Mr. Declan Thompson

Mr Declan Thompson - Harley Street

Inspection Report

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Overall summary

We carried out an announced comprehensive inspection of this service on 19 November 2015 as part of our regulatory functions. A breach of legal requirements was found. After the comprehensive inspection, the practice wrote to us to say what they would do to meet the legal requirements in relation to the breach.

We undertook this focused inspection on 21 March 2016 to check that they had followed their plan and to confirm that they now met legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Mr Declan Thompson – Harley Street on our website at www.cqc.org.uk.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services well-led?

The focused inspection concentrated on the key question of whether or not the practice was well led. We found that this practice was now providing well-led care in accordance with the relevant regulations.

The practice had improved its clinical governance and risk management protocols. These were being shared and discussed by staff. The principal dentist could demonstrate that the changes that had been made had led to improvements in the safe running of the practice as well as to the quality of care that patients received. For example, new audits assessing the quality of dental care record keeping, X-ray quality and infection control processes had all been carried out. There were clear action plans put in place in response to the audits. The practice could show that progress had been made towards implementing these plans.

We also found that governance in relation to staff recruitment and continued professional development had improved. All staff now had formal contracts in place and an appraisal process, which reviewed staff performance, as well as their learning and development goals, had now been carried out. There was also a new staff recruitment policy.

A range of other systems had also been improved. For example, improvements had been made to systems for recording information in patients' dental care records; this included the recording of written consent for treatments. We also noted that equipment, including the ultrasonic bath and X-ray machine, had been serviced. Other systems for monitoring safety and minimising risk had been introduced. This included systems for responding to alerts from external agencies, and monitoring of substances potentially hazardous to health (COSHH).

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Detailed findings

Background to this inspection

This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced, focused inspection on 21 March 2016. This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our comprehensive inspection on 19 November 2015 had been made. We inspected the practice against one of the five questions we ask about services: is the service well-led? This is because the service was not previously meeting some legal requirements.

At the previous, comprehensive inspection on 19 November 2015 we found that the practice was not well-led because the risk management, governance, and audit systems had not been used to effectively monitor and improve the quality of the service. We also found that dental care records could be improved and that a system for supporting and appraising staff needed to be established.

The focused inspection was led by a CQC inspector who had access to remote advice from a specialist advisor.

During our inspection visit, we checked that points described in the provider's action plan had been implemented by looking at a range of documents such as risk assessments and audits. We also carried out a tour of the premises and spoke with members of staff.

Are services well-led?

Our findings

Governance arrangements

We spoke with the principal dentist about the governance arrangements at the practice. We found that they had initiated a number of changes to their governance systems since the previous inspection.

There were new policies in place, for example, in relation to staff recruitment and for the reporting and investigation of incidents. Changes had also been made to improve the standard of record keeping in relation to staff employment, as well as to those related to patient care and treatments.

The principal dentist had made a number of changes in relation to maintaining patients' dental care records. Consent forms for specific treatments were available and patients were being asked to sign these. At each routine appointment the dentist had initiated a checklist system to ensure that all key topics, including medical history, outcomes of examinations, and oral health advice, had been fully covered and recorded.

There were also new systems for monitoring and reducing risks to patients and staff. The practice's arrangements for managing medical emergencies had been reviewed. We found that the practice held all relevant equipment and medicines in line with guidance issued by the Resuscitation Council UK and the British National Formulary.

There were arrangements in place for responding promptly to Medicines and Healthcare products Regulatory Agency (MHRA) advice. MHRA alerts, and alerts from other agencies, were received by the practice via email and copies of relevant documents were held in a file. These were disseminated at staff meetings, where appropriate.

There were also arrangements in place to meet the Control of Substances Hazardous to Health 2002 (COSHH) regulations. There was a COSHH file where risks to patients, staff and visitors associated with hazardous substances were identified. Actions were described to minimise identified risks. COSHH products were securely stored. Staff were aware of the COSHH file and of the strategies in place to minimise the risks associated with these products.

Leadership, openness and transparency

The principal dentist and dental nurse told us they had discussed and reviewed the recent changes in governance structures, as they were implemented, to ensure that a shared understanding of protocols and polices was developed.

We also found that formal contracts with associated job descriptions were now in place for all members of staff. Notes had been kept from appraisal meetings where staff performance had been reviewed and goals for future development had been set.

Learning and improvement

The practice had carried out three new audits since the last inspection. These covered infection control, X-ray quality and dental care record-keeping. Each audit had a documented action plan. Staff could demonstrate that progress had been made towards implementing these plans. For example, the infection control audit had led to staff taking additional training in the correct methods for segregating and disposing of dental waste, as well as the ordering of new waste bins to aid in the segregation process.

At our previous inspection we noted that the ultrasonic bath and the X-ray machine were overdue for a service. Both of these items had now been inspected and were well-maintained.

The practice had also engaged a new Radiation Protection Advisor (RPA). The X-ray equipment had been serviced in March 2016. Recommendations had been made by the RPA for improving the recording of information in a radiation protection file, in line with the Ionising Radiation Regulations (IRR) 1999 and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER). This included, for example, producing an updated version of the local rules. The principal dentist told us that they would be following up on the outcome of this report with a view to maintaining compliance with the relevant Regulations.

Staff had engaged in additional training within the past five months with a view to ensuring that they maintained the necessary skills to meet the needs of the patients visiting the practice. For example, the dental nurse had completed formal training in the Mental Capacity Act (2005). (The Mental Capacity Act 2005 (MCA) provides a legal framework for health and care professionals to act and make decisions on behalf of adults who lack the capacity to make particular decisions for themselves).