Leicester Medical Group

Inspection report

Thurmaston Health Centre, 573a Melton Road
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Date of inspection visit: 10/04/2018
Date of publication: 28/06/2018

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services well-led?	Inadequate

Overall summary

This practice is rated as Inadequate overall. This rating was given at our previous inspection 14 December 2017.

We carried out an unannounced focused inspection of Leicester Medical Group on 10 April 2018. This inspection was undertaken to follow up on breaches of regulations which had been identified at our previous inspection in December 2017 in relation to safe care and treatment and governance arrangements within the practice. We issued the practice with two warning notices requiring them to achieve compliance with the regulations set out in those warning notices by 14 March 2018. This focused inspection only included the safe and well led key questions.

At this inspection we found that all the requirements of the two warning notices had not been met. Additionally we found further serious concerns.

Our key findings across the areas we inspected for this focused inspection were as follows:

- Patients were at risk of harm because there was a lack of monitoring of the care and treatment of patients.
- There was a failure of some clinicians to treat patients in accordance with national clinical guidelines and we found examples of poor care and treatment which put patients at serious risk of harm.
- There were 38 outstanding tasks on the practice computer system dating back to mid-March 2018. This put patients at risk of delays in diagnosis, further investigation and treatment. One patient had not been informed that their test results indicated a diagnosis of diabetes.
- There was not an effective system to summarise patient records. We found 356 patient records in different areas of the practice which were waiting to be summarised. The practice were unaware of how many records were not summarised or how to identify this and therefore unable to say how long the records had been unsummarised. This put patients at risk as summarising patient records protects patients by ensuring that relevant and key information about patients is recorded and therefore available should another clinician need to refer to those records in order to ascertain what would be safe care and treatment for a particular patient.
- Actions had been taken to improve the system for safeguarding children but the system still required strengthening.
- At our inspection in December 2017 there was not a clear and effective system for reporting and acting on significant events. We found this was still the case which meant the practice did not have adequate systems to prevent or minimise the risk of safety incidents recurring or identifying and sharing learning from them.
- We found that not all blank prescription forms were kept securely.
- At this inspection we still had concerns with regard to the clinical oversight and governance arrangements in place.
- Performance of employed clinical staff could not be demonstrated through audit of their consultations, prescribing and referral decisions.
- The practice did not have effective systems to support the appropriate and safe management of medicines.
- During the course of our inspection we found out of date medicines in the practice and medicines which were not stored safely and could be accessed by patients. We also found confidential patient information which was accessible to patients in unlocked rooms.
- Medicines were administered to patients without relevant authorisation by a GP.
- Patients' health was not always monitored in a timely manner to ensure medicines were being used safely and followed up on appropriately.

The provider is no longer providing care or treatment from Thurmaston Health Centre.

As a result of the inspection team's findings from the unannounced focused inspection, as to non-compliance, but more seriously, the risk to service users' life, health and wellbeing, the Commission decided to issue an urgent notice of decision to impose conditions on the provider's registration to stop them carrying on regulated activities from this location under section 31 of the Health and Social Act 2008. The notice was served on the provider on 11 April 2018 and took immediate effect which means the provider is no longer able to carry on regulated activities from Thurmaston Health Centre, 573a Melton Road, Thurmaston, Leicester LE4 8EA.

The practice is still open but services are being provided by a different provider.

Population group ratings

Our inspection team

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser, a member of the CQC medicines team and a second CQC inspector.

Background to Leicester Medical Group

The provider of the Regulated Activities at Thurmaston Health Centre at the time of our inspection was Leicester Medical Group. It provides primary medical services to approximately 7,800 patients on the edge of the City of Leicester. The practice list had continued to grow and had increased from 6,794 in January 2016.

Leicester Medical Group is a partnership of two GPs. One of the GPs was primarily responsible for Thurmaston Health Centre while the other is responsible for the other Leicester Medical Group practice at Aylestone Surgery.

Services are provided from a single location at 573a Melton Road, Thurmaston Leicester.

