Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Dental Practice Inspection Report (Announced)

Cross Keys Dental Practice, Aneurin Bevan University Health Board

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Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163
Email: hiw@gov.wales
Website: www.hiw.org.uk

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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 Cross Keys Dental Practice, Aneurin Bevan University Health Board on 14 July 2025.

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

During the inspection we invited patients to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 18 questionnaires were completed by patients and 9 were completed by staff. 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

Designation as a Service of Concern

Our inspection on 14 July 2025 identified some significant risks to the safety of patients and staff. As a result, and in line with our escalation and enforcement procedures, Cross Keys Dental Practice was designated a Service of Concern on 08 August 2025. The setting has addressed the identified issues and has implement the necessary improvements.

Quality of Patient Experience

Overall summary:
Patients provided positive feedback about the care and service provided by the dental practice. The practice is committed to patient care and provided good patient information. However, dental team information boards needed to be updated and alternative formats for patient information were required.

Staff were observed treating patients with dignity and respect and maintained confidentiality. Patient records were appropriately maintained, and treatment options were clearly communicated with patients.

The appointment booking system was effective with emergency slots available daily and prioritisation available.

Whilst some patient information was available in English and Welsh, staff were not aware of the 'Active Offer' and did not routinely ask patients their language preference. Reasonable adjustments were in place to support accessibility and equality policies were up to date.

This is what we recommend the service can improve:

- Update team information boards to include information on dental nurses
- Implement the 'Active Offer'
- Provide patient information in alternative formats.

This is what the service did well:

- Ensured reasonable adjustments for accessibility and equality
- Good range of patient information available.

Delivery of Safe and Effective Care

Overall summary:
The practice maintained appropriate facilities and equipment for delivering dental services, with safe arrangements for patient care. However, staff areas required maintenance due to health and safety issues.

Infection prevention and control (IPA) measures were generally in place; however, the decontamination rooms need significant improvement and a WHTM 01-05 audit needs to be completed.

Safeguarding polices were in place and updated during the inspection with most staff appropriately trained.

We saw evidence of maintenance records for most X-ray units. However, one X-ray unit was overdue for quality assurance testing.

Patient records were mostly well maintained, however information on language preference and risk assessments were missing. There was no process in place for the follow up of referrals and staff were unfamiliar with LocSSIPs protocols.

Immediate assurances:

- Immediate improvement required to both decontamination rooms to ensure IPC is followed
- Fire risk assessment actions to be undertaken
- Quality assurance testing to be completed on surgery six X-ray machine.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

This is what we recommend the service can improve:

- Staff areas require improvement
- Follow up process to be implements for referrals
- Implement clinical fridge temperature checks.

This is what the service did well:

- All medical emergency equipment in date and readily available
- Wales Safeguarding Procedures were available.

Quality of Management and Leadership

Overall summary:
The practice had a clear management structure and held regular staff meeting with policies routinely updated. However, the current practice manager had not registered with HIW since taking over in 2019.

The practice is appropriately staffed with an adequate recruitment policy in place; however some recruitment checks were missing from staff records.

Patients were able to leave feedback, however there was no process in place to monitor the feedback once received. The complaints policy was available upon request and displayed behind reception however this required relocating to be seen more clearly.

Clinical audits were limited with several key areas not reviewed routinely. The practice had positive links with local services; however, they are not fully utilising quality improvement tools available from the health board.

Immediate assurances:

- Quality improvement audits need to be implemented
- Practice manage must register with HIW
- Appropriate pre-employment checks must be carried out.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

This is what we recommend the service can improve:

- Implement training matrix to ensure oversite of staff core training
- Implement procedure to monitor patient feedback.

This is what the service did well:

- Staff demonstrated understanding of duty of candour
- Policies were reviewed on a routine basis.

3. What we found

Quality of Patient Experience

Patient feedback

Overall, the responses to the HIW questionnaire were positive. We asked patients how they would rate the service provided by the setting. All 17 patients who responded rated the service as 'very good'.

Patient comments included:

> *"Always friendly and willing to help…"*
>
> *"…Friendly, caring staff, lovely clean and tidy facilities…"*
>
> *"I always receive excellent care from professional but friendly staff at the practice."*
>
> *"Staff are always friendly and professional."*

Person-centred

Health promotion and patient information
We saw a comprehensive range of patient information in the reception area. This included smoking cessation, information on health conditions and a notice board with information on sugar content within foods. The practice had a satisfactory patient information leaflet and statement of purpose, which were both available at reception.

Information on NHS charges were on display in both waiting areas. However, the private price list was only available on request.

The registered manager must display private treatment prices within patient areas.

We saw signs displayed notifying patients and visitors to the practice that smoking was not permitted on the premises, in accordance with current legislation.

The names of the dentists were displayed externally outside the practice. The names of the dentists and hygienists were displayed inside the practice, which also

contained their GDC registration numbers. However, we noted the board included the name of one dentist no longer working at the practice, and did not include the names and GDC numbers of the dental nurses working at the practice.

The registered manager must update the staff information board to display the names, job titles and GDC numbers of all registered staff working at the practice.

The practice opening times, telephone number and out of hours contact number were displayed clearly on the front door of the practice.

Dignified and respectful care
During the inspection we observed staff being polite, friendly and treating patients with kindness and respect. All patients who responded to the HIW questionnaire agreed that staff treated them with dignity and respect. The GDC nine core principles of ethical practice were displayed in the reception area and were available in English and Welsh.

We saw that a confidentiality agreement was in place which had been signed by all staff. The reception desk was in the downstairs waiting room and there was a separate waiting room upstairs. Staff had access to a separate room away from patients to allow privacy for confidential phone calls. We were told patients could have a discussion in private within the office if they wanted to discuss confidential details. There were solid doors to clinical areas including each surgery. However, we witnessed a door left open whilst clinical treatment was being carried out on two separate occasions.

The registered manager must ensure all doors to clinical areas are kept closed during treatments to ensure privacy for patients.

Individualised care
We reviewed a sample of 10 patient records and confirmed appropriate identifying information and medical histories were included.

All respondents who completed the HIW questionnaire said they were given enough information to understand the treatment options available to them and agreed the cost was made clear to them before receiving treatment.

Timely

Timely care

The practice arranged appointments by telephone or in person at reception and we heard telephone lines working effectively on the day. There was no online booking system available to patients.

We were advised the average waiting time between treatment appointments was two to five weeks but could be prioritised earlier if necessary. We were told the practice reserved morning and afternoon appointment slots each day for emergencies. Patients are informed they can access emergency appointments by calling the practice in the morning. Evening slots were available to help accommodate patients who were working or had children.

Staff in the surgery communicate using an instant messaging system to update reception staff on any delays. We were told reception staff would then inform patients verbally in person if there were any delays with appointments. Respondents to the HIW questionnaire said that it was either 'very easy' or 'fairly easy' to get an appointment when they needed one.

Equitable

Communication and language
We were informed none of the staff at the practice were able to speak Welsh. When asked, the practice manager told us staff would be directed to Welsh language training if interest was shown. We were assured that if patients wanted to speak Welsh or needed any other language this would be accommodated through Language Line.

We saw patient information such as health promotion leaflets and practice information were available in English and Welsh. However, we were told staff did not ask patients their preferred language when attending. When questioned, the practice manager informed us she had no knowledge of the 'Active Offer' of receiving care in the Welsh language. We were told they did not recall receiving support from the health board to enable them to implement the 'Active Offer'.

The registered manager is required to provide HIW with details of the action taken to improve the implementation of the 'Active Offer.'

The registered manager must ensure that the preferred language of patients is recorded within the patient record.

We were told patient information would be available in large print if requested, however other alternative formats were not available. Patients without digital access would receive information by letter and staff would contact patients on a landline number if available.

Rights and equality
The practice had an adequate and up to date policy in place to promote equality and diversity.

Staff told us preferred names and/or pronouns were recorded on patients records to ensure transgender patients were treated equally and with respect.

All respondents who answered the HIW questionnaire told us they had not faced discrimination when accessing services provided by the practice.

We found the practice had reasonable adjustments in place to ensure the setting was accessible to all. Disabled toilet facilities were available and there were ground floor surgeries for patients unable to use stairs.

Delivery of Safe and Effective Care

Safe

Risk management
We saw that external areas of the practice and patient facing areas internally were well decorated and visibly tidy with no obvious hazards. However, staff areas required some improvement. We saw a staff room available for lunch breaks and a staff toilet on the first floor. There was a dedicated staff changing room which was lockable, and where personal items could be stored. We found the following issues within the staff areas:

- Light fitting was loose outside of staff room
- Staff room was cluttered
- Wallpaper coming away within the staff toilet and in the corridor
- Cracks visible on the walls
- Holes in the carpet within the staff changing area.

The registered manager must improve the staff areas within the practice to ensure appropriate health and safety.

We saw two waiting rooms available, and each were of an appropriate size for the practice. However, the chairs within the waiting room were not made of a wipeable material.

The registered manager must provide chairs within the waiting that are of a wipeable material to support effective infection prevention and control (IPC).

The employer's liability certificate was available and displayed behind reception. We found dental equipment was in good working condition and single use items were in use where appropriate.

A range of health and safety risk assessments were in place and the health and safety executive poster was displayed in the office and behind reception.

We saw in date gas safety records, five yearly fixed wire testing and portable appliance testing (PAT). However, some appliances did not have PAT stickers displayed, and some documentation was missing dates.

The registered manager must ensure portable appliance testing documentation is complete with proof of testing available for all appliances.

We examined fire safety documentation and found adequate maintenance contracts in place. Fire extinguishers were available around the premises and had been serviced within the last year. We saw appropriate fire signage displayed, and evidence was seen of weekly checks undertaken on fire equipment. We noted one staff member had not completed fire safety training; certification of training was provided immediately following the inspection.

We examined an up-to-date fire risk assessment which had been completed by an external company in March 2025. We found actions that had been raised within the risk assessment had not been completed. Eight actions were 'medium' risk requiring completion within three months, and two actions were 'high' risk requiring completion immediately.

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.

Infection, prevention and control (IPC) and decontamination
We found appropriate infection prevention and control policies and procedures in place to maintain a safe and clean clinical environment. Cleaning schedules were available to support the effective cleaning of the practice.

We saw personal protective equipment (PPE) was readily available for all staff and the practice had suitable hand hygiene facilities available in each surgery and in the toilets. We were informed there was appropriate Occupational Health Support available to staff if required.

The practice had two designated rooms for the decontamination and sterilisation of dental instruments. We found appropriate processes and equipment in place to safely transport instruments around the practice. However, we found the decontamination rooms were not well maintained and in need of maintenance. We found the following issues:

- Broken ceramic tiles where the work surface met the wall
- Work surface was not sealed where it met the wall
- Thick layer of dust present on the extractor fan
- Layer of dust present on the autoclave
- Flooring not appropriately sealed where the floor meets the wall
- What appeared to be mould present on the wall
- Radiator had peeling paint and what appeared to be rust present
- Wooden cupboard handles were worn, not allowing appropriate IPC

- Work surface damaged causing peeling and exposing wood beneath
- Appropriate workflow was not in place.

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.

We saw a dental impression mixer and electrical equipment within the decontamination room. We advised the registered manager to relocate these items to another room in the practice to maintain appropriate IPC.

We found decontamination equipment was regularly tested and was being used safely. We saw evidence that staff had completed IPC training. We did not see evidence of an up-to-date Welsh Health Technical Memoranda (WHTM 01-05) audit; this was last completed in 2021. However, an alternative IPC audit had been completed within the last year.

We found the practice had an appropriate contract in place for handling and disposing of waste, including clinical waste. We saw evidence of appropriate arrangements in the practice for handling substances which are subject to Control of Substances Hazardous to Health (COSHH).

All respondents to the HIW questionnaire said the practice was 'very clean' and felt that infection prevention and control measures were being followed.

Medicines management
We found the practice had an appropriate medicines management policy in place which had been reviewed by all staff.

We saw evidence that staff recorded medicines administered to patients in their notes and we were told patients were given information about medicines prescribed.

We found the practice had a dedicated medical fridge within the office, however regular checks and recording of the fridge temperature was not being completed.

The registered manager must implement a process to ensure daily checks of the fridge temperature are being completed.

We saw the practice had an up-to-date medical emergency policy which was reviewed annually. We looked at staff training records and found all staff members had up-to-date training in cardiopulmonary resuscitation (CPR). Two members of

staff had completed first aid training, and their certificates were available within the office.

We inspected the equipment in place to deal with a medical emergency and found all items available and in date. We saw evidence that regular checks were being carried out on all emergency equipment. The medical emergency bag was kept within the decontamination room; we advised the practice manager to relocate the bag due to temperature sensitive medical drugs being present and the temperature of the decontamination room being high at times.

Safeguarding of children and adults
We saw evidence the practice had an up-to-date safeguarding policy in place. We noted the safeguarding policy did not have any external contact details for local safeguarding teams, however contact details were made available on a quick reference flow chart poster within the office. The relevant contact details were added into the policy on the day.

The practice had an appointed safeguarding lead and staff could access the Wales Safeguarding Procedures via their phones.

We looked at staff safeguarding training records and saw that three staff members had completed training to level three, which is considered good practice. However, we found that only nine of the sixteen staff members had completed appropriate safeguarding training. We received confirmation following the inspection that the remaining members of staff had subsequently completed their safeguarding training.

Management of medical devices and equipment
We found medical devices and clinical equipment were in good working order and suitable for purpose. Reuseable devices were disinfected appropriately, and arrangements were in place to promptly address any system failures. We found the practice had a CEREC machine and we were assured by the owner that the setting was registered with MHRA. Evidence of registration was provided to HIW shortly following the inspection.

We viewed evidence of servicing documents for the compressor which had been completed within the last year.

Documentation was in place to evidence the safe use of X-ray equipment and appropriate signage was available at each surgery. Local rules were displayed near to each X-ray machine in each surgery. We viewed evidence of maintenance records of X-ray equipment and noted that the three yearly quality assurance test for the X-ray machine in surgery six was last completed in January 2022 and

therefore not in date. The registered manager was told they could not use this X-ray machine until the testing had been completed. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix B.

Effective

Effective care

We found the practice had safe arrangements in place for the acceptance, assessment, diagnosis and treatment of patients. We found staff were following advice of relevant professional bodies and knew where to find information when required. However, when asked if Local Safety Standards for Invasive Procedures (LocSSIPs) were used to help minimise the risk of wrong tooth extraction, staff were not aware of the process.

The registered manager must fully implement and document the use of Local Safety Standards for Invasive Procedures (LocSSIPs).

Patient records

We saw a suitable system in place to ensure the safety and security of patient records. The practice had an appropriate records management and consent policy in place.

We reviewed a sample of 10 patient records. Overall, the recording of information was clear and maintained to a good standard. Each had patient identifiers, reasons for attending were recorded and medical histories were updated at each visit. We saw evidence smoking cessation and oral hygiene advice had been recorded where necessary. We did find the following areas that could be improved:

- No patients had language preference recorded
- Risk assessment was not recorded based on cavities, periodontal status, tooth wear and oral cancer
- 1/10 did not record radiographs within notes.

These omissions were discussed with the practice manager on the day of inspection. We suggested to the practice manager to use the patient record audit to ensure consistency within the patient records.

The registered manager must ensure that patient records are complete and include all relevant information in line with professional standards and guidance.

Alongside the omissions identified above, we did not find a robust follow up procedure in place for suspected oral cancer patients.

The registered manager must ensure a robust follow up procedure is in place for suspected oral cancer patients.

Efficient

Efficient
We found facilities and premises were appropriate for the services being delivered. Clinical sessions were managed efficiently, and the number of clinicians were sufficient for the service provided. We were told patient requiring urgent care were prioritised where possible.

Quality of Management and Leadership

Staff feedback

Staff who responded to the HIW questionnaire provide positive comments overall. All those who responded felt the facilities and environment were appropriate to ensure patients received the care required. Staff felt patient care was a top priority and patients were informed and involved with care decisions. All those who responded agreed the practice is a good place to work and would be happy for family to receive care at the practice.

Staff comments included:

> *"This is a lovely practice to work…"*
>
> *"I am currently part of a good team providing quality care in a supportive workplace."*

Leadership

Governance and leadership
We saw evidence that staff meetings were held monthly and noted suitable discussions around targets, decontamination duties and policies. These were attended by all staff members and those not in attendance were given a copy of the meeting minutes in person.

We saw evidence the practice manager updated policies and procedures on a routine basis. Staff members had access to these policies on the computers in practice.

We found a clear management structure in place to support the running of the practice. However, following the inspection, we found the current practice manager had not submitted the required registration documents to HIW. On investigation, it was found the previous registered manager left the practice in June 2019, and the current manager assumed the role in the same month. Failure to notify HIW of the departure of a registered manager and operating without appropriate registration for over six years is a breach of regulations. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix B.

The number of regulatory breaches we identified during the inspection was concerning. Following the inspection, and in line with our escalation and

enforcement procedures, Cross Keys Dental Practice was designated a Service of Concern on 08 August 2025. It was positive that the principal dentist and practice 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.

Workforce

Skilled and enabled workforce

In addition to management, the team comprised of four dentists, two hygienists, one therapist, four qualified nurses, three trainee nurses and one receptionist. We were told the practice has not used agency staff recently but sources them from dental agency companies when required. We found an appropriate system in place to ensure a suitable number of staff were working at any time.

We saw a suitable and up-to-date recruitment policy. The practice manager and the head nurse were responsible for the induction and supervision of new staff members. All staff were provided with an employee handbook to ensure staff understood their specific role and information relating to the practice. We were told any performance issues would be discussed with the individual staff member and a disciplinary procedure would follow.

We reviewed five staff member records and found suitable evidence was in place for GDC registration, professional indemnity and appraisals. However, we observed the following areas which required improvement:

- No evidence available of reference checks being received for any staff members
- Two of the five staff records did not have Disclosure and Barring Service (DBS) checks at the appropriate level
- One staff member employed in February 2025 had no evidence of a DBS check at any level.
- One staff member did not have evidence of immunity from Hepatitis B following vaccinations.
- No employment history for two staff members.

Further information on the issues we identified, and the actions taken by the service, are provided in Appendix B.

We reviewed a sample of five staff training records and found all staff members had up-to-date certification in place, with the omission of the previously mentioned safeguarding certification issues which were resolved within 24 hours of inspection.

We were told staff accessed training through 'Ty Dysgu' and inhouse training courses that were arranged by the practice. Of those who responded to the HIW questionnaire, staff said they felt they had appropriate training to undertake their role. On talking to the practice manager, we found they did not have a suitable training matrix in place to monitor the completion of mandatory training courses. We advised they put this in place to ensure compliance with core training.

Culture

People engagement, feedback and learning
The practice had a suggestions box available within the ground floor waiting room with forms for patients to provide feedback. We were informed patients could also provide feedback verbally in person or over the phone to staff members. We were told staff act on feedback when it is received; the practice manager discussed that a handrail had been installed following patient feedback. However, the practice confirmed that they do not routinely monitor feedback to identify any common themes.

The registered manager must implement a process for regularly assessing patient views.

The practice had an appropriate complaints policy which was reviewed yearly. We noted that this was displayed behind the reception area which meant it was not accessible to patients We were told that a copy of the complaints policy was available upon request from reception. However, we advised the practice manager to relocate the complaints policy from behind reception to the waiting area to ensure all patients were able to read the information. The policy included timescales for complaints, an escalation process if required and contact information for external bodies. However, we noted Llais and HIW information was not mentioned within the policy; this was added on the day.

We were informed the practice manager was responsible for complaints. If the complaint was regarding the practice manager, the principal dentist would take responsibility. We saw evidence of complaints being recorded within a dedicated complaints folder. We advised the practice manager to consider other ways of logging complaints so that common themes could be easily identified.

We viewed the duty of candour guidance which outlined responsibilities of staff members. Staff were confident in describing the process and we were told they had completed duty of candour training.

Information

Information governance and digital technology

The practice used an electronic system to manage patient records, policies and procedures. A paper system was in place for staff training records. There was an accident reporting system in place and we were told information was shared with staff members in team meetings.

Learning, improvement and research

Quality improvement activities

We saw audits for hand hygiene, antibiotic prescribing and an audit of dental surgeries. We saw evidence of an audit policy which had been reviewed within the last year; however, only three audits were mentioned within the policy and none of these had been completed. The practice did not provide evidence of audits taking place for smoking cessation, patient notes, radiographs or clinical waste. We also noted peer reviewing was not taking place, and the practice was not taking advantage of quality improvement tools available to them through Health Education and Improvement Wales (HEIW). Further information on the issues we identified, and the actions taken by the service, are provided in Appendix B.

The registered manager must review their audit policy to ensure it is fit for purpose.

Whole-systems approach

Partnership working and development

We were told the practice maintains a good working relationship with other primary care services such as the local pharmacy.

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
We looked at staff safeguarding training records and found the following: • Two staff members had out of date training • Three staff members had training, but no level of training was available • Two staff members did not have the appropriate level of training.	Staff may not know what to do in the event of a safeguarding issue.	Raised to the practice manager and responsible person.	Certificates were provided to HIW within 24 hours of inspection.

Appendix B - Immediate improvement plan

Service: Cross Keys Dental Practice

Date of inspection: 14 July 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.	We found the decontamination rooms were not well maintained and in need of maintenance. We found the following issues: • Broken ceramic tiles where the work surface met the wall • Work surface was not sealed where it met the wall • Thick layer of dust present on the extractor fan	The service must ensure the environment of both decontamination rooms are kept to a suitable standard to meet the requirements of WHTM 01-05 and enable effective decontamination and sterilisation of dental instruments.	Regulation 13(5) of The Private Dentistry (Wales) Regulations 2017	1, perform WHTM 01-01 audit. 2, refit both decon rooms, addressing all issues identified in non-compliance notice.	1, E. Hughes 2, J, alexander	1, WHTM 01-05 Audit conducted and submitted to HEIW Dental QI on 9.9.2025 2, work to finish 30th September 2025.

	• Layer of dust present on the autoclave • Flooring not appropriately sealed where the floor meets the wall • What appeared to be mould present on the wall • Radiator had peeling paint and what appeared to be rust present • Wooden cupboard handles were worn, not allowing appropriate IPC • Work surface damaged causing peeling and exposing wood beneath • Appropriate workflow was not in place.					Evidence to be submitted to HIW on completion
2.	We saw evidence of an audit policy which had been reviewed within the last year, however only three audits were mentioned within the policy, and these had not been completed. The practice did	The manager must review their quality improvement policy to ensure all mandatory audits are included, and schedule and	Regulation 16(1)(a) of The Private Dentistry (Wales) Regulations 2017	1, Review quality improvement policy. 2, Identify additional audits to include. 3, Plan time table for delivery of audits. 4, Deliver audits.	1-4 – E Heare	1-3, 18 July 2025. Completed 4, Start audit delivery 1st

	not provide evidence of audits taking place for smoking cessation, patient notes, radiographs or clinical waste.	implement the audits without delay.				August 2025 Completed
3.	We found actions that had been raised within the risk assessment had not been completed. Eight actions were 'medium' risk requiring completion within three months, and two actions were 'high' risk requiring completion immediately.	The manager must ensure all actions contained within their fire risk assessment are adequately addressed with evidence submitted to HIW of their completion.	Regulation 22(4)(a) of the Private Dentistry (Wales) Regulations 2017	Address all issues identified in Fire risk assessment.	E Heare + J Alexander	19th September 2025 Evidence to be submitted to HIW
4.	We observed the following areas which required improvement: • No evidence available of reference checks being received for any staff members • Two of the give staff records did not have Disclosure and Barring Service (DBS) checks at the appropriate level	The manager must provide evidence to HIW that enhanced DBS checks are in place for all staff who may be in contact with patients. In addition, evidence must be submitted of suitable pre-employment reference checks or a risk assessment covering the missing reference checks.	Regulation 18(1) of The Private Dentistry (Wales) Regulations 2017		E. Heare	All staff have enhanced DBS certificates completed 29.08.2025 Risk assessment completed 31.07.2025 Evidence submitted to HIW Completed

	• One staff member employed in February 2025 had no evidence of a DBS check at any level.					
5.	We viewed evidence of maintenance records of x-ray equipment, however the three yearly quality assurance test for the x-ray set in surgery six was last completed in January 2022 and therefore not in date.	The manager must not use the X-ray machine located in surgery 6 until evidence has been submitted to HIW of the requisite quality assurance inspection having taken place.	Regulation 13(2)(a) of The Private Dentistry (Wales) Regulations 2017		E. Heare	Critical 3-yearly routine test conducted on 31.07.2025 Evidence submitted to HIW Completed
6.	On investigation, it was found the previous registered manager left the practice in June 2019, and the current manager assumed the role in the same month. Failing to notify HIW of the departure of a registered manager and operating without appropriate registration for over six years is a breach of regulations.	The manager must apply to HIW to become the registered manager without delay.	Regulation 10(2) and 27 and The Private Dentistry (Wales) Regulations 2017		E. Heare	Application submitted 17.07.2025 Notification of registration 12.09.2025 Evidence submitted to HIW 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: Jonathan Alexander

Name (print): Jonathan Alexander

Job role: Practice Principal

Date: 21.07.2025

Appendix C - Improvement plan

Service: Cross Keys Dental Practice

Date of inspection: 14 July 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.	The private price list was only available on request.	The registered manager must display private treatment prices within patient areas.	The Private Dentistry (Wales) Regulations 2017 Regulation 6 (3)	Private price lists are now displayed in both patient waiting areas.	E.Heare Practice Manager	Completed on 22.08.2025 Photographic evidence provided to HIW
2.	We noted the board included the name of one dentist no longer working at the practice, and did not include the names and GDC numbers of the dental nurses working at the practice.	The registered manager must update the staff information board to display the names, job titles and GDC numbers of all registered staff working at the practice.	GDC Standards for the Dental Team Standards 6.6.10	Notice boards to be amended, removing the name of the dentist no longer working at the practice. Dental nurses to be added to the staff information board displaying names,	E.Heare Practice Manager J.Alexander Practice Principal	Dentist name removed from notice board completed 18.09.2025 Addition of GDC registered staff to be completed by 30.09.2025 On completion,

				job titles and GDC numbers		photographic evidence to be provided to HIW
3.	We witnessed a door left open whilst clinical treatment was being carried out on two separate occasions.	The registered manager must ensure all doors to clinical areas are kept closed during treatments to ensure privacy for patients.	The Private Dentistry (Wales) Regulations 2017 Regulation 15 (1)	Conduct staff training during the monthly staff meeting to highlight the importance of patient privacy	E.Heare Practice Manager J.Alexander Practice Principal	Added to the agenda for the staff meeting on 18.09.2025 Copy of meeting minutes to be sent to HIW as evidence following meeting on 18.09.2025 To be reviewed in follow up meeting October 2025
4.	The practice manager informed us she had no knowledge of the 'Active Offer' of receiving care in the Welsh language.	The registered manager is required to provide HIW with details of the action taken to improve the implementation of the 'Active Offer.'	The Private Dentistry (Wales) Regulations 2017 Regulation 13 (1)(a)	Research 'Active Offer' on Gov.uk. Contact the health board for advice on implementing Active Offer within the practice. To implement the Welsh greeting when answering the	E. Heare Practice Manager	Researched 'Active Offer, on Gov.uk on 03.09.2025 Contacted the Health Board for advice on 04.09.2025 Discuss the implementation

				telephone, identify any Welsh-speaking or learning staff within the practice. To be identified with a badge or lanyard. Use advertisements in both the medium of Welsh and English. Use tools on Gov.uk to ensure translations to Welsh are correct.		on Welsh greetings on reception and in surgery in next practice meeting held on 18.09.2025. To be implemented 19.09.2025 Request and display advertisements in the medium of Welsh and English- Ongoing
5.	We were told staff did not ask patients their preferred language when attending.	The registered manager must ensure that the preferred language of patients is recorded within the patient record.	The Private Dentistry (Wales) Regulations 2017 Regulation 13 (1)(a)	Add a custom field to patients' records to record the preferred language. Staff to ask the patient's their preferred language on arrival at the practice and record it in their records.	E. Heare Practice Manager	Custom field added to Dental software – 03.09.2025 Staff training on recording patients' preferred language in meeting held on 18.09.2025

						To be implemented 19.09.2025
6.	We found the following issues within the staff areas: • Light fitting was loose outside of staff room • Staff room was cluttered • Wallpaper coming away within the staff toilet and in the corridor • Cracks visible on the walls • Holes in the carpet within the staff changing area.	The registered manager must improve the staff areas within the practice to ensure appropriate health and safety.	The Private Dentistry (Wales) Regulations 2017 Regulation 22 (2)	Advised improvements to be made to staff areas	J Alexander Practice Principal	Improvements to the staff area to be completed by 31.10.2025 Photographic evidence to be submitted to HIW on completion
7.	The chairs within the waiting room were not made of a wipeable material.	The registered manager must provide chairs within the waiting that are of a wipeable material to support effective infection	The Private Dentistry (Wales) Regulations 2017 Regulation 22 (2)(a)	Wipeable chairs to be purchased to replace existing chairs	J. Alexander Practice Principal	Purchase to be completed 30.11.2025 Photographic evidence to be

		prevention and control (IPC).				sent to HIW once purchased
8.	Some appliances did not have PAT stickers displayed, and some documentation was missing dates.	The registered manager must ensure portable appliance testing documentation is complete with proof of testing available for all appliances.	The Private Dentistry (Wales) Regulations 2017 Regulation 22 (2)	Retesting of portable appliances without PAT stickers and those with documentation with missing dates	J.Alexander Practice Principal	Testing and documentation undertaken and updated to be completed by 18.09.2025 Documentation to be sent to HIW of evidence of completion
9.	Regular checks and recording of the fridge temperature was not being completed.	The registered manager must implement a process to ensure daily checks of the fridge temperature are being completed.	The Private Dentistry (Wales) Regulations 2017 Regulation 13 (4)	Temperature checks to be undertaken daily and recorded	E.Heare Practice Manager Ellie Hughes Head Nurse	Temperature checks are conducted daily and recorded. Records kept on computer. Implemented on 17.07.2025 Evidence sent to HIW
10.	When asked if Local Safety Standards for Invasive Procedures (LocSSIPs) were used to help minimise the risk of wrong	The registered manager must fully implement and document the use of Local Safety Standards	The Private Dentistry (Wales) Regulation 2017 Regulation 20 (1)(a)	To ensure all staff are trained with the process of LocSSIPs. Impliment and record on patients records	J.Alexander	Update Dental Software to add the LocSSIPs to enable dentist to record that the

	tooth extraction, staff were not aware of the process.	for Invasive Procedures (LocSSIPs).				process is being followed. Completed on 01.09.2025 Staff training during the meeting on 18.09.2025
11.	We found the following areas that could be improved: • No patients had language preference recorded • Risk assessment was not recorded based on cavities, periodontal status, tooth wear and oral cancer • 1/10 did not record radiographs within notes.	The registered manager must ensure that patient records are complete and include all relevant information in line with professional standards and guidance.	The Private Dentistry (Wales) Regulation 2017 Regulation 20 (1)	Conduct audits to ensure patients records are complete in line with professional standards	E.Heare Practice Manager	Annual Record Keeping audit and oral cancer audit to be conducted. Oral cancer audit to be completed in September 2025 Record-keeping Audit to be conducted in Oct 2025 following the audit timetable.
12.	We did not find a robust follow up procedure in	The registered manager must ensure a robust follow up procedure is in	The Private Dentistry (Wales) Regulations 2017	Protocol for referrals of suspected oral cancer patients and a	E. Heare Practice Manager	Protocol and procedure reviewed and

	place for suspected oral cancer patients.	place for suspected oral cancer patients.	Regulation 13 (9)(a)	follow-up procedure created	J.Alexander Practice Principal	amended to ensure a robust follow up procedure is in place to be completed by 18.09.2025 Staff awareness of new protocol and procedure at staff meeting on 23.10.2025
13.	The practice does not routinely monitor feedback for common themes.	The registered manager must implement a process for regularly assessing patient views.	The Private Dentistry (Wales) Regulations 2017 Regulation 16 (1)(a)	Patient views to be recorded and reviewed on a monthly and annually basis.	E.Heare Practice Manager J.Alexander Practice Principal	Patient views are recorded (computerised) commenced 01.08.2025 To be reviewed on a monthly basis to allow common themes to be identified. If common themes are identified, they are to be investigated and changes

						implemented - ongoing
14.	We saw evidence of an audit policy which had been reviewed within the last year; however, only three audits were mentioned within the policy and none of these had been completed. The practice did not provide evidence of audits taking place for smoking cessation, patient notes, radiographs or clinical waste.	The registered manager must review their audit policy to ensure it is fit for purpose.	The Private Dentistry (Wales) Regulations 2017 Regulation 16 (1)(a) Regulation 8 (1)(n)	Update existing policy to identify audits that are to be undertaken. Create an Audit timetable to implement and conduct monthly audits	E.Heare Practice Manager	Practice audit Policy to be updated by 05.09.2025 Timetable of audits created and commencement of audits 01.08.2025 Evidence of completed audits can be sent to HIW

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): Jonathan Alexander

Job role: Practice Principal

Date: 04.09.2025