our findings

Core staffing for the ward was three registered nurses on the early and late day shifts and two registered nurses on the night shift. There was a minimum of three nurses on day shifts and two nursing assistants on night shifts. However, there were regularly more unregistered nurses on shift, and these were bank staff. This was because there was a high level of enhanced observations. For example, on the day of our inspection there were 12 staff required for the day shift and 13 for the night shift.

The service had two vacancies for nursing assistants. There were enough support staff who worked on the ward to meet core staffing numbers. At the time of our inspection there was one vacancy for an activity coordinator.

There were two vacancies for registered nurses, both were for deputy ward managers and there were three more nursing roles about to become vacant. There was an active recruitment programme taking place and the trust offered financial incentives to encourage recruitment and retainment.

On the day shift of the first day of our inspection there was one nurse on shift when there should have been three nurses. This meant that the ward manager had to work in ward numbers, and staff said this was not unusual. On the day of our inspection short staffing was due to several staff having been assaulted by a patient on previous day.

Managers accurately calculated and reviewed the number and grade of nurses and nursing assistants for each shift, but there were not always enough staff available, in particular this was the case for nurses. We asked the ward to provide us with staffing data for the period 29 May to 12 June 2022. The trust was able to provide us with the full data that we required for 12 of the 15 days between these dates and this data indicated that 16% of shifts were short of staff. There were more challenges meeting registered nursing staff requirements than unregistered staff.

The service had high rates of bank and agency staff due to the level of enhanced observations and patient need on the ward. We reviewed staffing date from 29 May until 12 June 2022. Bank staff comprised on average of 76% of the total staff on shift during the time period reviewed. This meant on average only one in four staff were permanent staff. However, there was a variation between day and night shifts, with night shifts made up of 80% bank or agency staff and day shifts made up of 60% of bank staff on average. However, agency staff comprised of less than 1% of the overall workforce and there were regular bank staff who knew the patients and the ward, some of who were substantive staff who worked extra shifts.

The service usually had enough staff on each shift to carry out any physical interventions safely. However, when we reviewed incidents, we saw that on at least two occasions in the three months prior to our inspection there were insufficient trained staff to restrain a patient or administer medicine.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. Managers could call locums when they needed additional medical cover.

Mandatory training

Overall staff had completed and kept up-to-date with their mandatory training. Staff training compliance was on average 95%, which was the target the trust set for training compliance. However, levels of life support training were lower. Staff compliance was at 78% for Emergency Life support, as there were two staff who needed to complete this, one of whom was off work and therefore could not attend, and 73% for Immediate Life support where three staff needed to complete the training but one member of staff was off work and therefore could not attend. All staff who were available had been booked onto these training courses

Our findings

The mandatory training programme was comprehensive and met the needs of patients and staff and it was monitored by managers who reminded staff when they needed to update their training. This included care certificate training for unregistered staff.

Assessing and managing risk to patients and staff

Staff assessed risks to patients and themselves and followed best practice in anticipating, de-escalating and managing challenging behaviour, but did not always follow or record procedures that kept the ward safe. Staff used restraint only after attempts at de-escalation had failed. However, there had been several assaults on staff.

Assessment of patient risk

We reviewed two risk assessments. Staff completed a risk assessment and management plan for each patient on admission, but these were not very detailed and we saw one person's risk management plan had not been updated when there had been a change in their treatment.

We looked at two physical health records and saw that staff assessed and monitored and responded to patient's physical health.

Management of patient risk

We looked at two patient's care records and saw that staff knew about key risks to patients and normally acted to prevent or reduce risks. However, staff identified did not always know everything they needed to about patients or update these risks.

We asked staff to provide us with evidence of their daily security checks of the ward environment to make sure it was safe for patients. These should have taken place but were not recorded. Not all staff were clear about what checks should take place. We did not see evidence of consistent process for this.

The trust had a smoke-free policy in place. However, patients were being allowed to smoke in the outdoor area of the ward. This was introduced during the Covid-19 pandemic when patients were not able to take section 17 leave, and this had not been discontinued. Patients should not have had access to lighters but a safety incident had occurred earlier in June 2022 when a patient had managed to set fire to the mattress in the seclusion room as they had been able to secrete a lighter.

There had been number of physical assaults of staff on the ward. There had been 23 assaults of staff recorded as incidents between the 1st March and 19th May 2022. In addition, there had been a further incident the day before our inspection and there were three staff off sick due to having been assaulted.

Staff did not always follow procedures for the ward that were in place to keep the ward safe. For example, staff did not keep their belongings in the locker room off the ward, these were in the nursing office.

Staff told us that there had been an incident of drug use on the ward, but there had been no further issues since May 2022.

