Overall summary

We carried out an announced focussed inspection of Catterick Dental Centre on 6 September 2018.

We undertook an announced comprehensive inspection of this service on the 11 July 2017 and found the practice was not safe in accordance with CQC’s inspection framework. The clinical care provided to patients was of a very good standard. The shortcomings we identified did not have a significant impact on the safety and quality of clinical care.

A copy of the report from our last inspection can be found at:


Recommendations made following the inspection in July 2017 were:

- Review the practice’s infection control procedures, protocols and facilities giving due regard to guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: ‘Code of Practice about the prevention and control of infections and related guidance’.
- Review the arrangements for providing, maintaining and replacing equipment to ensure there is sufficient equipment to meet patients’ needs.

These recommendations formed the framework for the areas we looked at for this focussed follow-up inspection.

Our findings were:

| Are services safe? | Improvements required | × |
Background to this practice

Catterick Dental Centre was providing a service to a population of 3896; the majority aged between 18 and 50. The dental centre is a single storey building located in Catterick Garrison with seven surgeries. A full range of dental care is provided with the emphasis on preventative dentistry. Urgent same day appointments and an out-of-hours on-call service are provided. The practice is equipped to facilitate the use of sedation and also has access to enhanced practitioners for specialised dentistry. Patients requiring oral surgery are referred to the local NHS hospital.

The staff team consisted of a mixture of military and civilian personnel, including a practice manager, practice supervisor, senior dental officer, six dental officers, a dental hygienist, 10 dental nurses and a receptionist.

How we carried out this inspection

Prior to the inspection we reviewed information about the dental centre provided by the practice. During the inspection we spoke with the practice manager, the Senior Dental Officer (SDO), the infection prevention and control (IPC) lead and a dental nurse. We looked at documentation in relation to IPC and also checked the building, equipment and facilities.

Our key findings were:

- The practice was following the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: ‘Code of Practice about the prevention and control of infections and related guidance’.
- The premises had been significantly refurbished and clinical areas were now air conditioned, changing facilities had improved for staff with separate shower facilities for male and female staff.
- Chairside support was routinely in place for the hygienist. A risk assessment was in place for the occasions when this support could not be provided.
- A full dental service was not available at the practice as there had been a complete system failure in relation to radiology. The resilience plan had been activated and those patients requiring radiographs were receiving treatment and care at an alternative practice a short distance away.

We found areas where the practice could make improvements. CQC recommends that the practice:

- Despite a review and upgrade of radiology equipment as part of the refurbishment, problems with radiology safety have continued. As a result, the practice has been unable to offer a dental service that requires the taking of X-rays. Therefore, the arrangements for the provision of radiology requires a thorough review to ensure a consistent, safe and effective system to meet patients’ needs.

Dr John Milne MBE BChD, Senior National Dental Advisor
on behalf of CQC’s Chief Inspector of Primary Medical Services)
Our findings

We found that this practice was not safe in accordance with CQC's inspection framework.

The shortcomings did not have a significant impact on the safety and quality of clinical care.

Reporting, learning and improvement from incidents

At the previous inspection the SDO advised us that the practice had reported a number of significant events in relation to the failure to capture an image when taking X-rays over a 12-month period, including two significant events in the same week prior to our inspection. One of the X-ray sets was taken out of service due to concern about compromising patient safety. At the time there was a dedicated X-ray room at the practice.

As part of the refurbishment project, X-ray equipment was installed in each of the surgeries. Checks were made by the contractor before the equipment was used and it was deemed safe, meeting current radiation regulations. The practice re-opened a week before this inspection and soon after there were significant failures with radiology. The resilience plan was activated with the closure of the practice to patients needing or potentially needing an X-ray. The hygienist continued to provide a service. The same as when the practice was closed for refurbishment, patients were receiving a service from an alternative dental practice a mile away.

The SDO and PM provided evidence to confirm the radiology failure had been escalated to all concerned parties and was under investigation. It was thought to be a network system issue. The SDO advised us that the X-ray software equipment was due to be checked and reported on within the next week.

We received eight feedback cards from patients since the practice reopened, some of which were completed by patients who were attending the hygienist on the day of the inspection. All were positive about the service and access to appointments.

Infection control

At the previous inspection clinical facilities were not in accordance with the guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices and The Health and Social Care Act 2008: ‘Code of Practice about the prevention and control of infections and related guidance’. For example, there was damage to the cabinetry, work surfaces or flooring in five surgeries. There was no light
magnifier to check instruments for debris. The sterile date on some instrument pouches had expired and dental materials were out-of-date. The use of personal protective equipment was inconsistent across the staff team.

Not long after the last inspection the practice closed for a period of refurbishment. During the refurbishment, the dental team provided a service to its patients from an alternative dental practice located nearby. The practice reopened shortly before this inspection.

Decontamination facilities were available in each of the surgeries. As part of the refurbishment damaged cabinetry, work surfaces and flooring had been replaced. Air conditioning had been installed in each of the surgeries. In addition, toilet facilities for patients and staff had significantly improved. Male and female staff now had separate showering facilities. Processes had been developed to strengthen the checking of instrument pouches and dental materials. Light magnifiers had been purchased for clinical areas.