The provider is registered to provide the regulated activities of;

• Diagnostic and screening procedures

• Maternity and midwifery services

• Surgical procedures

• Treatment of disease, disorder or injury

The provider was not registered to provide the regulated activity of family planning at the time of our inspection although in December 2017 we found that the service was nevertheless being provided as coils were being fitted and removed.

The registered manager is registered to manage the regulated activities of;

• Diagnostic and screening procedures

• Surgical procedures

• Treatment of disease, disorder or injury

Maternity and midwifery services

At the time of our inspection in December 2017 they were not registered to manage the regulated activity of maternity and midwifery services but CQC took action to require the provider to ensure that both the provider registration is correct and that all the regulated activities are managed by a registered manager. Subsequently the registered manager successfully applied to be registered to provide the regulated activity of maternity and midwifery.

No application was received to register to provide the regulated activity of family planning and both during and following this inspection we found evidence that this was still being provided.

There are two GP partners, one nurse practitioner, one part time practice nurse and one part time locum practice nurse, two health care assistants and a clinical pharmacist. They are supported by a long term locum GP and a team of management, reception and administrative staff. The practice is an accredited training practice but at the time of inspection there were no Foundation Year doctors in place at the practice.

We had been told at the December 2017 inspection that there were plans to terminate one of the GP partnerships that the lead GP had entered into and for the other partner to move to Thurmaston Health Centre as a salaried GP, working part time.

It is not a dispensing practice.

Deprivation levels in the registered population are relatively low. The practice has slightly more than the average percentage of female patients aged 45-49 and slightly more than the average percentage of male patients aged 35-39. Otherwise the practice demographics of the practice registered list reflect those of practices nationally.

The practice is situated within a purpose built modern facility which is accessible to all and has ample on site car parking. The building is accessible to those with restricted mobility and those with mobility scooters and prams or pushchairs.

The practice lies within the West Leicestershire Clinical Commissioning Group (CCG). A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

The practice has opted out of the requirement to provide GP consultations when the surgery is closed. Out-of-hours services are provided by Derbyshire Health United, which is accessed via the NHS 111 service.

Inadequate

Are services safe?

The practice was rated as inadequate for providing safe services in December 2017. At this inspection although we found some areas where there had been some improvement, the warning notices we issued as a result of the findings at our December 2017 inspection had not been met and we found further serious concerns in some areas.

We found patients were put at risk due to:

- There were important tasks relating to patient care which had not been attended to.
- A backlog of summarising which meant that clinical information about patients was not being transferred to the patients' electronic records in a timely manner; therefore important information might not be available to clinical staff.
- The inspection team found examples where patients on high risk medicines had not been monitored in accordance with national guidelines.
- There were issues relating to uncollected prescriptions dating back to the beginning of January 2018.
- The system for safeguarding children required strengthening.
- There was not a clear and effective system for reporting and acting on significant events.
- We found out of date medicines in the practice and medicines which were not stored safely and were accessible by patients.
- We found examples of poor care and treatment which put patients at serious risk of harm.

Safety systems and processes

The practice did not have clear systems to keep people safe and safeguarded from abuse.

- The practice had some systems to safeguard children and vulnerable adults from abuse. Not all staff had received up-to-date safeguarding and safety training appropriate to their role.
- Staff took some steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice had not carried out appropriate staff checks on an ongoing basis.

At our inspection in December 2017 we found that the systems to safeguard children and vulnerable adults from abuse were not effective as although children about whom there were concerns had been identified and referred to the safeguarding authorities there were no meetings to discuss such patients with other healthcare professionals.

At this inspection we found that the system for safeguarding children still needed strengthening. The practice had worked with the Clinical Commissioning Group safeguarding team and had carried out a safeguarding audit. Meetings were now taking place with a health visitor but there were no minutes available and there were no specific details of conversations recorded in the patients' notes.

We were unable to view the child safeguarding register as we were told that the computer system was updating and would not generate the report. However we were told there were 47 patients on the register, but only 30 of them were children which indicated the register was not up to date.

