Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Dental Practice Inspection Report (Announced)

Windsor Dental Care, Cardiff and Vale University Health Board

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do.
We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Windsor Dental Care, Cardiff and Vale University Health Board on 01 May 2025.

Our team for the inspection comprised of a HIW healthcare inspector and a dental peer reviewer.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. A total of 18 questionnaires were completed. We also spoke to staff working at the service during our inspection. Feedback and some of the comments we received appear throughout the report

Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Patients provided positive feedback about the care and service provided by the dental practice. All but one of the 18 respondents rated the service as 'very good.' We found that staff were friendly and polite and treated patients with dignity and respect.

There was a limited amount of information available patients on how to maintain good oral health, although patients said they were given enough information to understand the treatment options available and the associated risks and benefits of the treatment.

The reception and waiting areas were separate, and doors to surgeries were kept closed during treatment, which helped to maintain patient privacy and dignity.

There was an up-to-date equality and diversity policy in place, and all patients said they had not encountered any discrimination when accessing services.

This is what we recommend the service can improve:

- Provide suitable information at the practice to promote good dental hygiene and oral health for patients
- Display the opening hours and names and GDC registration numbers of clinical staff working at the practice
- Update the patient information leaflet and ensure copies are available to patients attending the practice
- The language preference of patients must be recorded.

Delivery of Safe and Effective Care

Overall summary:
Staff were clear regarding their work roles and responsibilities. Patient areas were uncluttered and free of hazards.

Appropriate safeguarding policies and procedures were in place with a safeguarding lead appointed. All staff had completed up-to-date safeguarding training.

Dental records we reviewed were generally well maintained with only a few points for improvement.

Immediate assurances:
We identified many issues in relation to infection, prevention and control and decontamination procedures at the practice. We were not assured that appropriate arrangements were in place in relation to the safe storage, recording, administration and disposal of dental materials and medication stored at the practice. We were also concerned that the medical equipment being stored at the practice was not safe to use in a medical emergency. This is because:

- Several pieces of re-usable dental equipment had not been sterilised appropriately and were being loosely stored in a drawer that was dirty and stained
- Some pieces of re-usable dental equipment had been sterilised but had been packed into bags that did not have a packaged date or expiry date to indicate how long the equipment was safe to use
- We found dusty surfaces and a cobweb in surgery two which indicated that the environment had not been effectively cleaned
- One wall of surgery two was covered in thin wallpaper which was stained in places. The wall behind the wallpaper also appeared to be crumbling with loose plaster evident in some areas
- The dental chair in surgery two had several tears, and other chairs throughout the practice were made from soft material which would inhibit effective cleaning
- A daily checklist for setting up and cleaning down each surgery was not in place and there was no evidence that cleaning schedules were being maintained to record the cleaning being undertaken throughout the practice
- Dental impressions were being disinfected by spraying rather than use of a bath
- There was not an up-to-date audit under Welsh Health Technical Memorandum (WHTM) 01-05
- Daily checks to ensure that the temperature and pressure of the autoclave was satisfactory were not being recorded in a logbook
- Clinical waste bags were being inappropriately used for general waste and there was no process in place to ensure amalgam and gypsum waste products were being collected and disposed of appropriately
- We saw two sharps boxes at the practice had not been signed or dated when assembled
- All pieces of the emergency equipment were either out of date or did not have an expiration date written on them. There was no weekly checklist in place to ensure the emergency equipment was reviewed by staff and replaced as required
- We found that several items of dental materials were out-of-date in the drawers in surgery two

- There was no system in place to regularly check expiry dates and replace materials or equipment as needed
- A prescription pad was left unsecured in an unlocked drawer in surgery two
- There was no system in place to monitor and log the stock, use and dispensing of antibiotic medications
- No patient information leaflets were being stored with the antibiotics
- There was no system in place to monitor the temperature of the antibiotics being stored in surgery one
- We were told that staff disposed of expired medicines at the local pharmacy, but there was no evidence of receipts to document and support this
- The medicines management policy was not dated, and we found inaccuracies in its contents.

Details of the immediate remedial actions taken by the practice are provided in Appendix B.

This is what we recommend the service can also improve:

- Comprehensive environmental risk assessments must be undertaken to appropriately identify and manage potential hazards
- Secure storage facilities for staff must be provided
- The business continuity policy must be reviewed to ensure it is up to date
- A risk assessment must be developed to identify precautions to take for the safe handling, disposal, and storage of sharps to help prevent needlestick injuries in the absence of Safety Plus syringes
- Review and, where necessary, implement a ventilation system to ensure full compliance with the ventilation requirements outlined in WHTM 01-05
- Ensure disposable aprons and eye protection are available for staff during cleaning procedures
- Ensure the X-ray machine undergoes an electrical and mechanical check every year and implement a schedule of routine checks of the X-ray equipment by staff
- Adopt the use of LocSIPPs checklists to help provide safe care for patients undergoing invasive procedures
- Ensure that patient records are complete and include all relevant information in line with professional standards and guidance.

This is what the service did well:

- Evidence of regular fire alarm tests and fire drills
- Evidence of up-to-date Portable Appliance Testing (PAT), five-yearly electrical installation inspection and annual gas safety checks
- Staff had up-to-date training in CPR and first aid.

Quality of Management and Leadership

Overall summary:
Windsor Dental Care is a small practice owned by the principal dentist, who was supported by an associate dentist, practice manager and reception staff. We observed good staff working relationships and noted a positive working environment at the practice.

However, the significant number of urgent patient safety issues and recommendations issued in this report is concerning. It is positive that the principal dentist and registered manager have begun taking meaningful action to address these matters, but we have asked the practice to provide further assurance to HIW on the actions it will take to improve the governance and oversight arrangements in place at the practice to more effectively monitor compliance with relevant regulations and standards in future.

We found limited evidence of quality improvement activities taking place. This included a lack of a formal system in place to collect, review and act upon patient feedback. Improvements were also required to fully inform patients of the process for complaining internally and to the NHS through the Putting Things Right process.

In general, compliance with mandatory staff training and professional obligations was good, although staff must undertake Duty of Candour training.

This is what we recommend the service can improve:

- Ensure policies and procedures are reviewed and updated regularly
- Patient feedback must be actively sought and acted upon as required
- The complaints poster must display the name and contact details of the complaints lead and patients must be informed of the Putting Things Right process
- Clinical and non-clinical audits must be carried out to monitor service quality
- The practice should review the adoption of quality improvement training tools.

3. What we found

Quality of Patient Experience

Patient feedback

Overall, the responses to the HIW questionnaire were positive. All but one of the 18 respondents rated the service as 'very good.'

Patient comments included:

> *"I feel, knowing other practices, that this one is excellent. I feel at ease and always well informed."*
>
> *"Excellent surgery; 100% satisfied."*

Person-centred

Health promotion and patient information
We saw that fees for NHS and private services were clearly displayed to patients in the reception and waiting areas. However, there was no information available to patients on how to maintain good oral health to help prevent common issues. The names and General Dental Council (GDC) registration numbers of clinical staff working at the practice were not on display. We were provided with a copy of the patient information leaflet for the practice. However, we noted that it contained out of date information, and copies were not readily available to patients as required by the regulations.

The registered manager must:

- **Provide suitable information at the practice to promote good dental hygiene and oral health for patients**
- **Display the names and GDC registration numbers of clinical staff working at the practice**
- **Update the patient information leaflet and ensure copies are available to patients attending the practice.**

All patients who responded to the HIW questionnaire agreed that their oral health was explained to them in a way they could understand. All respondents also agreed they were given aftercare instructions on how to maintain good oral health and

given guidance on what to do and who to contact in the event of an infection or emergency.

Dignified and respectful care
During the inspection we saw staff treating patients with kindness and respect and it was clear that staff had formed good relationships with their patients. We received the following comments from patients in the HIW questionnaires:

> *"The staff are very friendly and polite."*

> *"Always very professional and friendly."*

The reception desk was separate to the waiting room which gave patients privacy when checking-in. We saw that doors to clinical areas were kept closed during treatment, and there were blinds and frosted glass on external windows to preserve patient privacy and dignity.

A practice confidentiality policy was in place which outlined the practice expectation to ensure the privacy of patient information. However, the nine core principles established by the GDC were not on display anywhere in the practice.

The registered manager must clearly display the nine core principles to inform patients of the high standards of care they can expect from their dental professionals.

Individualised care
All respondents who completed a HIW patient questionnaire said that they were given enough information to understand the treatment options available and the risks and benefits associated with those treatment options. All respondents agreed that the costs were made clear to them prior to commencing treatment.

All respondents told us they had been involved as much as they had wanted to be in decisions about their treatment and confirmed that their medical history was checked before receiving treatment.

Timely

Timely care
All respondents who completed the HIW patient questionnaire said it was easy to get an appointment when they needed one. We were told that patients are informed of any delays in appointment times on arrival. We were advised that the average waiting time between each treatment appointment was approximately two to three weeks.

The emergency out-of-hours telephone number was clearly displayed and visible from outside the premises. Most of the patients responding to the HIW questionnaire (15/18) confirmed they would know how to access out of hours dental care if they had an urgent dental problem. However, the opening hours were not on display to patients either inside or outside the practice.

The registered manager must display the opening hours of the practice to ensure accessibility and transparency for patients.

Equitable

Communication and language
Patients could book appointments by telephone or in person at reception, which helped to ensure patients without digital access could arrange treatment.

We found some bilingual written information on display at the practice. It was positive to see key documents, such as treatment consent and extraction information leaflets, had also been translated into other languages such as Ukrainian, Polish and Arabic.

We were told that translation services were available for patients whose first language was not English, and we noted a sign on display advising patients to inform reception staff if they require an interpreter. However, we did not see any evidence to indicate that the language preference of patients was being recorded within the sample of eight patient records we reviewed.