Staff did not always share key information to keep patients safe We saw that during the shift there were issues brought about by staff not knowing the right information about patients and the ward being disorganised. For example, staff did

not have knowledge of patient's care plans and therefore could not respond to a patient's request for specific items and that this raised the risk of conflict. Staff were also unable to locate a patient's continuous pressure airway machine and the patient had to wait for over half an hour before they could go to sleep as a result. At another point information about patient's monies was not clear and this caused delays for a patient.

Use of restrictive interventions

Levels of restrictive interventions were low. There had been 28 restraints in the three months prior to our inspection, nine of these restraints had been in prone position and there had been eight occasions of rapid tranquilisation. There had been 18 periods of seclusion for 10 different patients during the same period. However, periods of seclusion were lengthy.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

When a patient was placed in seclusion, staff did not always keep clear records and did not always follow best practice guidelines, particularly when a patient had to be secluded using their bedroom. The trust reported that staff searched patients and bedrooms to make sure they did not have anything that they could harm themselves or others with, but searches of the bedroom areas prior to seclusion were not recorded by staff. Where patients were secluded in bedrooms but able to use their bathrooms unsupervised staff did not record that this decision had been risk assessed.

We asked the trust to provide assurance that seclusion had been carried out safely in line with the Mental Health Act Code of Practice during the weekend of 28 and 29 May 2022 when six seclusions had taken place at the same time. The trust provided us with data which indicated that five patients were secluded in their bedrooms and one in the seclusion room. Nursing and medical reviews did not always take place during this weekend. We looked at the length of time that patients were in seclusion and these varied between 31 hours and 472 hours.

During the month following our inspection a Mental Health Act reviewer completed a Mental Health Act visit. They reviewed seclusion records and saw that the nursing reviews were not always completed by two nurses, in line with the Mental Health Act Code of Practice. It was explained by staff this was because there were not enough nurses on shift to have two nurses complete the review.

Safeguarding

Staff had safeguarding training about how to recognise and report abuse but did not always raise safeguarding concerns when they should have done. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff compliance for Level 1 and 2 safeguarding both adults and children was 100%. Level 3 safeguarding training for adults and children compliance was at 50%. However, there were two members of staff who had not completed this, one who was due to complete the training and the other member of staff was not at work and therefore could not complete the training.

We looked at care records and saw some good examples where staff had taken action to safeguard patients or children. However, staff did not always identify when a safeguarding alert needed to be raised. The trust provided us with data which indicated that there had been two safeguarding alerts raised on the ward in the last three months. However, we also saw that there were at least two incidents where a patient had assaulted another patient but staff had not raised a safeguarding alert with the local authority, they had though taken appropriate action to safeguard the patient locally on the ward This meant staff did not follow process to protect patients.

Our findings

Reporting incidents and learning from when things go wrong

Staff recognised incidents and reported them, but it was unclear whether there was embedded learning from incidents or that managers reviewed incidents in a timely way.

Staff knew what incidents to report and how to report them. There had been a total of 133 incidents reported in the three months prior to our inspection.

Managers debriefed and supported staff after any serious incident. We saw that patients were also debriefed after incidents.

Managers did not always investigate incidents thoroughly. There was evidence that some incidents that had been reported were responded to and that they were investigated. However, there were a number of incidents that had not been reviewed in the month prior to our inspection. There were 35 incidents that did not have a response recorded by a manager since 12 May 2022. It was not possible to see if incidents were managed in a timely way as this information was not fully shared with us.

Staff did not meet regularly to discuss incidents and learn from them. For example, when six patients were secluded simultaneously there was no review of the seclusions that took place to see if any learning could come from these**.** There were no regular team meetings or clinical supervision where learning could be discussed.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They were visible in the service, however they were not aware of all issues that we identified on the ward.

Leaders had the skills, knowledge and experience to perform their roles. However, the ward was challenged by the level of need that patients presented with. Staff had seen an increased level of patient risk and need since the COVID-19 pandemic. The ward manager had to work in staff numbers, due to staffing pressures and this left less time for them to perform their ward manager's role.

Leaders understood the service they managed but were not aware of all the issues we identified. However, they were aware that the ward environment was particularly challenging and were working to support newly qualified staff on the ward. The trust shared some positive feedback from newly qualified staff preceptees. Overall, however, there were gaps in governance which indicated leaders did not have full oversight of the ward.

Leaders were visible in the service and approachable for patients and staff. Staff told us the ward manager was supportive and visible. A senior leader explained they visited the ward most days.

