Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Dental Practice Inspection Report (Announced)

Smart Smiles Ebbw Vale, Aneurin Bevan University Health Board

Inspection date: 22 September 2025
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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 Smart Smiles Ebbw Vale, Aneurin Bevan University Health Board on 22 September 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 21 questionnaires were completed by patients and 10 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, patient feedback from the HIW questionnaire was positive, with respondents rating the service as ‘very good’ or ‘good’. Staff were observed treating patients with dignity and respect, and confidentiality was well maintained.

Copies of the practice patient information leaflet were readily available and treatment price lists were displayed. We found practice contact information, open times and clinician names were available. However, General Dental Council (GDC) numbers were not listed, and information was not always visible.

Care was timely, with appointments available within two weeks and emergency patients seen within 24 hours. Communication was inclusive with Welsh speaking staff and interpreter services available. The practice promoted equality and had reasonable adjustments in place for accessibility.

This is what we recommend the service can improve:

- Ensure all clinical staff names and GDC numbers are clearly displayed.

This is what the service did well:

- Patients rated the service positively and felt respected
- Timely access to appointments
- Welsh language readily available.

Delivery of Safe and Effective Care

Overall summary:
We found the practice to be well decorated and visibly clean and tidy. Facilities were appropriate for the service provided. The practice had appropriate building certification in place with appropriate fire checks being completed.

We saw appropriate policies in place for infection prevention and control (IPC) and well-maintained clinical rooms. We saw evidence that decontamination equipment was serviced and tested appropriately with most respondents to the HIW questionnaire saying the practice was 'very clean'.

We found appropriate safeguarding information available with staff trained to the appropriate level. We found staff followed professional guidance and maintained

clear, well documented patient records.

Immediate assurances:

- Annual servicing of X-ray machines had not been completed.

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:

- Medical emergency policy must be reviewed
- Staff required to complete BOC training.

This is what the service did well:

- Patient records were managed securely
- Safeguarding lead had level three training
- Local Safety Standards for Invasive Procedures (LocSSIPs) were in use.

Quality of Management and Leadership

Overall summary:
Staff feedback was positive with all respondents saying the practice was a good place to work. Staff felt well trained and involved in patient care.

We found a clear management structure in place, with regular team meetings taking place and updated policies accessible to all staff. The practice was appropriately staffed with systems in place to manage staff shortages if they arose. Staff records were complete with mandatory training up to date.

The practice had a complaints policy in place; however, it lacked information on Llais and clarity was needed due to inconsistencies about the complaints lead. Regular audits were conducted; however, we found the practice had not completed a smoking cessation.

This is what we recommend the service can improve:

- Quality improvement policy must be reviewed
- Complaints information needed updating.

This is what the service did well:

- Active patient feedback systems
- Positive staff culture.

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. Of the respondents who answered, all rated the service ‘very good’ (15/20) or ‘good’ (5/20).

Patient comments included:

> *"After 5 years of not having an NHS dentist I feel very lucky to have this as my dentist.”*
>
> *"All staff very inviting and friendly.”*

Person-centred

Health promotion and patient information
We saw information available on smoking cessation but found limited other oral health information displayed in the reception and waiting areas. We discussed this with staff, and received confirmation following the inspection that further health information had been displayed in the practice, such as posters on sugar awareness and woman’s oral health during pregnancy.

The practice had a satisfactory patient information leaflet and statement of purpose. Copies of the patient information leaflet were readily available at the reception desk; we were told the statement of purpose was available upon request.

Information on NHS and private treatment prices were on display within the waiting area. We saw signs displayed notifying patients and visitors to the practice that smoking was not permitted on the premises, in accordance with current legislation. Notices were on display to inform patients of CCTV in operation.

The names of dentists and hygienists were displayed outside the practice. However, this was on a digital screen that showed information on rotation with other promotional material. This could be easily missed as names were not always visible. We found General Dental Council (GDC) registration numbers were not available and not all GDC registered staff names were listed.

The registered manager must display the names and GDC registration numbers of all GDC registered staff in a place easily seen by patients.

The practice opening times, phone number and out of hours number were available outside the practice on the digital screen previously mentioned. However, the information on display at the practice was on rotation and was not always available for patients to see. We were told that the information was also available on the practice website and on the voicemail message. We advised the registered manager to display the information permanently to prevent patients from missing it. This was completed shortly following the inspection.

Dignified and respectful care

During the inspection we observed staff being polite, friendly and treating patients with kindness and respect. All respondents to the HIW questionnaire agreed that staff treated them with dignity and respect. We saw the GDC nine core principles of ethical practice were displayed in the reception area.

We saw a confidentiality agreement was in place which had been reviewed by all staff. Staff had access to an office behind reception away from patients to allow privacy for confidential conversations or phone calls. Doors to clinical areas were solid and kept closed during treatments to maintain patient privacy.

Individualised care

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

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

Timely

Timely care

The practice arranged appointments by telephone, in person and via email. We were told an online booking system was available for private patients. We heard telephone lines working effectively on the day.

We were advised the average waiting time between treatment appointments was approximately two weeks, however patients could be prioritised earlier if necessary. We were told the practice requested patients to call in the morning for emergency appointments and they would usually be seen within 24 hours. We were told the practice operated a waiting list for treatment appointments and if there were any cancellations, patients on this list would be contacted. We were told the

practice opened on Saturdays on a rota basis with the other practices in the Smart Smiles group. Afternoon appointments were available with the practice being open later on Mondays.

Staff within the dental surgeries could communicate using an instant messaging system to update reception staff on any delays. We were told reception staff would contact patients ahead of their appointment if there was a known delay or inform patients verbally in person if they were present. All respondents to the HIW questionnaire said it was either ‘very easy’ (16/21) or ‘fairly easy' (5/21) to get an appointment when they needed one.

Equitable

Communication and language
We were told there were three members of staff in the practice that were able to speak Welsh and saw a ‘Cymraeg’ poster available at the reception desk to show patients could speak Welsh if wanted. When asked, the practice manager told us staff would be directed to Welsh language training if interest was shown.

We saw information such as the GDC nine core principles, ‘concerns, comments or suggestions’ and NHS information posters were available in English and Welsh. We were told the practice received support from the local health board to implement the ‘Active Offer’ when needed.

The practice manager informed us that patient information was available in large print when requested and a hearing loop was available at the reception desk. We were told staff had access to Language Line interpreter services, and an interpreter would be arranged for patients attending whose first language was not English. Patients without digital access would have appointments communicated by telephone or letter. Any information would be printed for them when attending the practice.

Rights and equality
The practice had an adequate and up to date policy in place to promote equality and diversity. We saw staff had completed equality and diversity training. We were told preferred names and/or pronouns were recorded on patients records to ensure all 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 adjustments in place to ensure the setting was accessible to all. All surgeries in the practice were on the ground floor with surgery one having double doors to allow wheelchair access.

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 conference room was available for staff to use during lunch breaks, and we were told staff used this area as changing facilities. We saw adequate storage facilities for staff to store possessions safely. A staff toilet was available on the first floor which could also be used as changing facilities.

There were two waiting areas available, and each were of an appropriate size for the practice. There were two toilets available to patients downstairs; however, of the three toilets available in the practice, only one had female sanitary disposal bins available.

The registered manager must ensure sanitary disposal bins are available within all toilets in the building.

The employer's liability certificate was available and on display. 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 kitchen area where it could be easily seen by staff.

We saw evidence of an annual gas safety records, a five yearly electrical installation report and portable appliance testing (PAT).

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 fire signage displayed, and evidence was seen of routine checked 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 2025. We noted there was no process in place to review the fire risk assessment annually.
The registered manager must implement a process to ensure the fire risk assessment is reviewed annually.

Infection, prevention and control (IPC) and decontamination
We saw 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 throughout the setting. 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 process and safely transport instruments around the practice.

We found decontamination equipment was regularly tested and was being used safely. We saw evidence of daily logs for all equipment which were up to date. We saw evidence of IPC training and the practice had completed IPC audits annually with evidence of it being completed in February 2025.

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

Most respondents to the HIW questionnaire said the practice was ‘very clean’ (20/21) with the remaining saying it was ‘fairly clean’. All who responded to the question, said they 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 patients in their notes and we were told patients were given information about medicines prescribed. However, we noted there were no signs displayed to remind patients to inform dentists of any changes to their medical history. We advised the practice manager to implement posters within surgeries.

We found the practice had a dedicated medical fridge and saw evidence of daily checks of the fridge temperature. The fridge temperature checking sheet described the actions to be taken should the recorded temperature be outside the acceptable temperature range. We noted that this information was not included in the drugs policy, and we advised that the service may wish to add it for completeness. The policy was amended on the day of the inspection.

We saw the practice had a medical emergency policy in place which has been reviewed by all staff. However, it was not practice specific and was not based on current national guidelines for resuscitation.

The registered manager must review the medical emergency policy to ensure it includes practice specific information and current national guidelines for resuscitation.

We looked at staff training records and found all staff members had up to date training in cardiopulmonary resuscitation (CPR), and three staff members had completed first aid training. 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 and the medical emergency bag was kept in an accessible place. However, only 3/20 staff members had completed BOC specific oxygen cylinder training. We also noted an oxygen cylinder policy was not in place.

The registered manager must ensure all staff complete BOC oxygen cylinder training.

The registered manager must implement an oxygen cylinder policy.

Safeguarding of children and adults
We saw evidence the practice had an up-to-date children and adults at risk safeguarding policy in place. We found the relevant external contact details for local safeguarding teams were present and a quick reference safeguarding flow chart was present. We were told all dentists and the practice manager had access to the Wales Safeguarding Procedures app on their mobile devices.

The practice had an appointed safeguarding lead who had safeguarding training to level three which is seen as good practice. All other staff within the practice had up to date safeguarding training to an appropriate level.

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.

The practice had a CEREC machine, and we saw evidence that the setting was registered with MHRA.

On the day of inspection, we viewed evidence of servicing documents for one of the two compressors which had been completed within the last year. We were informed the other compressor required parts following the servicing which was being completed the following day. Servicing documents were provided shortly following the inspection for the second compressor.

Documentation was in place to evidence the safe use of X-ray equipment and appropriate signage was available at each surgery. We saw local rules were available near to each X-ray machine within the surgeries; however, they were not on permanent display. We advised better placement due to the likelihood of them being misplaced. We found information regarding the risks and benefits of X-rays were available within the dedicated X-ray room; however, this information was not available within the surgeries.

The registered manager must make available information on the risks and benefits of X-rays in each place where an X-ray machine is in use.

We viewed evidence of three yearly routine examinations of the X-ray equipment. However, yearly servicing documentation was not available for any of the X-ray machines in the practice. The registered manager was told they could not use any of the X-ray machines until the testing had been completed. 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.

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 ten 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.

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 patients requiring urgent care were prioritised where possible.

Quality of Management and Leadership

Staff feedback

Staff who responded to the HIW questionnaire provided 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 there.

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 duty of candour, reception duties and new staff members. These were attended by all staff and meeting minutes were shared with team members who were unable to attend.

We saw evidence the practice manager updated policies and procedures on a routine basis. Staff members had access to these policies within the policy folder within the office.

Workforce

Skilled and enabled workforce
In addition to the practice manager, the team comprised of six dentists, two hygienists, six qualified nurses and five trainee nurses. We were told the practice have use of staff from other practices within the organisation if a staff shortage occurred. 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 employment and induction 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 five staff member records and found suitable evidence was in place for professional indemnity, GDC registration certificates, employment history and

disclosure and barring checks. However, we noted one staff member did not have evidence of immunity from Hepatitis B. This was resolved on the day of the inspection. Further information regarding this can be found in Appendix A.

We reviewed a sample of five 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 which could be monitored by management. Of those who responded to the questionnaire, staff said they felt they had appropriate training to undertake their roles, and all said they had fair and equal opportunities.

Culture

People engagement, feedback and learning
The practice had QR codes available within the waiting areas which allowed patients to leave a Google review and provide 'working feedback' which is linked to the dental software used in practice. Feedback questionnaires are sent digitally to patients via 'working feedback' at the examination appointment and at the end of treatment. We were told paper feedback forms are available, however they must be requested from reception.

We were told 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 displayed 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 at the reception desk in leaflet form; however, we would advise the practice manager to move the leaflets so that patients can take this information confidentially.

The policy included timescales for complaints, an escalation process if required and contact information for external bodies. We noted there were no contact details for Llais within the complaints policy. We advised the practice manager to add this information.

We were informed the area manager was responsible for complaints. However, there were differences between the complaints policy and the concerns leaflets on reception as to who the person responsible for complaints was.

The registered manager must update the complaints policy and leaflets to provide consistent information on who the complaints lead is within practice.

We saw evidence of a complaints folder where complaints were monitored for common themes. We were told verbal concerns were logged on the individual patient's file. We advised the practice manager to implement a written verbal concerns log to ensure it could be monitored for common themes.

We viewed a duty of candour guidance which outlined the 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 and had use of an online compliance system. A mixture of paper and digital records 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 were told clinical staff undertook open peer reviewing across multiple sites within the organisation. We saw audits for IPC, radiography, patient records, clinical waste and waiting times. However, we did not see audits for smoking cessation.

The registered manager must ensure that the practice undertakes a smoking cessation audit to help identify any gaps in current practice.

We were told audits were completed at regular intervals and outcomes were shared with staff. However, we noted the quality improvement policy required development.

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

Whole-systems approach

Partnership working and development

We were told the practice does not have an ongoing relationship with other primary care services; however, engagement takes place as and when required.

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
Evidence of Hepatitis B immunity was missing for one staff member.	The staff member could be at risk of contracting Hepatitis B and may not get the correct medical attention.	Raised to the practice manager.	A risk assessment was put in place for the staff member in the event they may be non-responsive

Appendix B – Immediate improvement plan

Service: Smart Smile Ebbw Vale

Date of inspection: 22 September 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.	Yearly servicing documentation was not available for any of the X-ray machines in the practice.	The registered manager must provide HIW with evidence of the electromechanical testing for all X-ray machines within the practice. The practice must not use the X-ray machines until evidence has been submitted.	Regulation 13(2)(a)	Alan Thorne Reliatec Ltd attended the practice on 24/09/2025 to service the xray equipment.	Leonard Smart	24/09/2025

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):	**Leonard Smart**
Job role:	**Registered Manager and Owner**
Date:	**25/09/2025**

Appendix C - Improvement plan

Service: Smart Smiles Ebbw Vale

Date of inspection: 22 September 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 found General Dental Council (GDC) registration numbers were not available and not all GDC registered staff names were listed.	The registered manager must display the names and GDC registration numbers of all GDC registered staff in a place easily seen by patients.	GDC Standards 6.6.10	This was already available in our practice leaflet and on our website, since inspection we have also implemented a staff poster which is now on display in our patient waiting area this includes gdc number, qualification and position at our practice for each member of staff.	Zoe James	Complete

2.	Of the three toilets available in the practice, only one had female sanitary disposal bins available.	The registered manager must ensure sanitary disposal bins are available within all toilets in the building.	The Private Dentistry (Wales) Regulations 2017 Regulation 22(2)(c)	Initial - Signed agreement on 03/11/25 waiting for new sanitary bins to arrive.	Zoe James	Complete
3.	We noted there was no process in place to review the fire risk assessment annually.	The registered manager must implement a process to ensure the fire risk assessment is reviewed annually.	The Private Dentistry (Wales) Regulations 2017 Regulation 22(4)(e)	This was already in my diary but I have now implemented an online database to remind me when all assessments and services are due.	Zoe James	Complete
4.	The medical emergency policy was not practice specific and was not based on current national guidelines for resuscitation.	The registered manager must review the medical emergency policy to ensure it includes practice specific information and current national guidelines for resuscitation.	The Private Dentistry (Wales) Regulations 2017 Regulation (8)(1)(q)	This have now been updated and provides the information on where the medical kit is kept in practice and who our registered first aiders are.	Zoe James	Complete
5.	3/20 staff members had completed BOC specific oxygen cylinder training. We also noted an oxygen cylinder policy was not in place.	The registered manager must ensure all staff complete BOC oxygen cylinder training.	The Private Dentistry (Wales) Regulations 2017 Regulation 17(3)(a)	All staff, including non registered staff have now completed the BOC oxygen cylinder training and certificates are in staff folders.	Zoe James to ensure all staff to complete	Complete

6.	We noted an oxygen cylinder policy was not in place.	The registered manager must implement an oxygen cylinder policy.	The Private Dentistry (Wales) Regulations 2017 Regulation (8)(1)(o)	Oxygen Cylinder Policy Complete and signed by all staff members on 20/10/25, added to policy folder.	Zoe James	Complete
7.	We found information regarding the risks and benefits of X-rays were available within the dedicated X-ray room; however, this information was not available within the surgeries.	The registered manager must make available information on the risks and benefits of X-rays in each place where an X-ray machine is in use.	The Private Dentistry (Wales) Regulations 2017 Regulation 9(a)	Available on day in OPT/Vista scan room and given to patients before exposure. These are now also placed in each surgery at all times and readily available before exposure.	Zoe James	Complete
8.	There were differences between the complaints policy and the concerns leaflets on reception as to who the person responsible for complaints was.	The registered manager must update the complaints policy and leaflets to provide consistent information on who the complaints lead is within practice.	The Private Dentistry (Wales) Regulations 2017 Regulation 21(1) GDC Standards 5.1.5	On the day of inspection the complaints leaflet had registered manager Leonard Smart as the complaints manager and the complaints procedure had Thomas Crooks as complaints manager, this was an error and updated all complaints	Zoe James	Complete

				information now clearly state that Thomas Crooks is our Complaints Manager		
9.	We did not see audits for smoking cessation.	The registered manager must ensure that the practice undertakes a smoking cessation audit to help identify any gaps in current practice.	The Private Dentistry (Wales) Regulations 2017 Regulation 16(1)	We are going to enrol on the smoking cessation audit.	Zoe James	To be enrolled by 28/11/25
10.	We noted the quality improvement policy required development	The registered manager must review their quality improvement policy to ensure it is fit for purpose.	The Private Dentistry (Wales) Regulations 2017 Regulation 8(1)(n)	This has now been updated and includes audits, team based reflection on how we can improve patients experience at practice.	Zoe James	Complete

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): **Leonard Smart**

Job role: **Registered Manager**

Date: **10/11/2025**