The registered manager must ensure that the language preference of patients is recorded to support effective communication and ensure they receive appropriate care.

Rights and equality
Appropriate policies outlined the practice approach to supporting the rights of patients and staff. These included policies on bullying and harassment and standards of conduct for staff. A consent policy was in place to help ensure the rights of patients who lack capacity are upheld.

We were told that the rights of patients were further upheld by allowing patients to choose their preferred pronouns and names on their records. All patients who responded to the HIW questionnaire told us they had not faced any form of discrimination when accessing this service.

We found that the practice was not accessible or suitable for people with mobility difficulties. The entrance to the practice is only accessible via several steps up

from street level. Furthermore, the patient toilet was not wheelchair friendly due to its size and because it had a stepped entrance. Patients responding to the HIW questionnaire appeared to be aware of the accessibility issues. One patient commented:

"Not accessible for wheelchairs, uncertain r.e. other disabilities"

Staff told us that patients are informed when they register about the accessibility issues at the practice and are signposted to other dental practices as alternative options if required.

Delivery of Safe and Effective Care

Safe

Risk management
The environment of the dental practice appeared tired and worn which reflected the age of the building. We found Surgery 1 was being maintained to a good standard to help deliver safe and effective care to patients. However, improvements were required in Surgery 2; one wall was covered in thin wallpaper which was stained in places. The wall behind the wallpaper also appeared to be crumbling with loose plaster evident in some areas.

Our concerns regarding this were dealt with under our non-compliance notice process. This meant that we wrote to the service immediately following the inspection requiring that urgent remedial actions were taken. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix B.

We were told that a 'safety of premises' risk assessment is carried out annually. However, due to the environmental concerns we identified during the inspection, we were not assured as to its effectiveness.

The registered manager must ensure that comprehensive environmental risk assessments are undertaken to appropriately identify and manage potential hazards that could impact staff, patients, and the surrounding environment.

We saw evidence of up-to-date Portable Appliance Testing (PAT), five-yearly electrical installation inspection and annual gas safety checks. An approved health and safety poster was clearly displayed for staff to see, and we confirmed that employer's and public liability insurance was in place.

We inspected fire safety arrangements at the practice and saw evidence of weekly alarm tests and regular fire drills. Fire safety training had been completed by all staff. Fire exits were clearly signposted, and 'no smoking' signs were displayed as required. There was a fire equipment maintenance contract in place. However, we saw that the last fire risk assessment had been undertaken in 2007. We discussed this with the registered manager who arranged for a new fire risk assessment to be undertaken by a competent fire safety professional.

The registered manager must submit the completed fire risk assessment to HIW and provide evidence that action has been taken to address any potential fire risks identified.

During our tour of the practice we noted that staff did not have any storage facilities to store their personal items.

The registered manager must provide secure storage facilities for staff as required by the regulations.

There was a business continuity policy in place with procedures to be followed should it not be possible to provide the full range of services due to an emergency event or system failure. However, we noted that some of the contact details required updating.

The registered manager must review the business continuity policy and ensure that it is accurate and up to date.

Infection, prevention and control (IPC) and decontamination
All respondents who completed the HIW patient questionnaire felt the setting was clean and all but one felt infection and prevention control measures were being followed, with the remaining respondent saying they were partially evident.

However, during the inspection we identified many issues in relation to infection, prevention and control and decontamination procedures at the practice. This meant we could not be assured that suitable arrangements were in place to keep the premises and dental equipment clean to help prevent and control the spread of infection.

It was positive that staff made immediate attempts to remedy some of the issues we identified during the inspection. However, the issues we identified demonstrated a long-standing lack of established governance arrangements in place to ensure that regulatory and best practice compliance is always maintained in relation to infection prevention and control to protect the health, safety and welfare of patients and staff.

Our concerns regarding this were dealt with under our non-compliance notice process. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix B.

The practice had a designated infection control lead and policies available in relation to infection prevention and control and decontamination. However, these had not been reviewed since 2019. Given the number of issues we identified during the inspection we were also not assured as to the quality of the policies.

The register manager must undertake a comprehensive review and update their infection prevention and control and decontamination policies to ensure

they align with the latest national guidelines and evidence-based best practices.

We were told that the practice had suitable occupation health support available for staff. However, the practice was not using Safety Plus syringes, and there was no risk assessment in place to identify actions to take to help prevent needlestick injuries. We also saw no needlestick flowcharts displayed in clinical areas to help staff should such an injury occur.

The registered manager must:

- **Produce a risk assessment to identify precautions to take for the safe handling, disposal, and storage of sharps to help prevent needlestick injuries in the absence of Safety Plus syringes**
- **Produce and display in clinical areas a needlestick injury flowchart which provides a clear, step-by-step guide for staff to follow immediately after a sharps-related incident.**

The practice had a designated room for the decontamination and sterilisation of dental instruments, as recommended in Welsh Health Technical Memorandum WHTM 01-05. The procedures for processing, decontamination and sterilisation of dental instruments were generally well understood by staff. However, we noted that the practice did not undertake start of day and end of day checks to help ensure the autoclave is functioning correctly. We discussed this with staff who immediately ordered some new logbooks to subsequently begin undertaking and documenting these checks in future. We also noted that visors or protective aprons were not available to staff in the decontamination room and that the room did not have a ventilation system to help control airflow.

The registered manager must:

- **review and, where necessary, implement a ventilation system to ensure full compliance with the ventilation requirements outlined in Welsh Health Technical Memorandum (WHTM) 01-05**
- **Ensure disposable aprons and eye protection are available for staff during cleaning procedures.**

Hand washing sinks were available in the dental surgeries, patient toilet and decontamination room. We checked staff records and saw evidence that clinical staff were suitably immunised against Hepatitis B and that staff had completed relevant infection prevention and control training.

Medicines management
During the inspection we were not assured that appropriate arrangements were in place in relation to the safe storage, recording, administration and disposal of dental materials and medication stored at the practice. This is because:

- There was no system in place to regularly check expiry dates and replace dental materials. As a result, we found several out-of-date items of dental materials (root canal sealer and bonding cement) that were not fit for purpose
- There was no system in place to monitor and log the stock, use and dispensing of antibiotic medications
- No patient information leaflets were being stored with the antibiotics
- There was no system in place to monitor the temperature of the antibiotics being stored at the practice
- A prescription pad was left unsecured in an unlocked drawer
- There was no evidence that documented safe disposal of expired medication
- The medicines management policy was not dated, and we found inaccuracies in its contents.

Our concerns regarding these issues were dealt with under our non-compliance notice process. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix B.

During the inspection we reviewed the contents of the medical emergency bag. We found that all pieces of equipment were either out of date or did not have an expiration date written on them. There was no weekly checklist in place to ensure the emergency equipment was reviewed by staff and replaced as required. While a checklist was in place to check for and replace expired syringes and needles, we were not assured that this system was effective as we found out-of-date adrenaline syringes and needles at the practice. The practice also confirmed to us that staff had not completed training in relation to the correct operation of oxygen cylinders manufactured by BOC as set out in the Patient Safety Notice 041 reminder issued by Welsh Government.

It was again positive that staff made immediate attempts to order new emergency equipment and drugs. However, these issues presented a clear risk that patients would not receive effective medical assistance in the event of a medical emergency at the practice while awaiting professional medical help. Our concerns regarding these issues were dealt with under our non-compliance notice process. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix B.

We reviewed staff training records and saw evidence that staff had up-to-date training in CPR and first aid.

Safeguarding of children and adults
The practice had an appointed dedicated safeguarding lead. We saw a suitable policy was in place in relation to safeguarding which contained the contact details for the local safeguarding team. The practice may wish to consider placing safeguarding flowcharts in each surgery for easy access in the event of a concern.

We saw all staff had completed appropriate training in child and adult protection and were aware of who to contact in the event of a concern.

Management of medical devices and equipment
We found the dental surgeries were suitably equipped to provide safe and effective dental treatment. Equipment appeared in good condition and fit for purpose.

The practice had a radiation protection file as required by the regulations. Clinicians indicated patients were suitably informed of the risks and benefits of radiation and we saw that radiation exposures were correctly captured within patient records. We noted the local rules were easily locatable in each surgery. The training records we inspected confirmed all staff had received suitable training for their roles.

We saw evidence that the X-ray equipment had received regular servicing every three years. However, the practice could not provide evidence to confirm that electrical and mechanical maintenance checks were being undertaken annually. We also noted that staff were not undertaking their own routine inspections of the equipment.

The registered manager must:

- **Ensure the X-ray machine undergoes an electrical and mechanical check every year to ensure it remains safe**
- **Implement a schedule of routine checks of the X-ray equipment by staff to ensure all features are in good condition and functioning correctly.**

Effective

Effective care
We found the practice had safe arrangements for the treatment of patients and we were assured that regulatory and statutory guidance was being followed when treatment was provided. Staff were clear regarding their work roles and

responsibilities. However, we noted that the practice did not use Local Standards for Invasive Procedures (LocSSIPs) checklists which can help reduce the risk of wrong site tooth extraction.

The registered manager must adopt the use of LocSIPPs checklists to help provide safe care for patients undergoing invasive procedures. We also recommend that the LocSIPPs flowchart is placed in each dental surgery.

Patient records
We saw a suitable system was in place to help ensure patient records were safely managed and stored securely in line with the practice records management policy.

We reviewed the dental records of eight patients. Each record had the initial medical history and subsequent updates, recorded and signed by both patient and dentist. We saw evidence of full base charting, soft tissue examination and that treatment planning and options, and baseline Basic Periodontal Examination (BPE) were recorded where appropriate. All records indicated that recall was in accordance with National Institute for Health and Care Excellence (NICE) guidelines. However, we noted the following areas which required improvement:

- There was no evidence that oral cancer screening was being undertaken or documented in any of the eight records
- The recording of risk assessments based on dental caries, periodontal disease and tooth wear was missing in four of the eight records
- The oral hygiene and diet status was missing in three of the eight records
- Informed consent was not recorded in three of the eight records
- We were told that treatment plans were not being provided to private patients.

The registered manager must:

- **Ensure that patient records are complete and include all relevant information in line with professional standards and guidance**
- **Provide HIW with details of the action taken to address our findings in relation to the completeness of patient records.**

Efficient

Efficient
The number of dental surgeries and clinical sessions provided by the dentists appeared to meet the needs of its patients. Staff told us that emergency appointments were included in the daily schedule and patients requiring urgent care were prioritised and accommodated where possible the same day.

Quality of Management and Leadership

Leadership

Governance and leadership
The practice was under the direction of the principal dentist, who was the owner and responsible individual with HIW. There was a wide range of policies and procedures in place to support staff. However, we noted that some had not been reviewed or updated since 2019.

The registered manager must put processes in place to ensure that policies and procedures are reviewed on a regular basis.

During the inspection we saw staff working well together as a team. However, we could not be assured that there were effective and proactive arrangements in place to maintain regulatory compliance, complete audits and manage risks. This is due to the large number of immediate concerns about patient safety identified during the inspection that are detailed in Appendix B. This report also contains many recommendations in Appendix C that the practice must act on. We consider the number of regulatory breaches to be concerning. It is positive that the principal dentist and registered manager have begun to take meaningful action to address these matters but there is an expectation that there will be evidence of a notable improvement in this respect at the time of the next inspection.

The registered manager must provide assurance to HIW on the actions it will take to improve the governance and oversight arrangements in place at the practice to more effectively monitor compliance with relevant regulations and standards.

Workforce

Skilled and enabled workforce
Appropriate arrangements appeared to be in place for employing staff. We saw policies and procedures detailing the recruitment process which included suitable fitness to work checks made on prospective employees. These checks included proof of identity, the right to work, qualifications and vaccinations and use of the Disclosure and Barring Service (DBS).

We reviewed a sample of staff files and saw evidence that staff were registered with the GDC, covered by professional indemnity insurance, and that DBS checks had been carried out. Staff files contained job descriptions, employment contracts and written references for the employees.

Culture

People engagement, feedback and learning
We found no evidence of a formal system in place to collect, review and act upon patient feedback.

The registered manager must actively seek feedback from patients and act on any feedback received as a means of assessing and monitoring the quality of service provision.

There was a complaints procedure in place which included appropriate timescales for response and how to escalate the issue if required. However, we noted that the complaints poster on display in the waiting area did not include the relevant name and contact details of the name of the person responsible for handling complaints. We also did not see a Putting Things Right poster on display to inform patients how to complain to the NHS.

The registered manager must update the complaints poster to display the name and contact details of the complaints lead and ensure patients are informed of the Putting Things Right process.

Whilst we were told there had been no incidents to date that had triggered the Duty of Candour process, staff had not received appropriate training on this subject.

The registered manager must ensure staff complete appropriate Duty of Candour training and provide HIW with evidence when completed.

Information

Information governance and digital technology
The practice used electronic systems to manage patient records. A records management policy was in place to set out the arrangements for safely handling patient information.

Learning, improvement and research

Quality improvement activities
We found limited evidence of quality improvement activities taking place. Antibiotic prescribing and smoking cessation audits had been carried out. However, there was no records of audits regarding health and safety, healthcare waste or patient records. We were also told that the practice did not use quality improvement training tools, and we recommended that these be considered.

The registered manager:

- **must put a programme in place to carry out regular clinical and non-clinical audits, to monitor and improve the service quality.**
- **should review the adoption of quality improvement training tools.**

Whole-systems approach

Partnership working and development
We saw an appropriate process in place to follow up on any referrals made to other service providers.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summarises the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified and resolved during the inspection.			

Appendix B - Immediate improvement plan

Service: Windsor Dental Care

Date of inspection: 01 May 2025

The table below includes any immediate concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	Several pieces of re-usable dental equipment had clearly not been sterilised and decontaminated because previous dental materials were visible on their surfaces.	Re-usable dental equipment must be appropriately sterilised and decontaminated between uses.	Regulation 22(2)(a) and Regulation 13(5)	Isopherm manual cleaning books purchased and used.	Natalie Horsell	Completed
2.	Re-usable dental equipment had not been packaged and were being loosely stored in a drawer that was dirty and stained.	Re-usable dental equipment must be packaged in bags marked with a packaged date or expiry date following the decontamination process.	Regulation 22(2)(a) and Regulation 13(5)	Larger bags purchased and stamps for dating.	Natalie Horsell	Completed

3.	We found dusty surfaces and a cobweb in surgery two which indicated that the environment had not been effectively cleaned.	Surgery two must be deep cleaned to remove dust and cobwebs.	Regulation 22(2)(a) and Regulation 13(5)	Cleaned all drawers. Removed chair. Steam cleaned floors, walls and units.	Natalie Horsell	Completed
4.	One wall of surgery two was covered in thin wallpaper which was stained in places. The wall behind the wallpaper also appeared to be crumbling with loose plaster evident in some areas.	Consideration must be given to replacing the wallpaper coverings in surgery two to enable effective maintenance and cleaning.	Regulation 22(2)(a) and Regulation 13(5)	Wall cover purchased. Surgery work being done end of May.	Natalie Horsell	Completed
5.	The dental chair in surgery two had several tears which would inhibit effective cleaning	The tears on the dental chair in surgery two must be repaired or covered appropriately to enable effective cleaning.	Regulation 22(2)(a) and Regulation 13(5)	Plastic wipeable chair covers purchased and used.	Natalie Horsell	Completed
6.	Several chairs throughout the practice, including a sofa in surgery one, a chair in surgery two and chairs in the waiting room were made from soft material, which would also inhibit effective cleaning.	The fabric chairs throughout the practice must be removed or replaced to enable effective cleaning.	Regulation 22(2)(a) and Regulation 13(5)	New chairs purchased and delivered and old chairs replaced.	Natalie Horsell	Completed

7.	A daily checklist for setting up and cleaning down each surgery was not in place.	A checklist must be put in place for the daily setting up and closing down of the surgery.	Regulation 22(2)(a) and Regulation 13(5)	Isopherm cleaning books bought for each surgery.	Natalie Horsell	Completed
8.	There was no evidence that cleaning schedules were being maintained to record the cleaning being undertaken throughout the practice.	Cleaning schedules must be developed and used to record and evidence the cleaning being undertaken throughout the practice.	Regulation 22(2)(a) and Regulation 13(5)	As above, used for practice.	Natalie Horsell	Completed
9.	Dental impressions were being disinfected by spraying rather than use of a bath.	Procedures for disinfecting dental impressions must be updated to use a bath rather than spray.	Regulation 22(2)(a) and Regulation 13(5)	Two baths and solutions purchased and put into each surgery.	Natalie Horsell	Completed
10.	There was not an up-to-date audit under Welsh Health Technical Memorandum (WHTM) 01-05. The previous audit had been undertaken in 2021.	A WHTM 01-05 audit must be carried out as soon as reasonably practicable.	Regulation 22(2)(a) and Regulation 13(5)	Applied for audit 07 May 2025, awaiting reply.	Natalie Horsell	Completed
11.	Daily checks to ensure that the temperature and pressure of the autoclave was satisfactory before being used for sterilising	Daily checks must be undertaken to ensure the autoclave is working effectively before being used for sterilising and	Regulation 22(2)(a) and Regulation 13(5)	Isopherm and autoclave books bought and used and TST strips.	Natalie Horsell	Completed

	and decontaminating dental equipment were not being recorded in a logbook.	decontaminating dental equipment.				
12.	Clinical waste bags were being inappropriately used for general waste.	Only clinical waste must be disposed of in clinical waste bags.	Regulation 22(2)(a) and Regulation 13(5)	New contract to remove cardboard, paper and plastics.	Natalie Horsell	Completed
13.	There was no process in place to ensure amalgam and gypsum waste products were being collected and disposed of appropriately.	Amalgam and gypsum waste products must be disposed of appropriately.	Regulation 22(2)(a) and Regulation 13(5)	Initial contract added.	Natalie Horsell	Completed
14.	We saw two sharps boxes at the practice had not been signed or dated when assembled.	Sharps boxes must be signed and dated when assembled.	Regulation 22(2)(a) and Regulation 13(5)	Now signed and dated.	Natalie Horsell	Completed
15.	All pieces of emergency equipment were either out of date or did not have an expiration date written on them.	In-date emergency equipment and drugs must be available at the practice in accordance with the Resuscitation Council UK guidelines for dental practices.	Regulation 31	All perishables replaced. New Isopherm medical book filled.	Natalie Horsell	Completed

16.	There was no weekly checklist in place to ensure the emergency equipment was reviewed by staff and replaced as required.	Weekly checklists must be maintained appropriately to check for and replace out-of-date emergency equipment and drugs.	Regulation 31	Medicine book and medical checklist from Isopherm purchased and used.	Natalie Horsell	Completed
17.	Staff had not completed training in relation to the correct operation of oxygen cylinders manufactured by BOC as set out in the Patient Safety Notice 041 reminder issued by Welsh Government.	The practice must complete the actions identified in PSN 041, including training requirements.	Regulation 31	BOC training completed and WHTM 01-05 started.	Natalie Horsell	Completed
18.	We found several items of dental materials that were out-of-date in the drawers in surgery two. There was no system in place to regularly check expiry dates and replace materials or equipment as needed.	A system must be put in place to ensure that materials and equipment used in dental treatment are regularly checked, and expired items replaced.	Regulation 13(4)	Lists of equipment and use by dates done for each surgery.	Natalie Horsell	Completed
19.	A prescription pad was left unsecured in an unlocked drawer in surgery two.	Prescription pads must be kept secure at all times.	Regulation 13(4)	Moved to lockable cabinet.	Natalie Horsell	Completed

20.	There was no system in place to monitor and log the stock, use and dispensing of antibiotic medications.	A system must be put in place to monitor the stock, use and dispensing of antibiotic medications.	Regulation 13(4)	Spreadsheet done for dispensing of medicines and sheet for amounts kept in practice.	Natalie Horsell	Completed
21.	No patient information leaflets were being stored with the antibiotics.	Patient information leaflets must be provided when dispensing antibiotics to patients.	Regulation 13(4)	Ordered and printed and placed with medicines.	Natalie Horsell	Completed
22.	There was no system in place to monitor the temperature of the antibiotics being stored in surgery one.	Consideration must be given to where antibiotics are stored within the practice to enable effective monitoring to ensure they are being kept within their recommended temperature range.	Regulation 13(4)	Kept in locked cabinet kept cool.	Natalie Horsell	Completed
23.	We were told that staff disposed of expired medicines at the local pharmacy, but there was no evidence of receipts to document and support this.	Evidence must be maintained of appropriate disposal of expired medicines.	Regulation 13(4)	Initial supplied new disposal box and contract.	Natalie Horsell	Completed
24.	The medicines management policy was not dated, and we found inaccuracies in its	The medicines management policy must be reviewed and updated to ensure it accurately	Regulation 13(4)	Policy renewed and signed.	Natalie Horsell	Completed

	contents. For example, the policy stated that no medications were being dispensed at the practice, but it was clear that the practice was dispensing two types of antibiotics to patients.	reflects the arrangements in place at the practice.				

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print): **Natalie Horsell**

Job role: **Registered Manager**

Date: **08 May 2025**

Appendix C - Improvement plan

Service: Windsor Dental Care

Date of inspection: 01 May 2025

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Risk/finding/issue		Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	There was no information available to patients on how to maintain good oral health. The names and GDC registration numbers of clinical staff were not on display. The patient information leaflet contained out of date information and copies were not readily available to patients.	The registered manager must: • Provide suitable information at the practice to promote good dental hygiene and oral health for patients • Display the names and GDC registration numbers of clinical staff working at the practice • Update the patient information leaflet and ensure copies are	Health promotion and patient information	Oral health poster ordered from HIW and put up in waiting room. All staff GDC numbers on display in waiting room. New patient information leaflet in waiting room.	Natalie Horsell	Completed

		available to patients attending the practice.				
2.	The nine core principles established by the GDC were not on display anywhere in the practice.	The registered manager must clearly display the nine core principles to inform patients of the high standards of care they can expect from their dental professionals.	Dignified and respectful care	Principles printed and laminated and on display in waiting room.	Natalie Horsell	Completed
3.	The opening hours were not on display either inside or outside the practice.	The registered manager must display the opening hours of the practice to ensure accessibility and transparency for patients.	Timely care	Opening hours placed on front door.	Natalie Horsell	Completed
4.	We did not see any evidence to indicate that the language preference of patients was being recorded within their patient records.	The registered manager must ensure that the language preference of patients is recorded to support effective communication and ensure they receive appropriate care.	Communication and language	Patients asked on arrival language preference. This is recorded on patient file.	Natalie Horsell	Completed
5.	We were told that a 'safety of premises' risk assessment is carried out annually. However, due to the	The registered manager must ensure that comprehensive environmental risk assessments are undertaken	Risk management	WHTM 01-05 completed. All environmental risks that were identified in inspection have been rectified.	Natalie Horsell	Completed

	environmental concerns we identified, we were not assured as to its effectiveness.	to appropriately identify and manage potential hazards that could impact staff, patients, and the surrounding environment.				
6.	The last fire risk assessment undertaken at the practice was in 2007.	The registered manager must submit the completed fire risk assessment to HIW and provide evidence that action has been taken to address any potential fire risks identified.	Risk management	New fire assessment carried out and will be uploaded to HIW.	Natalie Horsell	Completed
7.	Staff did not have any storage facilities to store their personal items.	The registered manager must provide secure storage facilities for staff as required by the regulations.	Risk management	All belongings are kept in reception cupboard.	Natalie Horsell	Completed
8.	Some of the contact details in the business continuity policy required updating.	The registered manager must review the business continuity policy and ensure that it is accurate and up to date.	Risk management	Updated and completed.	Natalie Horsell	Completed
9.	The infection prevention and control and decontamination policies had not been reviewed since 2019. Given the number of issues we identified	The register manager must undertake a comprehensive review and update their infection prevention and control and decontamination policies to ensure they align with the	Infection Prevention and Control (IPC) and Decontamination	All policies were updated.	Natalie Horsell	Completed

	during the inspection we were also not assured as to the quality of the policies.	latest national guidelines and evidence-based best practices.				
10.	The practice was not using Safety Plus syringes and there was no risk assessment in place to identify actions to take to help prevent needlestick injuries. We also saw no needlestick flowcharts displayed in clinical areas to help staff should such an injury occur.	The registered manager must: • Produce a risk assessment to identify precautions to take for the safe handling, disposal, and storage of sharps to help prevent needlestick injuries in the absence of Safety Plus syringes • Produce and display in clinical areas a needlestick injury flowchart which provides a clear, step-by-step guide for staff to follow immediately after a sharps-related incident.	Infection Prevention and Control (IPC) and Decontamination	Risk assessment completed, posters in surgery.	Natalie Horsell	Completed
11.	We also noted that visors or protective aprons were not available to staff in the decontamination	The registered manager must: • review and, where necessary, implement a	Infection Prevention and Control (IPC) and Decontamination	Visors and aprons were available, kept in separate room off decontamination room. Window above sink kept	Natalie Horsell	Completed

	room and that the room did not have a ventilation system to help control airflow.	ventilation system to ensure full compliance with the ventilation requirements outlined in Welsh Health Technical Memorandum (WHTM) 01-05 • Ensure disposable aprons and eye protection are available for staff during cleaning procedures.		open. Air purifier purchased and placed in decontamination room. All PPE is available for all staff always.		
12.	We saw no evidence that electrical and mechanical maintenance checks were being undertaken annually on the X-ray equipment. We also noted that staff were not undertaking their own routine inspections of the equipment.	The registered manager must: • Ensure the X-ray machine undergoes an electrical and mechanical check every year to ensure it remains safe • Implement a schedule of routine checks of the X-ray equipment by staff to ensure all features are in good condition and functioning correctly.	Management of medical devices and equipment	All X-ray machines checked as per radiation protection guidelines. Checks are made by public health England and staff.	Natalie Horsell	Completed

13.	The practice did not use Local Standards for Invasive Procedures (LocSSIPs) checklists.	The registered manager must adopt the use of LocSIPPs checklists to help provide safe care for patients undergoing invasive procedures. We also recommend that the LocSIPPs flowchart is placed in each dental surgery.	Effective care	LocSIPPs checklists now completed for patients.	Natalie Horsell	Completed
14.	We identified some omissions in the clinical entries within patient records.	The registered manager must: • Ensure that patient records are complete and include all relevant information in line with professional standards and guidance • Provide HIW with details of the action taken to address our findings in relation to the completeness of patient records.	Patient records	All patient records updated and complete patient notes audit completed and team meeting held.	Natalie Horsell Jack turner	Completed
15.	We noted that some policies had not been reviewed or updated since 2019.	The registered manager must put processes in place to ensure that policies and	Governance and leadership	Policies are checked yearly and read this is dated on the front page	Natalie Horsell	Completed

		procedures are reviewed on a regular basis.		of book not on every policy.		
16.	We could not be assured that there were effective and proactive arrangements in place.	The registered manager must provide assurance to HIW on the actions it will take to improve the governance and oversight arrangements in place at the practice to more effectively monitor compliance with relevant regulations and standards.	Governance and leadership	Compliance logbooks in place. regular team meetings scheduled. Audits completed	Natalie Horsell	Completed
17.	We found no evidence that patient feedback was actively sought, reviewed or acted upon.	The registered manager must actively seek feedback from patients and act on any feedback received as a means of assessing and monitoring the quality of service provision.	People engagement, feedback and learning	Feedback questionnaires will be issued to patients yearly.	Natalie Horsell	Completed
18.	The complaints poster on display in the waiting area did not include the relevant name and contact details of the name of the person responsible	The registered manager must update the complaints poster to display the name and contact details of the complaints lead and ensure patients are informed of the	People engagement, feedback and learning	Updated and Putting Things Right poster in practice.	Natalie Horsell	Completed

	for handling complaints. We also did not see a Putting Things Right poster on display to inform patients how to complain to the NHS.	Putting Things Right process.				
19.	Staff had not received training on the Duty of Candour.	The registered manager must ensure staff complete appropriate Duty of Candour training and provide HIW with evidence when completed.	People engagement, feedback and learning	Duty of Candour training completed.	Natalie Horsell	Completed
20.	We found limited evidence of quality improvement activities taking place. We were also told that the practice did not use quality improvement training tools.	The registered manager: • must put a programme in place to carry out regular clinical and non-clinical audits, to monitor and improve the service quality. • should review the adoption of quality improvement training tools.	Quality improvement activities	Audits completed And placed for yearly updates. Logbooks used.	Natalie Horsell	Completed

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): **Natalie Horsell**

Job role: **Registered Manager**

Date: **27 June 2025**