London Hair Transplant Clinic Ltd

London Hair Transplant Clinic

Inspection report

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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	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Good
Are services well-led?	Requires Improvement

Summary of findings

Overall summary

Our rating of this service improved. We rated it as requires improvement because:

We carried out a focused follow up inspection of Safe, Effective and Well led domains to check compliance with concerns identified in conditions imposed in February 2023 and warning notice imposed in March 2023. At this inspection we found:

- Although the provider had taken action to comply with the provisions of Regulation 12: Safe Care and Treatment, and Regulation 17: Good Governance, there were still some areas of poor practice.
- The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection.
- The design, maintenance and use of facilities, premises and equipment did not wholly keep people safe.
- The service did not always use systems and processes to safely prescribe, administer, record and store medicines.
- Leaders did not fully manage the priorities and issues the service faced. They did not always identify and escalate relevant risks and issues. There was no formal written strategy to turn the vision of the service into action. Not all staff could access systems to find the data they needed to understand performance, make decisions and improvements.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse. Staff assessed risks to patients, acted on them and kept good care records.
- The service had recently implemented systems to monitor the effectiveness of the service and made sure staff were competent.
- Leaders were visible and approachable in the service for patients and staff. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Surgery	Requires Improvement 	See the overall summary above for details.

Summary of findings

Contents

Summary of this inspection

Background to London Hair Transplant Clinic

London Hair Transplant Clinic is a cosmetic surgery service operated by London Hair Transplant Clinic Ltd. The service is an independent healthcare service and does not offer any NHS care. The service mostly carried out hair transplants, but in the 13 months before our inspection had also begun to offer more invasive cosmetic surgery procedures including breast augmentation, rhinoplasty, liposuction and abdominoplasty. The service provided care to privately paying adults, but also offered rhinoplasties to young adults aged 16 and above.

The service was rated inadequate following a comprehensive inspection in February 2023. We used our enforcement powers to serve an urgent notice of decision to impose conditions to the provider under Section 31 of the Health and Social Care Act 2008. We also used our enforcement powers to serve a Warning Notice to the provider under section 29 of the Health and Social Care Act 2008. This was served for failing to comply with Regulation 17: Good Governance.

We carried out a focused, follow up inspection of Safe, Effective and Well led domains to check compliance with concerns identified during our previous inspection. In order to re-rate Safe, Effective and Well led, we inspected and reported on all the key lines of enquiries.

The service had a registered manager, who was also the lead clinician.

How we carried out this inspection

During our inspection we spoke with three members of staff including the service manager, nursing and allied staff. We carried out an interview with the registered manager on 20 April 2023. We reviewed five patient records, medicines, guidelines and staff records.

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.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service 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 service MUST take to improve:

- The service must ensure that all equipment including the fire extinguisher are serviced in line with manufacturer guidelines (Regulation 12(2) (e)).
- The service must ensure medicines are managed safely. They must ensure all medicines are in date, stored securely and labelled appropriately (Regulation 12 (2) (g)).
- The service must control infection risks well. They must ensure sinks are designed in line with national guidance, sharp bins are labelled and stored appropriately, and equipment are free from infection risk (Regulation 12 (2) (h)).
- The service must ensure the risk register is comprehensive and includes all relevant risks (Regulation 17 (2) (a) (b)).

Summary of this inspection

- The service must ensure equipment are appropriately located for the purpose for which they are being used. They must ensure there are adequate resuscitation equipment on each floor (Regulation 15 (1) (f)).

Action the service SHOULD take to improve:

- The service should ensure that staff meetings are well attended and the minutes contain sufficient detail to provide a clear understanding of what was discussed.
- The service should ensure all relevant staff have access to clinical records, policies and performance data.
- The service should ensure all medical gas cylinders are stored safely.
- The service should ensure clinical audits are fully embedded to monitor patient outcomes.
- The service should ensure that staff conduct detailed assessment of patient psychological and emotional needs.
- The service should ensure there is a named safeguarding lead who has completed at least level 4 safeguarding children training.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Surgery	Requires Improvement	Good	Not inspected	Not inspected	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Not inspected	Not inspected	Requires Improvement	Requires Improvement

Requires Improvement

Surgery

Safe	Requires Improvement
Effective	Good
Well-led	Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up-to-date with their mandatory training. We reviewed the staff training matrix and substantive staff had completed all their mandatory training modules.

The mandatory training was comprehensive and met the needs of patients and staff. Mandatory training requirements included a range of modules such as conflict resolution, equality and diversity, fire safety, infection prevention and control, information governance, resuscitation and safeguarding.

The service had implemented a system to monitor mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training.

Consultants working under practising privileges were required to provide evidence of compliance with mandatory training. We reviewed mandatory training records for consultants during our inspection and saw that the service was awaiting up to date training records for two of the consultants.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff had received training specific for their role on how to recognise and report abuse. Safeguarding children and adults training formed part of the mandatory training programme for staff. Staff had completed safeguarding training for adults and children up to level 3.

The service offered rhinoplasties to young adults aged 16 and 17 years. However, the service did not have a level 4 trained safeguarding named professional or level 5 trained designated professional in line with best practice.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave examples of concerns they would report and knew the contact details for the agencies they would report to. This included the safeguarding lead and local authorities.

Requires Improvement

Surgery

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff did not always use equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and the premises visibly clean.

Clinical areas were clean and had mostly suitable furnishings which were clean and well-maintained. All areas of the clinic including the theatres were visibly clean. However, we noted that the surgical light in one of the first-floor theatres was still covered in cling film which increased infection risk. The surgical couch covering was still not fully intact and had been mended, this also increased the risk of infection.

The design of the sinks was not in line with guidance. Sinks in clinical areas had overflow pipes. The national guidance states these should not be used in clinical areas, as they can be an area for bacterial growth.

We found unlabelled sharps bin on the floor of the main theatre on the first floor. We also found some washed items drying on the cloth rack in the corridor.

The service had recently implemented systems to identify surgical site infections, however this was not yet embedded at the time of our inspection.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff were bare below the elbow and the service had sufficient PPE for patient care.

The service had implemented systems to decontaminate equipment. The service had a service level agreement with an NHS trust for the decontamination of equipment.

The service had implemented a monthly hand hygiene audit and a monthly infection control and prevention audit. Hand hygiene audits from March and April 2023 showed all staff were compliant with the standards being audited. The service achieved 98% compliance for the infection prevention and control audit in March and April 2023.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use equipment. Staff managed clinical waste well.

At the time of our inspection, the main theatre was located on the first floor. The theatre had laminar flow, meaning the air circulation was controlled. There were theatres on the ground floor where hair transplant procedures were carried out. The theatres met the requirements for a clean procedure.

The service had a lift on the first floor; however, the lift was not wide enough to accommodate a trolley/medical bed in the event of an evacuation. The lift could accommodate an ambulance chair. The service had purchased an evac chair for use in the event of an emergency.

Following our inspection, the service informed us they have moved theatres for invasive procedures to the ground floor. They would now be used for procedures involving general anaesthesia or sedation. This meant such patients could easily be evacuated in the event of any emergency. Theatres on the first floor would only be used for hair transplant procedures and those requiring local anaesthesia.

Requires Improvement

Surgery

During our inspection not all medical gas cylinders were stored securely. We found freestanding gas cylinders throughout the service without appropriate racking or trolleys. Following our inspection, we were provided with evidence to show that cylinder racks had been purchased to secure medical gas cylinders.

There was an emergency medical trolley on the first floor, however, we were not provided with evidence of daily checks during our inspection. Following our inspection, we were provided with a monthly resuscitation trolley checklist dated 20 April 2023 which showed the trolley contained all necessary equipment/medication.

There was no resuscitation trolley on the ground floor during our inspection and it was unclear how the emergency trolley on the first floor would be brought down to the ground floor if a patient were to deteriorate there. Staff informed us they had ordered an additional resuscitation trolley.

The service had implemented a monthly fire checklist. Audits from March and April 2023 showed staff complied with relevant standards.

The service had also implemented a monthly health and safety audit. The audit reviewed several standards including fire exits, fire /smoke alarm and staff training. The audit also reviewed testing and servicing of fire extinguishers, gas and boiler appliances, legionella water testing, among others. Audit results from March 2023 and 4 April 2023 showed compliance with all standards reviewed.

Most equipment were up to date for servicing. However, we found an out-of-date fire extinguisher (March 2018) on the first floor during our inspection despite the fire audit and health and safety audit indicating that fire extinguishers were serviced annually.

Staff managed clinical waste well in most cases. There were arrangements for handling, storage and disposal of clinical waste. Waste was segregated with separate bins for general waste and clinical waste.

The service had two patient rooms and both had call bells.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. The service made sure patients knew who to contact to discuss complications or concerns.

Risk assessments had improved since our last inspection.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool. This included pre-assessment checklists to identify potential risks such as allergies and assessing patients' medical history and suitability for treatment.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The service had a deteriorating patient policy which defined clear roles and responsibilities for staff to act in an emergency. All staff had completed resuscitation training to care for patients in an emergency.

The service had implemented a monthly surgical World Health Organisation (WHO) "Five steps to safer surgery" checklist audit. An audit of 10 patient records in March and April 2023 showed staff complied with all checks required.

Requires Improvement

Surgery

The service now had a defined inclusion and exclusion criteria which included a definitive list of procedures undertaken at the clinic.

The service had a fire evacuation plan which included actions staff should take in the event of a fire incident.

Staff shared key information to keep patients safe when handing over their care to others. Staff followed a standard process to share clinical information with GPs when necessary.

Staff informed us the service was in the process of arranging a contract with a supplier to access blood products for use in an emergency.

Nursing and Allied Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

The service had enough nursing and support staff to keep patients safe.

The service now had clearly defined minimum staffing levels for each procedure. The service had recently implemented a policy which specified the staffing recommendations for scheduled operating lists. The service had created a checklist for surgical procedures. For example, hair transplant procedures would involve two technicians and one surgeon. Cosmetic surgery procedures would involve a surgeon, an anaesthetist, a scrub nurse, an Operating Department Practitioner (ODP) and a Health Care Assistant (HCA). We reviewed patient records which had been completed to show that the appropriate number of staff were involved in each procedure.

The service did not use agency staff.

Medical Staffing

The service had enough medical staff with the right qualifications, skills, training and experience to care for patients.

The service had enough medical staff to care for patients during surgical procedures. Medical staff were employed using practising privileges and appointments were booked in line with surgeon and anaesthetist availability. Surgeons and anaesthetists were identifiable in patient records.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely. The service had registered with the Breast and Cosmetic Implant Registry (BCIR) in order to record all cosmetic implants carried out on the registry.

Record keeping had improved since our last inspection.

Patient notes were comprehensive and all staff could access paper records easily. Patient notes were recorded on paper and then scanned unto electronic systems. We reviewed three patient records. Records were detailed and included details of pre-assessments carried out, observation chart, medication chart, recovery notes, consent form, COVID 19 terms and conditions and discharge summary. Each record included details of staff involved in the care of the patients and their designation.

Requires Improvement

Surgery

The service had recently registered with the Breast and Cosmetic Implant Registry (BCIR) in order to record all cosmetic implants carried out on the registry.

The service had implemented a medical records audit. Audit results from March and April 2023 showed that staff achieved 91% and 95% compliance respectively. The audits identified if there were any learnings. For example, in March 2023, the audit identified the need to ensure all patients signed the COVID consent form and to ensure writing on the form was legible.

Records were stored securely in filing cabinets and on electronic systems.

However, access to electronic records was held only by the service manager. They had to send a code to authorise access for other members of staff. Although this improved security, it meant if they were not on site, staff were not able to access records immediately and had to request the code.

Medicines

The service did not always use systems and processes to safely prescribe, administer, record and store medicines.

Although medicines management had improved since our last inspection, there were still several areas of poor practice.

The service had a medicines management policy, which described the storage, prescribing and safe administration of medicines.

Staff completed medicines records accurately and kept them up-to-date. We reviewed three medicine records and saw they were completed, signed and dated. Staff recorded information about patient allergies.

Medicines management and storage was inconsistent. Medicines were mostly stored in secure cabinets. Controlled drugs (CD) were stored in a secure cupboard. CD records were regularly updated in line with best practice. However, we saw that a medicines cupboard in one of the theatres on the ground floor was unlocked.

We reviewed a random sample of medicines and found that most of them were in date. However, we found an expired pack of medicines which had been prescribed for a patient in a medicines cabinet on the ground floor. We also found two out of date ampoules in a tray of medicines in the main theatre on the first floor. This was immediately removed by staff.

Fridge temperature checks were inconsistent. Records reviewed showed that fridge temperatures in one of the ground floor theatres was last checked on 3 March 2023, while the temperature in the main theatre upstairs was last checked on 4 March 2023.

Incidents

The service had recently implemented systems and processes to manage patient safety incidents.

The service had implemented incident reporting systems and processes since our last inspection. The service had an incident reporting policy and staff knew what incidents to report and how to report them.

Staff recorded incidents on an incident form. This was updated on the governance tracker. We reviewed the tracker which showed three incidents reported. However, we noted that the governance tracker had not yet been updated with a recent incident seen on the service's software system.

Requires Improvement

Surgery

Staff informed us they received feedback from the investigation of incidents. They met to discuss the feedback and looked at improvements to patient care. For example, the service kept spare fuses following an experience of suction failure which caused a surgery to be rescheduled.

Staff understood the duty of candour. They told us it involved being open and transparent and giving patients and their families a full explanation if and when things went wrong.

Is the service effective?

Good

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service had recently implemented formal policies and protocols in line with national guidance and evidence-based practice.

The service had recently implemented clinical policies and protocols to direct staff to plan and deliver high quality care. Policies were up to date and in line with national guidance. However, we noted that only the service manager had direct access to electronic systems where policies were stored. This meant if they were not on site, staff were not able to access policies immediately and had to request a code.

The service had implemented a programme of audits to monitor compliance with guidelines this included health and safety audit, hand hygiene, medical records, fire checklist and WHO checklist audit.

However, we did not see any evidence that staff conducted detailed assessment of patient psychological and emotional needs.

Nutrition and hydration

Patients fasting before surgery were not without food for long periods.

Patients were not kept waiting for long periods of time if they needed to fast before surgery. Surgical lists were booked to ensure patients were not kept waiting, therefore they only needed to fast for minimal amounts of time. Patients who were undergoing hair transplants, which can take hours, were offered food and drink throughout the day.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Staff prescribed, administered and recorded pain relief appropriately. We saw this was recorded in patients' prescription charts.

Patient outcomes

The service had implemented systems to monitor the effectiveness of care and treatment.

Requires Improvement

Surgery

The service had implemented an audit programme to monitor compliance with guidelines. This included a template for monitoring surgical site infections. At the time of our inspection, there were conditions imposed preventing the service from carrying out procedures under general anaesthetics and conscious sedation. This meant the service was not in a position to monitor the effectiveness of care and treatment for invasive cosmetic procedures.

The focused inspection was conducted one month after the first comprehensive inspection leaving a brief time for the provided to demonstrate improvements in patient outcomes.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff had completed relevant training required for their role. Managers regularly reviewed the registrations and revalidations of relevant clinic staff to make sure they were up to date.

Managers gave all new staff a full induction tailored to their role before they started work. New members went through a probationary period and completed competency training.

Managers supported staff to develop through yearly, constructive appraisals of their work. The clinic's appraisal data showed all staff received yearly appraisals.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team.

There were good working relationships between staff members. Surgeons, nurses and allied health professional staff all supported each other.

Seven-day services

Patients could contact the service seven days a week for advice and support after their surgery.

The clinic opened from 9am to 6pm on Monday to Saturday. The clinic also had facilities to care for patients overnight where necessary. Patients were provided with a telephone number to contact the service after hours.

Health promotion

Staff assessed each patient's health at every appointment and provided patients information relevant to their procedure.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance and ensured that patients gave consent in a two-stage process with a cooling off period of at least 14 days between stages. They understood how to support patients.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff could describe their roles and responsibilities under the Mental Health Act. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decision about their care.

Requires Improvement

Surgery

Staff followed national guidance and ensured patients had a 14-day cooling period between the initial consultation and surgery in case a patient changed their mind.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Consent forms were completed and signed in all patient records reviewed.

Staff had received training in Mental Capacity Act as part of their safeguarding adults training.

Is the service well-led?

Requires Improvement

Our rating of well-led improved. We rated it as requires improvement.

Leadership

Leaders had the skills and abilities to run the service. They were visible and approachable in the service for patients and staff. However, they did not fully manage the priorities and issues the service faced.

The clinical lead and surgeon, who was also the registered manager had overall accountability for the service. The clinical lead also worked as a consultant intensivist at an NHS Trust. The clinical lead was supported by the service manager and a senior nurse.

Staff were positive about the leadership of the service. They informed us managers were visible and approachable. They felt well supported by the clinical lead of the service.

Since our last inspection, managers had implemented systems and processes to improve the service. However, the systems were newly implemented and not fully embedded. For example, the risk register was not comprehensive and did not reflect all the risks identified during our inspection.

Vision and Strategy

The service had a vision for what it wanted to achieve but had no formal strategy to turn it into action.

The service had a vision to maintain the highest standards of safety and infection control to ensure that patients received the best possible care. However, the service did not have a formal written strategy to implement its vision.

The service highlighted its core values as compassion, excellence, integrity, teamwork, innovation and respect.

Staff we spoke with said they were committed to providing excellent care.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care.

Staff informed us there was a positive culture within the service. They felt respected, supported and valued. Staff had opportunities for training and development.

Requires Improvement

Surgery

Staff felt they worked well together in a good team and confirmed they were focused on the needs of patients.

Staff felt able to raise concerns and report incidents locally.

The service had implemented systems to better manage patient expectations. The service had updated its complaint policy and improved its complaint process to enable patients report concerns without fear. They have also registered with the independent federation of doctors to provide patients with opportunities to escalate complaints.

The service had a diverse team of staff, and staff we spoke to felt they worked in a fair and inclusive environment.

Governance

Leaders had recently implemented systems to operate effective governance processes. Staff at all levels were clear about their roles and accountabilities.

Since our last inspection, the service had implemented systems and processes to support the delivery of care. This included policies and clinical pathways, an interpreting service, an audit programme and registration with relevant bodies such as the BCIR. The service had implemented a governance tracker to manage and track incidents, compliments, complaints, CQC notifications and the risk register. Employment records, including staff training and appraisal records had been updated on the provider's system.

The service had implemented service level agreements with third party organisations for the delivery of some of its services, for example, decontamination of equipment.

Staff were clear about their roles and responsibilities; however, we were not assured there were regular opportunities to meet and learn from the performance of the service. The service held monthly staff meetings where staff discussed key operational and clinical issues. However, this was not always attended by all staff. For example, only two staff attended the last meeting in March 2023. Minutes of meetings only listed the issues/topics discussed. The minutes did not contain sufficient detail to provide a clear understanding of what was discussed.

Management of risk, issues and performance

Leaders had recently implemented systems to manage performance and risks. However, they did not always identify and escalate relevant risks and issues.

The service had a risk register which identified controls in place to mitigate against the impact from the risks.

There were four open risks on the risk register. These were regarding advance staff planning, cleaning schedules, incident management systems and resuscitation equipment checks.

The risk register did not include some of the main risks around the environment, infection prevention and control and medicines management identified during our inspection.

The service had implemented a programme of audits to monitor compliance with guidelines. This included a template for monitoring surgical site infections. However, this was not yet embedded due to the short time frame between our recent inspections.

Requires Improvement

Surgery

Information Management

The service had recently implemented systems to collect reliable data and analyse it. However, not all staff had access to find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

Access to individual patient's records were restricted to authorised staff. Electronic devices were password protected and staff signed out of computer systems when they were not in use. However, only the service manager had direct access to the organisation's electronic system. This meant other staff did not always have access to gain information relating to policies, national guidance and performance.

The service had recently registered with the BCIR in order to record all cosmetic implants carried out on the registry.

Staff had received training in information governance as part of their mandatory training.

Engagement

Leaders and staff engaged with patients and staff to plan and manage services.

The service held monthly staff meetings where staff discussed patient care and administrative issues. The service obtained feedback from patients following each consultation and treatment.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services.

The service had systems to monitor staff training and development. Staff had taken advantage of the opportunities available to learn, develop and improve their skills.

The service had implemented systems to address areas of concern identified in our previous inspection. This included policies and procedures, monitoring staff training and competencies, governance and registration with relevant bodies.

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
Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The service must ensure that all equipment including the fire extinguisher are serviced in line with manufacturer guidelines (Regulation 12(2) (e)). • The service must ensure medicines are managed safely. They must ensure all medicines are in date, stored securely and labelled appropriately (Regulation 12 (2) (g)). • The service must control infection risks well. They must ensure sinks are designed in line with national guidance, sharp bins are labelled and stored appropriately, and equipment are free from infection risk (Regulation 12 (2) (h)).

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment • The service must ensure equipment are appropriately located for the purpose for which they are being used. They must ensure there are adequate resuscitation equipment on each floor (Regulation 15 (1) (f)).

Regulated activity	Regulation
Treatment of disease, disorder or injury Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must ensure the risk register is comprehensive and includes all relevant risks (Regulation 17 (2) (a) (b)).