Culture

Our findings

Staff we spoke to told us they were respected and valued. They told us they could raise any concerns without fear, but staff had not done this prior to our inspection and instead they had contacted the CQC. There were insufficient opportunities for all staff to be well supported in their roles

Staff felt respected and valued but not all staff felt safe. We could not fully corroborate the issues that had been shared with us in the whistle blowing about cultural tensions between different staff. One staff member said that several other staff did not always speak in English between themselves and this also happened in front of patients. They did not describe cultural tensions however.

The whistle blower reported to us that they had previously raised concerns directly to managers but that these had not been responded to and therefore they came to us with their concerns. However, on inspection staff we spoke to did not identify barriers to speaking up.

Staff knew how to use the whistle-blowing process and about the role of the Freedom to Speak Up Guardian. After our inspection the trust organised for the Freedom to Speak up Guardian to come to speak to staff on the ward to explore if there were any tensions or concerns.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always well managed.

Governance systems were not effective in identifying all issues on the ward:

We identified issues in relation to cleanliness, adherence to infection prevention control and environmental risks had not always been identified and put right by managers.

There were gaps in staff adherence to the Mental Health Act code of practice which had not been identified and improved and this meant that the trust was not following statutory guidance and did not ensure patients' rights.

There was a lack opportunities to learn from incidents. There were a range of whole service meetings including clinical governance, health and safety and cross service ward manager meetings but there was not a way for relevant information and learning from incidents to be shared with the team as there were no regular team meetings or supervision.

Clinical supervision was not embedded on the ward. The trust supervision policy recommended clinical supervision every four to six weeks, but the minimum standard was every eight weeks. This was not achieved on the ward; staff did not have regular supervision. Compliance was at 12%, despite staff working in a stressful and challenging environment most staff did not have an opportunity to individually discuss their work with their line manager.

There were gaps in safeguarding procedures and processes which had not been identified and learned from; not all alerts had been raised in line with trust policy.

The service's staff sickness and turnover were both high. The ward manger explained there had been no specific themes or concerns identified in relation to turnover. Staff assaults and COVID-19 were themes for staff sickness.

Our findings

However, there was evidence that governance systems were effective in some areas. For example, in respect of training, the service had also recently introduced daily safety huddles for the ward and information from these was reported into a service wide daily safety huddle.

Staffing was challenging but the trust did what they could to try to make sure there were enough staff on shift and there was an active programme of recruitment.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Not all risk information had been updated in one patient's record. This meant the team did not have all the information they required for safe care and treatment. In addition, staff did not always know everything they needed to about patients, to easily respond to their needs.

There were not full and adequate governance systems in place on the ward. There was no local risk register, that staff could add risks to and that fed into divisional and organisational risk registers.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

The trust must ensure that the ward is clean, well-maintained and fit for purpose. Repairs to the ward structure and environment must be completed promptly when they arise. (Regulation 15)

The trust must continue to ensure that all staff have access to individual alarms, keys and fobs and know how to access the anti-barricade door key. (Regulation 12)

The trust must ensure that staff adhere to infection prevention control procedures in line with trust policy. (Regulation 12)

The trust must ensure that staff follow the trust's seclusion policy and national guidance whilst carrying out seclusion. (Regulation 12)

The trust must ensure that any environment used for seclusion is suitable and safe for seclusion purposes. (Regulation 12).

The trust must ensure they safely manage risk items on the ward associated with smoking (Regulation 12)

The trust must ensure there are effective governance processes in place on the ward to ensure:

1. There continue to be processes for the effective management of alarms, keys and fobs.

2. That staff have regular opportunities for team meetings and clinical supervision and that learning from incidents is embedded in these.

3. The trust must ensure that all safeguarding incidents are raised appropriately, and that staff follow policy and process.

4. The trust must ensure there is a way for staff to identify and record local risks which are then shared with the wider organisation.

5. The trust must ensure that all aspects of ward activity are regularly audited so that areas for improvement can be identified promptly in all areas where there have been regulatory breaches. (Regulation 17)

Action the trust Should take to improve:

The trust should ensure staff wear identification, so that it is clear to staff and other patients who they are.

Our findings

The trust should ensure that all information in relation to patients is shared effectively and that risk management plans are updated regularly and when there are changes to patient's care and treatment.

The trust should ensure that they support the ward with appropriate staffing levels and staff skill mix to ensure there are enough suitably skilled staff available to keep the ward safe.

The trust should ensure they provide a culture where they encourage staff to come forward to speak openly about any tensions or difficulties in the team

The trust should ensure that staff know how to make a safeguarding referral and who to inform if they had concerns.

Our inspection team

Our inspection team consisted of three inspectors and an inspection manager. We carried out the inspection over two days and visited the service both at night and in the day.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance