Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Bath Orthodontics

Sydney Road, Bath, BA2 6NR

Tel: 01225481890

Date of Inspection: 31 October 2012

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We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Cleanliness and infection control	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Dr. Eric Tonge
Overview of the service	Bath Orthodontics treats NHS patients (children) and private patients (children and adults). It specialises in the treatment of malocclusions (improper bites) with the use of dental braces and retainers.
Type of service	Dental service
Regulated activities	Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

	Page
Summary of this inspection:	
Why we carried out this inspection	4
How we carried out this inspection	4
What people told us and what we found	4
More information about the provider	4
Our judgements for each standard inspected:	
Consent to care and treatment	5
Care and welfare of people who use services	7
Safeguarding people who use services from abuse	9
Cleanliness and infection control	10
Requirements relating to workers	12
Records	13
About CQC Inspections	14
How we define our judgements	15
Glossary of terms we use in this report	17
Contact us	19

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an announced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 31 October 2012, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

What people told us and what we found

People we met at the practice were all satisfied with the care and treatment they had received. They told us staff were friendly, professional and sensitive if they were apprehensive. One person said they had been nervous about the treatment but had been reassured and put at ease by staff. Another person said: "it's really good here. Friendly and relaxed". The parent of a young person receiving treatment said "everyone is really patient. It's very focussed upon the patient and very reassuring".

We found the practice was gaining valid informed consent from people, including young people. Staff knew when consent was required and how to determine who was or was not able to make an informed decision. The provisions of the Mental Capacity Act 2005 were followed. People received safe and effective care from a practice that was clean and well appointed. Staff were experienced, skilled and knowledgeable. People's private information was held confidentially and only authorised staff had access to records.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

All the people we talked with at Bath Orthodontics on the day of our visit who were being treated were young people (they were under the age of 18 years). We also talked with their parents who were accompanying them. One of the parents had also been a patient at the practice. Parents told us they were involved with the treatment "each step of the way" but both they and the practice respected the rights of young people to be included in or make their own decisions.

The young people and/or their parents said they had been able to give valid consent and asked to sign a consent form. If the person was a child who was judged not to be able to give their own valid consent, the person's parent or guardian signed the consent form, sometimes alongside the child. When a person came to the practice for follow-up treatment they were asked for their consent verbally before the treatment took place. People told us they were told by the orthodontist or orthodontic therapist what treatment was proposed. They then agreed with treatment taking place by verbal or implied actions.

People told us they knew they could withdraw their consent at any time. Older children who had been judged as competent to make their own decisions said they understood they could make decisions about the treatment even if this was not following the advice of the healthcare professional. We were told the fee structure for private patients was made clear at the outset and people were able to give consent knowing the probable costs of the treatment.

Staff we met at the practice said gaining consent started with the first consultation and was a "step-by-step process". They said people were told their treatment options at their first consultation. People were told the risks and benefits of the treatment so they could make a valid informed decision. People returned to the practice after a cooling-off period (likely to be a number of weeks at least) for their first treatment. People were asked for specific consent if a trainee member of staff was working with them or observing treatment.

The practice treated mostly young people under the age of 18 years either privately or

through an NHS referral. The orthodontist and orthodontic therapist were aware of their responsibilities to judge if a young person was capable of making their own decisions. They said they followed the 'Gillick Competencies' framework to judge the young person's ability to understand and weigh up the options. Staff also said they started from a presumption that young people who had reached age 16 years had capacity to consent, but still evaluated each person on their merits.

The practice had treated people who did not have capacity under the provisions of the Mental Capacity Act 2005 to give valid consent. People who were judged not to have capacity had been treated with the least restrictive or stressful options in their best interests. The orthodontist told us no person would be treated if it was judged as being against the person's will or not in their best interests. The orthodontist told us a person might be unable to have treatment at the practice if they exhibited behaviour staff were not able to safely manage.

The practice had a consent policy and a policy in relation to the provisions of the Mental Capacity Act 2005. All staff had signed and dated a declaration to say they had read and understood these policies.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

Young people and their parents told us the treatment they had was good. One person said: "it's really good here. Friendly and relaxed". Another person said: "I am very pleased with my treatment so far. It's going well and making progress". The parent of a young person receiving treatment said "everyone is really patient. It's very focussed upon the patient and very reassuring". This person also told us they had been asked to complete two satisfaction surveys in the past year to give their views on the practice.

People told us the treatment was well explained. People were told what they could expect in terms of any discomfort following treatment. They said the information as to how they would feel had been accurate and one person said: "pretty much what they told me to expect". We were told the practice made it clear people could get in touch at any time and discuss any concerns. People receiving treatment said they were given clear advice about caring for their teeth, braces and retainers.