The lead GP showed us some examples of children on the child protection register who had safeguarding alerts on their computer records and family members who also had alerts to show there were safeguarding concerns within the family. However one patient record we viewed had a safeguarding code added to their consultation record but the code was not linked to an alert which meant that the child may have been at risk if other clinicians were not aware of potential safeguarding concerns when they saw the child.

At our inspection in December 2017 we found that relevant checks had not always been carried out before people started to work at the practice. For example, we saw that a long term locum GP who worked at the practice had no references. At our inspection on 10 April 2018 we looked at the staff file for the locum GP and saw that there were now two references available and we also saw evidence of a current DBS check. However the indemnity insurance certificate was out of date and only provided cover for one session despite the locum covering two sessions at the practice. The safeguarding children training certificate was only for level one, not level three as required for GPs and the adult safeguarding training certificate had expired in March 2018. Furthermore there was a basic life support certificate but this only applied to adults and not children.

Inadequate

Are services safe?

We asked to see a locum policy and were shown a policy which the practice manager told us was reviewed annually. It was dated 2016 with no reviews documented. We were told this was only used when locums applied for a position. The information was out of date as it gave guidance on the process within the practice for coil fitting. However, the practice were not permitted to fit or remove coils as they were not registered with CQC to provide the regulated activity of family planning and the policy should have been updated to reflect this.

Information to deliver safe care and treatment

Staff did not have the information they needed to deliver safe care and treatment to patients.

The records we saw showed that information needed to deliver safe care and treatment was not always available to staff.

- We reviewed the practice's processes for keeping accurate and timely patient records. We found that there was not an effective system for summarising new patient records or identifying which records still needed to be summarised. We found 356 patient records in different areas of the practice which were waiting to be summarised but the practice were unable to say which records still required summarising and how long the records had been unsummarised. This put patients at risk as summarising patient records protects patients by ensuring that relevant and key information about patients is recorded and therefore available should another clinician need to refer to those records in order to ascertain what would be safe care and treatment for a particular patient.
- The process described for changing patients records based on information from discharge or out-patient letters did not give us assurance that the practice had a system in place that ensured the accuracy of changes made.
- We found that tasks were not being dealt with in a timely manner. This put patients at risk of delays in diagnosis, further investigation and treatment.
- We looked at a sample of patient consultations and saw that relevant information was not always documented to ensure decisions could be made about safe care and treatment.

Appropriate and safe use of medicines

The practice did not have reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including emergency medicines and equipment did not minimise risks.
- Staff had not prescribed or administered medicines to patients or given advice on medicines in line with current national guidance.
- Patients' health was not adequately monitored in relation to the use of medicines and followed up on appropriately. Patients were not always involved in regular reviews of their medicines.

At our inspection in December 2017 we found that the practice systems for appropriate and safe handling of medicines were not always effective. For example, we found out of date medicines in the practice and there was not an effective system to monitor the temperature of refrigerators which were used to store vaccines.

At our inspection in April 2018 in respect of monitoring of refrigerator temperatures we found there was now a standard operating procedure (SOP) in place to describe the process for fridge monitoring and we saw that medicines requiring refrigerated storage were stored appropriately. Fridge monitoring was being done daily, in most cases twice daily, in line with the SOP. However, we saw one occasion, for one of the fridges, where the temperature had exceeded the required level and we did not see documentation to support actions taken in line with the SOP.

In respect of out of date medicine and medicine security, at our April 2018 inspection we conducted a tour of the premises and during this we found both in date and out of date medicines in various areas of the practice which were not stored safely and were accessible to patients. We were told some of these rooms on the first floor were not used by the practice but the layout of the building allowed patients from the practice to access these unlocked rooms. Another downstairs room was also unlocked and unattended, it contained medicines. The room was directly off the patient waiting area and was used by the healthcare assistant (HCA). In this room we also found that blank prescriptions were not being kept securely as blank prescription forms were found in the unlocked printer when the room was also unlocked and the HCA had left for the day. The March practice meeting minutes documented that all rooms should be locked when not in use.

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Are services safe?

The process for managing emergency drugs was still not effective. We saw signage displayed around the practice directing staff to emergency equipment and drugs in several locations around the building. However we found two out of date adrenaline vials in one of the emergency anaphylaxis kits. We were told that the signage was incorrect as following a recent practice meeting the emergency drugs were now only stored in one location and drugs available in other rooms were no longer being checked for expiry dates. The practice meeting minutes from March 2018 did not reflect discussion about the changes to the location and checking of emergency drugs.

On the day of our inspection we found that Patient Specific Directions (PSDs) were not in place for health care assistants (HCAs) who were administering vitamin B12 injections in the practice and the lead GP was unaware that HCAs should only administer immunisations and injections with the authorisation of a PSD signed by the GP. A (PSD) is a written instruction, signed by a prescriber for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis and an HCA is not permitted to give an injection without a signed PSD in line with the Medicines Act 1968.

The practice manager told us there were no PSDs for HCAs and that the lead GP would review the patient record before they issued a prescription for the medication when the patient attended for each injection. We found evidence that a patient had been given a vitamin B12 injection by an HCA on the day of our inspection without a signed prescription. This would put the patient at risk of receiving medicines that had not been legally authorised.

At our inspection in December 2017 we found issues with prescribing errors. At this inspection we spoke to reception staff about how repeat prescriptions were produced in the surgery and we were told that neither the medicine review date nor the issue numbers for each item were adhered to when the reception staff produced repeat prescriptions. We were told by a member of staff that they had been told to over-ride a warning that asks the reception staff to check for authorisation for a medicine by the clinician once the 'number of issues' had been reached. The practice manager told us they had introduced a new protocol for repeat prescriptions but this included no reference to ensuring a medicine review was being offered to patients. Staff confirmed that patients would not know when a review of medicines was needed and there was currently no process for recall for medicine reviews.

We looked at the process for dealing with uncollected prescriptions and found there were a large number of prescriptions which had not been collected by patients dating back to January 2018.The patients' records had not been updated to describe this. This meant that a clinician carrying out a medication review would not know patients had not been receiving prescriptions. It is good practice to ensure that prescriptions that are uncollected are deducted from the patient's computer record, a note made in notes that the prescription was not collected and the prescription destroyed. If the prescription is for important treatment or for a vulnerable patient, (for example, antiepileptic medicines or Parkinsons treatments) it would be good practice for the surgery to contact the patient and check whether there are any concerns. We were told uncollected prescriptions were only cleared every three months.

We looked at patient records relating to the uncollected prescriptions and found further significant issues of concern. These included; inadequate recording of consultations, delayed referrals, patients with newly diagnosed conditions not receiving timely treatment, very overdue medication review dates, codes being added to patient records suggesting medication reviews had been completed but no evidence to support this, long term condition reviews not taking place, evidence based guidelines not being followed and monitoring for high risk drugs not protecting patients.

For example there was a prescription for thyroxine still awaiting collection four weeks after it had been issued. The patient was therefore not receiving treatment for their new diagnosis of hypothyroidism. No contact had been made with the patient to ascertain why the prescription had not been collected. Additionally the lead GP had added 'medication review done' code to this patient's records on Saturday 7 April 2018 with no documentation to reflect that the review had taken place or the patient spoken to.

We were concerned that medicine reviews were not effective or safe and had not been conducted with the involvement of the patient where this was appropriate. We found that 755 'medication review done' codes had been added on Saturday 7 April 2018, 672 on Sunday 8 April 2018

and 285 on Monday 9 April 2018 by the lead GP. Multiple reviews were completed within a minute of each other. This could not allow sufficient time to incorporate the necessary elements required for a safe medication review.

A medicine review is undertaken to ensure that the medications a patient is taking are still appropriate and are having the desired effect without causing any side effects or complications. A medication review should therefore ensure that the patient has had a review of the conditions that they are being treated for and review any investigations or monitoring that is required.

We found that many of the patients that were coded as having had a medicine review had no evidence to document that a review had taken place. In addition many had overdue blood tests, blood pressure checks or other long term condition needs which should have been identified and addressed if a review had taken place. Most of the codes suggesting a review had taken place had been added outside of practice opening hours so we could not be assured that patients were contacted where necessary.

At our inspection in December 2017 we found that patients in receipt of medicines under shared care arrangements with secondary providers did not have alerts on their patient record indicating this, meaning practitioners would not have the full medication history to facilitate safe prescribing in terms of interactions and medicine reviews. At our April 2018 inspection we found this was still the case. The systems relating to high risk drug monitoring did not minimise risks and ensure that patients taking these medicines were receiving appropriate monitoring.

We found that patients taking Leflunomide, a disease modifying drug used to treat various forms of arthritis, were not having regular blood pressure checks as recommended by national guidance. Blood tests and blood pressure should be monitored at least every three months once the patient is stable on treatment and more frequently if the patient is at higher risk of toxicity or treatment is combined with another disease modifying antirheumatic drug (such as methotrexate). Some patients had not had their blood pressure recorded for over 6 months. When this was discussed with the lead GP they told us they were not aware of the need for blood pressure checks in these patients, which is recommended by NICE guidance and the British Society for Rheumatology.

Patients taking Spironolactone, a medicine used to treat high blood pressure and heart failure were not having regular urea and electrolytes testing or blood pressure monitoring. MHRA guidance states that renal function and potassium levels should be monitored regularly for patients taking Spironolactone especially when they are also taking other medications that affect kidney function.

One patient had abnormal blood test results recorded at the end of March 2018 which could have indicated a side effect of the medication but we saw no evidence that action had been taken in response to this despite the patient having seen the lead GP in April 2018. Another patient should have been having two monthly blood tests but there was no evidence this was being done. The last recorded blood test was in December 2017.

One patient whose records we reviewed had renal function test results consistent with a diagnosis of Chronic Kidney Disease stage 3 (CKD3). The diagnosis had been recorded in the patient record and the patient had not been contacted to advise them they had this long term condition which requires monitoring and treatment.

Lessons learned and improvements made

The practice did not learn or make improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses but managers were not aware of incidents that had taken place in the practice.
- The systems in place were still not adequate for reviewing and investigating when things went wrong. The practice could not always demonstrate that they had learned and shared lessons, identified themes or taken action to improve safety in the practice.

At our inspection in December 2017 we found that the system in place for monitoring significant events, their investigation and what action had been taken as a result was not effective and when serious incidents happened the practice had not ensured that the staff and GPs involved had learned

from the events or that the learning was communicated to staff in an effective manner.

At this inspection we found that the system was still ineffective. We reviewed documentation provided by the practice relating to significant events including: recording forms, minutes of meetings and patient records. We found

Inadequate

Are services safe?

there was a lack of investigation and analysis which meant risks were not identified from significant events, learning was not adequately identified or recorded in order to prevent a reoccurrence and appropriate action had not been taken in response to significant events.

Please refer to the Evidence Table for further information.

Inadequate

Are services well-led?

Leadership capacity and capability

Leaders did not have the capacity and skills to deliver high-quality, sustainable care.

- Although the lead GP was knowledgeable about some priorities relating to the quality and future of services they were unable to demonstrate that they understood the challenges and were addressing them.

At our inspection in December 2017 we found that the partners did not have the capacity to deliver high-quality, sustainable care due to the lead GP's workload and commitments at other practices. This was still the case at our April 2018 inspection. We found a lack of accountable leadership and governance and the practice were unable to demonstrate strong leadership in respect of safety.

We found there was poor clinical oversight of the provision of the regulated activities to ensure compliance with the Health and Social Care regulations. for example, in relation to medicine reviews, significant events and in respect of patient impact and outcomes.

At the time of this inspection we found that partnership had been terminated at the end of March 2018 and were told that the salaried GP was due to start work at Thurmaston Health Centre in May 2018. In the meantime the patient list size had continued to grow, with around a further 250 patients registering since our December 2017 inspection but a full time nurse had left since our last inspection and the full time nurse practitioner was also due to leave at the end of April 2018.

