Follow up Report

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

Pinnacle Orthodontics

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We followed up on our inspection of 02 May 2013 to check that action had been taken to meet the following standard(s). We have not revisited Pinnacle Orthodontics as part of this review because Pinnacle Orthodontics were able to demonstrate that they were meeting the standards without the need for a visit. This is what we found:

Assessing and monitoring the quality of service provision ✓ Met this standard

Details about this location

Registered Provider	Kings Heath Dental Practice
Registered Manager	Mr. Dinesh Balkrishna
Overview of the service	The practice offers a range of orthodontic treatments to people of all ages. The practice provides services to both NHS and private patients.
Type of service	Dental service
Regulated activities	Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury

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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'

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Summary of this follow up review

Why we carried out this review

We carried out an inspection on 02 May 2013 and published a report setting out our judgements. We asked the provider to send us a report of the changes they would make to comply with the standards they were not meeting.

We have followed up to make sure that the necessary changes have been made and found the provider is now meeting the standard(s) included within this report. This report should be read in conjunction with the full inspection report.

We have not revisited Pinnacle Orthodontics as part of this review because Pinnacle Orthodontics were able to demonstrate that they were meeting the standards without the need for a visit.

How we carried out this review

We reviewed information given to us by the provider.

We have not revisited Pinnacle Orthodontics as part of this review.

What we found about the standards we followed up

We visited Pinnacle Orthodontics on 2 May 2013. During this inspection we found the service was not compliant with the regulation relating to quality assurance.

This was because we saw the practice had procedures in place to monitor the service but improvements had not been implemented where issues had been identified.

A recent audit showed patient records were not being updated with all the information the dentist required to alert them to medical conditions a patient might have.

We issued a compliance action to the provider and asked them to send us an action plan explaining what they would do to improve. We reviewed the action plan and evidence of its completion. This told us what the provider had done to become compliant with the regulation.

We saw a notice had been sent out to all staff which highlighted the importance of recording medical alerts on records appropriately.

We reviewed the findings of an audit on patient records conducted in May 2013. The audit showed a significant improvement in the recording of patient information. We saw evidence that the results of the audit had been discussed in a practice meeting. A further audit was planned for the end of August 2013 to continue monitoring progress in this area.

Appropriate action had been taken to ensure an effective system is in place for monitoring and assessing the quality of the service provided.

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 reviewed

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

Reasons for our judgement

We visited Pinnacle Orthodontics on 2 May 2013. During this inspection we found the service was not compliant with the regulation relating to quality assurance. We found the provider did not have effective systems in place to regularly assess and monitor the quality of the service people received.

This was because we saw the practice had procedures in place to monitor the service but improvements had not been implemented where issues had been identified.

For example: We saw the practice had undertaken a recent audit in October 2012 on patient record keeping. The audit showed 3% of patients had no medical history form filed on their patient record. It also showed 27% did not have a medical alert recorded, when the patient had a medical condition which should have been identified as a medical alert.

The practice manager was unable to show us how the practice had acted on the findings of this audit.

We examined four patient records. We saw a patient record for one person who the practice had recently treated. The medical history of the individual showed a range of medical conditions including asthma, hayfever and an allergy to anti-biotics. The individual's medical history had been completed on three separate occasions. None of the medical conditions had been recorded as a medical alert on either the paper record or the computerised record for that individual. This showed further evidence that the issues identified in the recent audit had not been addressed.

The practice had a procedure in place for obtaining the views and opinions of people who used the service. We saw evidence of comments patients had made regarding the practice in customer satisfaction surveys. We were unable to view an audit of the patient satisfaction survey or an analysis of the comments patients had made, as this had not been conducted at the time of our visit. We were told this was planned for May 2013.

We issued a compliance action to the provider. We asked the provider to send us an action plan explaining what they would do to improve their quality assurance and

monitoring procedures.

The provider submitted an action plan and produced evidence of its completion. This told us what the provider had done to become compliant with this regulation.

We saw a notice had been sent out to all staff on 3 May 2013 immediately following our visit. The notice highlighted the importance of recording medical history information and medical alerts on both paper and computerised records. The notice informed staff that accurate records are essential in ensuring the correct treatment is given to patients, and they are protected from harm.

An audit was performed on patient records in May 2013 and sent to us. We reviewed the findings of the audit. The audit looked at the records of 35 patients who had been treated in May 2013 using a random selection system. Patient records were re-viewed for all of the dentists at the practice. The audit showed a significant improvement in the recording of patient information. We saw evidence that the results of the audit had been discussed in a practice meeting. A further audit was planned for the end of August 2013 to continue monitoring progress in this area.

The provider informed us an audit will be scheduled every three months to monitor compliance in relation to the issues previously identified.

We saw the minutes of a staff meeting that had been held at the practice in July 2013. The meeting was used to discuss the updating of patient records, and to propose a change in procedure to make this more accurate. We saw that further meetings were planned to keep staff up to date with the results of future audits and procedure changes. This demonstrated the practice had acted on the findings of the previous audits to improve their systems.

In addition, an analysis of the patient survey had been conducted following our visit. The survey showed a high percentage of patients were satisfied with the treatment they received. We saw the results of the survey had been analysed and actions identified to improve the service.

The information we reviewed from the provider showed that appropriate action had been taken to ensure there is an effective system in place for monitoring and assessing the quality of the service provided.

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 other services less often. 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.

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. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). 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.

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