The parent of one person receiving treatment had been a patient at the practice in the past as had one of their other children. They told us the staff gave them confidence and their own results had been "great" which was why they were happy to come back to the practice. People said they were able to book appointments to suit them. They said they had been aware of the time-commitment the treatment involved.

There was a patient comments' book in the waiting room. The practice manager reviewed entries, considered anything a person had commented upon negatively, and made changes to the practice if possible.

The practice had one private consultation room and otherwise an open-plan treatment room with one treatment area screened from the others. People told us the open-plan arrangement did not concern them. One person said they occasionally would prefer to use the screened area, but had not been offered this option.

Staff at the practice had been trained in cardiopulmonary resuscitation (CPR). There was an automated external defibrillator at the practice which was in working order. Staff had been trained in its use and its location was clearly marked. The practice had emergency medicines and portable oxygen. All emergency medicines and equipment held followed the guidelines of the Resuscitation Council (UK)'s standards for clinical practice for dental

practitioners. The practice had a separate X-Ray suite. We were told the walls, door and glass window were constructed to radiation-safe standards. There were local operating rules on the wall and the equipment was monitored by an external radiation protection advisor.

The practice had a medicines' refrigerator. The provider may find it useful to note the temperature gauge was showing the refrigerator was below freezing temperature. Medicines stored at the bottom of the refrigerator had small deposits of ice and the packaging was damp. Staff told us they checked the temperature daily but had not been recording this. This may mean some medicines had been stored below a safe temperature.

All the people we talked with said they had provided a medical history for themselves or a dependent child when they came for their consultation. They said the questions asked seemed fair, comprehensive and appropriate. At further appointments, the practice had checked with the person or their family member whether there had been any changes in the medical history. We checked 17 sets of medical notes at random and each one had a completed medical history form. We also noted any allergies or medical concerns were highlighted and cross-referenced these with the computer records.

The practice had policies including patient safety and patient confidentiality. All staff had signed and dated a declaration to say they had read and understood these policies.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

Staff at the practice had undertaken level 1 child safeguarding training. Training for dealing with concerns for vulnerable adults had been booked with the local Primary Care Trust. Staff we spoke with were able to tell us about the signs of possible abuse for a child or vulnerable adult. This included neglect and a vulnerable person in a poor state of mental or physical health. Staff understood their responsibilities for reporting any concerns either to the practice lead for safeguarding or to the local authority safeguarding team.

The practice manager was the lead for safeguarding and had undertaken level 2 training in child safeguarding. The practice displayed a flow-chart for staff to follow with clear instructions as to their responsibilities. This chart included the telephone numbers of the duty teams and out-of-hours teams at the local authority.

There was a safeguarding policy and all staff had signed and dated a declaration to say they had read and understood the policy.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed. People were cared for in a clean, hygienic environment.

Reasons for our judgement

People we talked with told us they thought the practice was clean, well appointed, and staff were aware of infection prevention and control. People said clinical staff wore uniforms and protective gloves when they were carrying out treatment. People were given an eye-shield to wear for their own safety when they were being treated.

The treatment rooms had disposable latex free clinical gloves in various sizes; plastic disposable aprons, household gloves for cleaning and decontamination purposes; face masks; and eye protection. Dental staff had approved footwear and were wearing appropriate uniforms supplied by the practice. Staff removed their uniforms during lunch and uniforms were not worn outside of the practice. If a member of staff was disposing of clinical waste outside the practice, they wore a disposable apron for the short period they were outside. Gloves, masks and aprons were discarded as clinical waste. Disposable single-use sharp instruments were placed in clinical waste containers. The provider may find it useful to note sharps' containers were placed on the floor in the practice. This might mean the boxes had been vulnerable to being kicked over and contaminated or sharp instruments spilled onto the floor. The practice addressed this during our visit.

The orthodontic nurses described their cleaning regime and confirmed they cleaned the areas required by decontamination protocols. This included between treatments cleaning the local work surfaces, the dental chair, and spittoons. The dental unit water lines were flushed through at the start and end of every day when the practice was operating. The provider may find it useful to note the flushing took 30 seconds when the guidance recommended at least two minutes. This may mean the water lines had not been sufficiently flushed of standing water.

The computer keyboards, computer mouse, and the handles of the inspection lights had plastic covers which were changed twice daily. The dental heads were covered with a plastic cover when not in use.

We observed thorough cleaning of equipment and plastic covers were replaced during the lunchtime break. Staff were wearing gloves and aprons and using appropriate cleaning agents and equipment. Mops and buckets were clean and dry. The dental chairs were mostly in good condition although one had small splits in the covering. Staff were not aware of the order in which to remove their personal protective equipment, which we

brought to the attention of the practice manager.

The decontamination of reusable instruments took place in the main open-plan treatment area. The instrument flow from dirty state to clean state was satisfactory. The areas where dirty and clean instruments were handled were indicated by 'red' and 'green' signs. To decontaminate reusable instruments, the practice used a mixture of hand washing and rinsing, ultrasonic cleaning, sterilising and drying. Clean instruments were placed in sealed bags and marked with the date the instrument was sterilised and when that expired. The practice used a steriliser of the type where instruments could be stored for up to 21 days. We saw dates on the instruments matched the expiry date requirement and none we saw had expired.

The Department of Health guidance: 'HTM 01-05: decontamination in primary care dental practices' sets out the essential standards that must be met and best practice standards that practices should be planning to achieve. The orthodontic therapist was the lead for infection control and was aware of the requirements of HTM 01-05. The audit regimes followed these decontamination principles. We observed the orthodontic nurses' instrument cleaning process. They initially used a small plastic container to scrub dirty instruments placed in the single sink, before rinsing them in the same sink. They checked under lit magnification if the instruments appeared clean. Instruments were then placed into the ultrasonic machine before moving to the steriliser and air-dried on racks. The provider may find it useful to note, although an ultrasonic washer was in use, where manual scrubbing of dirty instruments is carried out, the practice should have two separate bowls or sinks for manually cleaning and rinsing instruments. The bowls or sinks should be of a suitable size for the instruments and hands to be placed below the water line to avoid splashing and potential cross contamination.

The main treatment room and the private treatment room had a hand-wash-only sink. There was soap, paper hand towels and alcohol gel available. The clinical waste bin in the main treatment room had an ill-fitting lid and did not operate effectively due to the top being too close to the work surface above. The other bins in the treatment rooms were said to be for clinical waste only but they were not marked as such and did not contain the appropriate bin liners.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

The practice manager told us staff turnover was low and the practice had not needed to recruit staff in the last two years. If recruitment was undertaken, the practice would advertise locally. Applicants would be required to complete an application form. Interviews would be conducted and notes taken and retained of the applicant's performance.

Staff who were appointed would be required to provide two references, with one being from their last employer or educator if appropriate. New staff were also required to provide photographic identification, proof of any required qualifications and professional registrations, and, if required, their Hepatitis B status.

All staff at the practice had enhanced Criminal Records Bureau (CRB) checks. The provider may find it useful to note CRB disclosures were retained on personnel files and not returned to the member of staff or destroyed after six months (unless there had been a valid reason to retain them).

We reviewed two sets of staff files. Each had a signed contract and the member of staff had been given a signed contract. Staff had been given a job description and a staff handbook. The files contained copies of any training certificates; CRB disclosure and emergency contact details. The provider may find it useful to note references had not been previously obtained for staff employed at the practice. The practice manager told us the practice was aware of this shortcoming and new staff would not be permitted to work at the practice if satisfactory references were not obtained.

The practice did not use agency or locum staff. There were no foreign nationals working at the practice at the time of our visit, but the practice manager was aware of the requirement to obtain valid work permits and a valid police check of the person.

Records ✓ Met this standard

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People's personal records including medical records were accurate and fit for purpose. Staff records and other records relevant to the management of the services were accurate and fit for purpose. Records were kept securely and could be located promptly when needed.

Reasons for our judgement

People told us they felt their medical records and private information was held securely and remained confidential. They said they had not heard or seen private information relating to anyone else when visiting the practice.

We reviewed 17 sets of paper medical records notes. We found them fit for purpose; names and contact details were clear; and they contained only appropriate information about people. Medical records were held both on paper and on a computer database. Records were stored securely. The practice was also locked and secure when not occupied.

The computer system was password-protected and passwords were changed regularly. Staff had signed a confidentiality agreement around the security of people's private information. The computer data was backed-up each night and a copy of the data taken off site for security.

The practice kept records in relation to the day-to-day management of the service. Staff personnel files were kept in a locked file and only accessible to authorised staff. The practice also had records in relation to managing the premises. This included portable appliance testing (PAT) records; fire safety records and reports; X-Ray and other equipment servicing and maintenance; incident and accident reports; clinical waste consignment notes; and general operating policies and procedures. There were staff rotas available for inspection for the last year. The provider may find it useful to note staff rotas are required to be retained and available in a format for inspection for four years.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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