Another nurse had increased their hours by 12 hours per week but there was still a shortfall in clinical sessions. In addition, there was no longer a trainee doctor at the practice which further reduced the number of clinical sessions available. The lead GP told us they were thinking of asking a locum GP who was present on the day of our inspection to carry out some regular sessions going forward. When we discussed this with the practice manager they were not aware of these plans. The challenges and risk created by an increasing list size and inadequate clinical capacity was not being managed effectively.

Vision and strategy

The practice did not have a clear vision and credible strategy to deliver high quality, sustainable care.

At our inspection in December 2017 we found that although the practice had a vision to deliver high quality care and promote good outcomes for patients. We had concerns whether it was capable of doing so in view of GP staffing levels and the workload of the main GP partner due to a lack of clinical oversight in some areas.

At this inspection we had further concerns about the practice's ability to deliver the vision as although the practice had worked with the Clinical Commissioning Group to initiate some improvements, the lack of improvement we saw in the areas we looked at and the further issues we identified did not support a vision of high quality care and good outcomes for patients.

Governance arrangements

At our inspection in December 2017 we found that although there were clear responsibilities, roles and systems of accountability to support good governance and management, they were not always effective. At this inspection we found there were a lack of clear responsibilities, roles and systems of accountability to support good governance and management.

- Practice leaders did not have sufficient established policies, procedures and activities to ensure safety. Policies and processes were not always followed and therefore there was no assurance that they were operating as intended.
- The governance and management of partnerships, joint working arrangements and shared services did not always promote interactive and co-ordinated person-centred care.
- There was a lack of accountability and confusion around responsibilities between practice leaders which put patients at risk and created a lack of oversight,
- Structures, processes and systems to support good governance and management were lacking and we found ineffective systems in place in many areas such as in respect of monitoring of patients on high risk medicines, safe storage of medicines and prescriptions, the administration of medicines by HCAs, summarising patient records, dealing with tasks in a timely way, clinical supervision, significant events, uncollected prescriptions and medication reviews.

Managing risks, issues and performance

Inadequate

Are services well-led?

At our inspection in December 2017 we found that the processes for managing risks, issues and performance were not always clear. In the areas we looked at during this inspection we found processes for managing risks, issues and performance were not effective.

- There was not an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice did not operate effective processes to manage current and future performance. Performance of employed clinical staff could not be demonstrated through audit of their consultations, prescribing and referral decisions. There was a lack of oversight of incidents by practice leaders.

In December 2017 we found the provider was not registered to provide the regulated activity of family planning although the service was provided. Action was taken by the CQC to stop the provider carrying on the activity without registration and the provider told us they would stop the activity until registered correctly. However we found evidence at our inspection in April 2018 and following that inspection that the regulated activity of family planning had been provided after the provider had stated they would not do so and no attempt to register with CQC to provide the activity had been made.

At our previous inspection we had also identified that there was no registered manager for the regulated activity of maternity and midwifery. The provider did complete the necessary registration relating to this when they were told that this was required..

We had concerns about clinical supervision and oversight of other clinicians in the practice by the lead GP. This led us to review some consultations carried out by the nurse practitioner. The lead GP told us that the nurse practitioner was confident seeing most patients but did not like seeing children although we saw many examples of consultations with children being undertaken by this member of staff. They also told us that the clinical pharmacist saw patients suffering from headaches, minor illness, back pain and also carried out medication reviews. The lead GP told us they reviewed the clinical pharmacist and the nurse practitioners consultations when they were specifically asked to do so, however there were no formal processes for clinical supervision, oversight or audit of their work and the lead GP did not have any plans in place to do so.

Appropriate and accurate information

The practice did not have appropriate and accurate information.

- There was not an effective system to summarise patient records which meant the appropriate information may not have been available to clinicians. We found 356 patient records in different areas of the practice which were waiting to be summarised.
- There were not robust arrangements in line with data security standards for the confidentiality of patient identifiable data and records. Patient identifiable information was available in various unattended rooms in the practice which were accessible by patients.

Please refer to the Evidence Table for further information.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these. We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Urgent notice of decision to stop providing regulated activities from the location**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance