Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Dental Practice Inspection Report (Announced)

Portwall Dental Surgery, Aneurin Bevan 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 Portwall Dental Surgery, Aneurin Bevan University Health Board on 18 August 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. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 23 questionnaires were completed by patients and 5 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

Quality of Patient Experience

Overall summary:
Overall, we found the service to be highly rated by patients with all respondents rating it as 'very good'. Feedback highlighted professionalism, friendliness and clarity of communication from staff, as well as ease in making and changing appointments.

The setting offered a wide range of health promotion materials, including leaflets on smoking cessation, oral health and sedation treatments. Treatment costs and emergency care details were visible and accessible within the patient information folder.

Staff were observed treating patients with kindness and respect. Confidentiality was well managed, with private areas available for confidential conversations and doors to clinical areas kept closed.

Patient records were appropriately maintained and patients felt well informed about treatment options and costs. Appointments were arranged via phone, email or in person with emergency appointments available usually within 24 hours. While there was no online booking system, patients were able to contact the setting via their website.

This is what the service did well:

- Provided patient information in alternative formats
- Accessible surgeries and toilet facilities
- Arrangements were in place to protect the privacy of patients.

Delivery of Safe and Effective Care

Overall summary:
We found the setting was well maintained with appropriate patient and staff facilities. Health and safety policies were in place, and fire safety measures were appropriate. However, the fire risk assessment had not been reviewed annually though this was addressed on the day of inspection. Portable appliance testing (PAT) documentation was in place, however some appliances lacked visible or up-to-date stickers.

Infection prevention and control measures (IPC) were robust with personal protective equipment (PPE) readily available. Medicines management was

effective with secure storage in place. Appropriate checks were completed on the medical fridge, and we found emergency equipment readily available. Most staff had up-to-date cardiopulmonary resuscitation (CPR) with arrangements in place for those awaiting training.

Medical devices and equipment were in good working order with appropriate maintenance records in place. X-ray equipment was appropriately used and maintained, however, the local rules needed updating to include the name of the Radiation Protection Advisor (RPA).

This is what we recommend the service can improve:

- Ensure all appliances display current PAT stickers
- Improve documentation of medical history forms.

This is what the service did well:

- Effective medicines and emergency equipment management
- Clean, safe and tidy environment
- Appropriate and regular audits completed.

Quality of Management and Leadership

Overall summary:
Staff who responded to the HIW questionnaire provided positive feedback. Respondents felt patient care was prioritised and felt informed and involved in decision making. All respondents agreed the practice was a good place to work and would recommend the setting to family members.

Leadership and governance arrangements were found to be suitable for the setting. We saw evidence of monthly staff meetings with a range of topics discussed. Policies were routinely updated and accessible. However, not all staff had reviewed the policies.

Recruitment procedures were in place; however, we found area for improvement within documentation of staff.

The practice encouraged patient feedback through various means. Written feedback was monitored and shared with staff, however, there was no visible evidence of how feedback led to improvements.

This is what we recommend the service can improve:

- Ensure all staff have reviewed policies and procedures
- Improve pre-employment documentation.

This is what the service did well:

- Positive staff culture
- Effective training system and access to development opportunities
- Clear leadership structure.

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; 23 patients responded and rated the service as 'very good'.

Patient comments included:

> *"All of the staff are very professional and very friendly. I would recommend this practice to all my friends."*
>
> *"… Cannot speak highly enough of them…"*
>
> *"… Always explain things and answer questions…"*
>
> *"… Easy to make and change appointments."*

Person-centred

Health promotion and patient information
We saw a good range of patient information available in the reception area. This included information leaflets on smoking cessation, oral health, diet and information on treatments available. The practice had a satisfactory patient information leaflet and statement of purpose, which were both available at reception within the patient information folder.

We found specific patient information was available for conscious sedation treatment such as sedation technique, patient escort information, pre and post treatment instructions and anxiety management.

Information on treatment prices was displayed within the main waiting area and this was also available within the patient information file on the reception desk.

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 other registered health care professionals were displayed inside the practice, which also contained their General Dental Council (GDC) registration numbers.

The practice telephone number, email address and website address were displayed clearly at the entrance to the practice. The opening hours and emergency out of hours details were available on the practice voicemail. Information on out of hours care was also available within the patient information folder at reception.

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 in English. It was noted this was also available in Welsh within the patient information folder.

We saw a confidentiality policy in place which had been reviewed by all staff. The main reception desk was within the downstairs waiting room and there were two other separate waiting rooms: one towards the back of the building and one upstairs. Staff had access to a storeroom away from patients upstairs where they could transfer calls to allow privacy for confidential conversations. We were told patients could have conversations in private in one of the surgeries if they wanted to discuss confidential details. There were solid doors to clinical areas including each surgery which were kept closed whilst treating patients.

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

Where applicable, all respondents who completed the HIW questionnaire agreed that 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, by email or in person at reception. We heard telephone lines working effectively on the day. There was no online booking system available to patients, however patients could send a message to the practice with queries via a contact form on the website.

We were advised the average waiting time between treatment appointments was one week. Where an appointment may be needed sooner, a waiting list was available, and staff would try to arrange an earlier appointment with the clinicians help. Patients are informed they can access emergency appointments by calling the practice any time of day and we were told they can usually be seen within 24 hours.

Staff within the surgeries can communicate using an instant messaging system to update staff on any delays. We were told reception staff would then inform patients verbally in person of any delays or would phone the patient ahead of their appointment where possible. Respondents to the HIW questionnaire said it was 'very easy' (18/23) or 'fairly easy' (5/23) to get an appointment when they need one.

Equitable

Communication and language
We saw patient information such as the statement of purpose, patient information leaflet, complaints policy and privacy notice available within the patient folder in English and Welsh. The practice manager informed us patient information was available in large print if requested.

We were told if patients attended and their first language was not English, the practice would arrange an interpreter who would either attend in person, via video call or via telephone.

We were told patients without digital access would have all appointments communicated by telephone and appointment cards would be provided. Patients could also receive any information by letter when requested.

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 to 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. On the ground floor, there were four surgeries and accessible toilet facilities. There were chairs within the waiting rooms with arm rests, and

the practice manager told us quieter times were set aside, and quiet areas were available for those that required it.

Delivery of Safe and Effective Care

Safe

Risk management
We saw that external and internal areas of the practice were well decorated and visibly clean and tidy with no obvious hazards. A staff room was available for lunch breaks and staff had access to adequate locker facilities to store their possessions safely. A staff toilet was available on the first floor which was used as changing facilities. There were three waiting areas available, and each were of an appropriate size for the practice.

The employer's liability certificate was available within the patient information folder at reception. We found dental equipment was in good working condition and single use items were in use where appropriate.

We saw an appropriate health and safety policy in place as well as a range of health and safety risk assessments. The health and safety executive poster was displayed in the decontamination room. We advised the practice manager to relocate this to an area where all staff were able to access and see the information.

We saw evidence of a five yearly fixed wire testing and portable appliance testing (PAT). While we reviewed documented evidence detailing which appliances had undergone testing, we noted some appliances did not display PAT stickers and some that were available were out of date.

The registered manager must ensure proof of portable appliance testing is available on all appliances within the setting.

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 signage displayed, and evidence was seen of routine checks undertaken on fire equipment. We saw all staff had up to date fire safety training certificates available.

We examined a fire risk assessment which had been completed by an external company in September 2023 and all actions required had been completed. However, this had not been reviewed. The practice manager reviewed the fire risk assessment on the day of the inspection and provided documented evidence to HIW within 24 hours of inspection. Further details on actions taken are in Appendix A.

The registered manager must implement a process to review the fire risk assessment annually.

Infection, prevention and control (IPC) and decontamination
We found an appropriate infection prevention and control policy 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. 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. We saw the practice used Safety Plus syringes to lower the risk of sharps injuries and sharps injury protocols were available in all surgeries.

The practice had a designated room for the decontamination and sterilisation of dental instruments. The decontamination room was well maintained with appropriate processes and equipment in place to safely transport instruments around the practice.

We found decontamination equipment was regularly tested and was being used safely. We saw evidence of daily logs and we were told information from the autoclaves were downloaded monthly. We saw evidence of staff IPC training and the practice had completed IPC audits at six monthly intervals.

We found the practice had an appropriate contract in place for the 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 staff.

We saw evidence that staff recorded medicines administered to patient in their notes and we were told patients were given information about medicines prescribed. Any adverse reactions to drugs were discussed in monthly practice meetings.

We found the practice had a dedicated medical fridge away from the patient area and we saw evidence of daily checks of the fridge temperature. Staff were able to explain the procedure in place in the event of a failed temperature.

We saw the practice had an up-to-date medical emergency policy which was reviewed annually. We looked at staff training records and found 18/20 staff members had up to date training in cardiopulmonary resuscitation (CPR). The two staff members who had not completed the training had risk assessments in place and dates to undertake the training had been arranged. All members of staff who carried out conscious sedation treatment had up-to-date Immediate Life Support (ILS) certification. Two members of staff had completed first aid training, with a further two staff members booked to attend the training course. We saw a first aid kit available with all items in place and in date.

We inspected the equipment in place to deal with a medical emergency and found all items available and in date. We saw evidence of regular checks being carried out on all emergency equipment. The medical emergency bag was kept in an accessible area with signage available on the door.

We found prescription pads and medical drugs were stored securely with a log in place to monitor the use of sedation medication.

Safeguarding of children and adults
We saw evidence the practice had an up-to-date safeguarding policy in place. We found the relevant external contact details for local safeguarding teams were present and information on All Wales national procedures. A quick reference safeguarding flow chart was available within the policy and in the patient information folder at reception. The practice had an appointed safeguarding lead and staff were aware of support available to them in the event of a safeguarding concern.

We looked at safeguarding training records and saw staff had up to date safeguarding training to an appropriate level. The safeguarding lead had completed training to level three which is considered good practice.

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 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. We viewed evidence of maintenance records of X-ray equipment and local rules were displayed near to each X-ray machine in each surgery. However, it was noted the Radiation Protection Advisor (RPA) information needed to be added to the local rules.

The registered manager must update the local rules to include the name of the Radiation Protection Advisor.

We found the setting had safe and appropriate facilities and equipment in place to provide conscious sedation to patients. We reviewed up-to-date documents about the clinical use of sedation. We found equipment and procedures were in place to monitor patients during treatment and deal with medical emergencies if they were to arise.

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. Local Safety Standards for Invasive Procedures (LocSSIPs) were used to help minimise the risk of wrong tooth extraction.

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 nine patient records. Overall, the recording of information was clear and maintained to a good standard. Each patient had identifiers, reasons for attending were recorded and medical histories were updated at each visit. We saw evidence that smoking cessation and oral hygiene advice had been recorded where necessary, radiographs and risk assessments had been recorded and all information necessary within notes for conscious sedation was present. However, we were concerned that the medical history form could be blank once completed by the patient and no signature required to show it has been completed, leaving room for confusion. This was discussed with the registered manager on the day of the inspection.

The registered manager must ensure medical history forms are fully completed and include the patient's signature.

Quality of Management and Leadership

Staff feedback

Staff who responded to the HIW questionnaire provide positive comments overall. All those who responded agreed the facilities and environment were appropriate to ensure patients received the care required. Staff agreed 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:

> *"Such a lovely practice to work at with a great team who always put the patients first."*

> *"Excellent patient care and a happy team…"*

Leadership

Governance and leadership

We found a clear management structure in place to support the running of the practice. We saw evidence that staff meetings were held monthly and noted suitable discussions around policies, stock, IPC information and training. These were attended by all staff members and those not in attendance were given a copy of the meeting minutes to read and sign.

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. However, we found that not all staff members had signed to say they had reviewed the policies.

The registered manager must ensure all staff members are compliant with reviewing practice policies and procedures.

Workforce

Skilled and enabled workforce

In addition to the practice manager, the team comprised of five dentists, one specialist oral surgeon, one specialist periodontist, three hygienists, six qualified nurses, two trainee nurses and two receptionists. We were told the practice uses

agency staff for nursing and sources them from dental companies when required. We were told they request the same nurse when agency is used to ensure it does not affect continuity of care. 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. 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 in private and a disciplinary procedure would follow if necessary.

We reviewed six staff member records and found suitable evidence was in place for professional indemnity, Hepatitis B vaccination and appraisals. However, we observed the following areas which could be improved:

- Evidence of immunity from Hepatitis B following vaccinations was not available for one clinician
- 4/6 staff members had no references available
- 2/6 staff members had no pre-employment history
- Although GDC checks had been undertaken, GDC certificates were not available for some staff members
- Disclosure and barring service (DBS) checks had been undertaken with evidence available via website, however certificate evidence was not available.

The registered manager must review their employment procedures to ensure pre-employment checks are appropriately completed and records are routinely reviewed to ensure compliance.

We reviewed a sample of six staff member training records and found all staff members had completed their mandatory training with up-to-date certification in place.

Staff had access to an online inhouse training system. We saw details of staff up-to-date training on the compliance system which could be monitored by management. We found staff members completing conscious sedation treatment had suitable training in place with certification available. We were told extra training was made available to staff when requested with the example of two staff members currently undertaking a sedation course. Of those who responded to the questionnaire, staff said they felt they had appropriate training to undertake their role and most (4/5) said they had fair and equal access to workplace opportunities.

Culture

People engagement, feedback and learning

The practice had a feedback box available beside the reception desk with a paper feedback form for patients to complete. Patients were also able to scan a QR code to leave a Google review. We were told any verbal feedback was not recorded; we advised the registered manager to implement a log for verbal feedback to monitor for any common themes. We were told written feedback was monitored daily by the practice manager. The practice manager contacted patients if required and all feedback was shared with the team. We noted there was no information on display on how the practice had learned and improved from feedback received, we advised the practice manager this would be a good way to communicate with patients that their feedback has been acted upon.

The practice had an appropriate complaints policy which was reviewed annually. This was available in the patient information folder at the reception desk and copies were available upon request. The policy included timescales for complaints, an escalation process if required and contact information for external bodies.

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 a complaints folder where complaints were monitored for common themes.

Learning, improvement and research

Quality improvement activities

We were told clinical staff undertook open peer reviewing. We saw audits for radiography, patient records, hand hygiene, clinical waste, controlled drugs and antibiotic prescribing. We were told audits were completed at regular intervals and outcomes were shared with staff in team meetings. The setting had use of an online compliance system which provided any quality improvement audits required.

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
The fire risk assessment had not been reviewed.	Risk to patients and staff if fire risk had not been identified.	Raised issue to the practice manager and registered manager.	The practice manager reviewed the fire risk assessment and sent documented evidence within 24 hours of inspection.

Appendix B - Immediate improvement plan

Service: Portwall Dental Surgery

Date of inspection: 18 August 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.	No immediate concerns found.					

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):

Job role:

Date:

Appendix C - Improvement plan

Service: Portwall Dental Surgery

Date of inspection: 18 August 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.	We noted some appliances did not display PAT stickers and some that were available were out of date.	The registered manager must ensure proof of portable appliance testing is available for on all appliances within the setting.	The Private Dentistry (Wales) Regulations 2017 Regulation 22 (2)	We have had telephone communication with PAT testing company that was responsible for the testing in 2024. They have confirmed all appliances were successfully tested and recorded in the log inventory sheet, but accept some stickers were missing from some appliances. We have arranged for	Kath Pritchard (Practice Manager)	20/08/2025

				them to do a full PAT testing in 2026 within the 2year period from the previous test.		
2.	We reviewed a fire risk assessment, however it was not reviewed annually.	The registered manager must implement a process to review the fire risk assessment annually.	The Private Dentistry (Wales) Regulations 2017 Regulation 22 (4)(e)(f)	This was completed on the day of inspection, as noted in appendix A (page 22) of the inspection report. A automated reminder has been set for future annual risk assessments. This is within our practice management software.	Kath Pritchard (Practice Manager)	20/08/2025
3.	It was noted the Radiation Protection Advisor (RPA) information needed to be added to the local rules.	The registered manager must update the local rules to include the name of the Radiation Protection Advisor.	The Ionising Radiation (Medical Exposure) Regulations 2017, Regulation 6	All local rules have now been updated to include the RPA information and are displayed currently where required	Laurence Folland (Registered Manager)	Completed 19/08/2025
4.	Concern that the medical history form can be blank once completed by the patient and no signature required	The registered manager must ensure medical history forms are fully completed and include the patient's signature.	The Private Dentistry (Wales) Regulations 2017 Regulation 20 (1)(a)	All clinicians have been informed of this finding. The patients signed medical forms are scanned to the patient record even if	Kath Pritchard (Practice Manager)	Implemented immediately

	to show it has been completed, leaving room for confusion.			there is no relevant medical history declared. The clincians have also been informed to write in the 'other' section of the Exact software medical form 'no relevant medical history has been declared'. This should ensure no medical form appears blank.		
5.	We found that not all staff members had signed to say they had reviewed the policies.	The registered manager must ensure all staff members are compliant with reviewing practice policies and procedures.	The Private Dentistry (Wales) Regulations 2017 Regulation 8	All policies had recently been updated and transferred to an online management system from a paper system, which staff were in the process of reviewing at the time of inspection. All staff have been advised to complete this review process. This was discussed at our practice meeting on 01/09/25. Policy	Kath Pritchard (Practice Manager)	All staff aim to be 100% compliant by 01/12/25

				review will then be undertaken annually, and or when any amendments are made to policies. An automated email reminder system is in place.		
6.	• Evidence of immunity from Hepatitis B following vaccinations was not available for one clinician • 4/6 staff members had no references available • 2/6 staff members had no pre-employment history	The registered manager must review their employment procedures to ensure pre-employment checks are appropriately completed and records are routinely reviewed to ensure compliance.	The Private Dentistry (Wales) Regulations 2017 Regulation 18 (2)(e)	1 – The clinician in question is checking for evidence of immunity. If unable to obtain this information then a blood test will be undertaken. If the clinician is a HepB non responder a risk assessment will be conducted for this individual. 2 & 3 – Many of the team members were known to the practice owners or had been employed by the practice owners at a	Kath Pritchard (Practice Manager)	1) By 01/12/25 2&3) Completed 20/07/25

	• Although GDC checks had been undertaken, GDC certificates were not available for some staff members • Disclosure and barring service (DBS) checks had been undertaken with evidence available via website, however certificate evidence was not available.			previous location, prior to onboarding, and have worked here for many years. Where documents have not been obtained, risk assessments have now been carried out, including character references (where applicable). This has been updated on our compliance software 4 – GDC renewals process had just taken place for all nurses and hygienists, so not all team members had uploaded new certification by the time of inspection. This has been requested from all staff members. 5 – Certification to be requested from		4) To be 100% compliant by 01/12/25 5) By 01/12/25

				relevant team members. For all future DBS checks the staff member must present their DBS certificate so it can be added to the management software. We have now designed a comprehensive onboarding procedure checklist document which is in place for all future recruitment to ensure capture of all required documentation.		

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): LAURENCE FOLLAND

Job role: Practice Principal (Registered Manager)

Date: 01/10/2025