Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Dental Practice Inspection Report (Announced)

Deintyddfa Hapus Dental Practice, Cwm Taf Morgannwg 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.

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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 Deintyddfa Hapus Dental Practice, Cwm Taf Morgannwg University Health Board on 25 November 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. A total of 26 were completed. We also spoke to staff working at the service during our inspection. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Overall, patients provided positive feedback to the HIW questionnaire. All patients rated the service as very good or good. Staff were observed treating patients with dignity and respect, and patient feedback highlighted staff friendliness.

The practice provided clear information on treatment options, costs and emergency out of hours information. Bilingual information was provided, and translator services were available through Language Line.

Reasonable adjustments were in place to support patient access and appropriate confidentially processes were noted. We were told the rights of transgender patients were upheld, however there was no equality and diversity policy in place.

This is what we recommend the service can improve:

- Implement equality and diversity policy.

This is what the service did well:

- Timely appointment access
- Information available in Welsh language
- Our of hours information available for registered and non-registered patients.

Delivery of Safe and Effective Care

Overall summary:
We found the practice to be of an appropriate size and generally well maintained with clean clinician areas. However, we noted areas of discolouration on walls in staff areas.

A health and safety risk assessment was in place, however a process to review this annually needed to be implemented. We saw appropriate fire safety arrangements were in place with fire equipment being tested on a routine basis. However, we found the fire risk assessment required reviewing, as some sections were incomplete and control measures had not been specified.

We found appropriate infection prevention and control measures in place. Decontamination processes were effective, and evidence of regular testing and audits were in place. Regular checks were carried out on medical emergency

equipment. However, some items were missing which was resolved on the day of inspection.

Safeguarding policies were in place which were aligned with national guidance with local contacts available.

Clinical equipment was in good working order with appropriate maintenance in place. Patient records were kept appropriately; however, patient notes required some improvement.

This is what we recommend the service can improve:

- All staff to complete child safeguarding
- Ensure all required information are present in local rules
- Implement medical emergency policy
- Ensure patient records are complete and include all relevant information.

This is what the service did well:

- Appropriate storage facilities for staff possessions
- All staff were trained in first aid
- Suitable decontamination processes in place
- Clinical sessions were managed efficiently.

Quality of Management and Leadership

Overall summary:
The practice had a clear management structure in place with evidence seen of formal meetings taking place. Staff had access to updated policies, and appropriate staffing levels were being maintained.

Recruitment and induction processes were in place; however, some pre-employment checks had not been recorded.

Audits for clinical quality improvement were being routinely completed. Patient feedback was acted upon, and complaints were being managed through a clear process. However, some information needed to be added to the complaint's procedure.

This is what we recommend the service can improve:

- Review process for pre-employment checks
- Implement Duty of Candour policy and training
- Disability audit is required.

This is what the service did well:

- Policies were reviewed annually
- Clear management structure in place.

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 as 'very good' (25/26) or 'good' (1/26).

Patient comments included:

> *"All staff very friendly and helpful."*
>
> *"… treated as an individual and in a supportive manner."*
>
> *"Very pleasant staff"*

Person-centred

Health promotion and patient information
We saw a range of patient information available within the reception area. This included information on smoking cessation and oral health. The practice had a patient information leaflet available within the waiting area. A Statement of Purpose (SoP) was also available on the practice website. We found both documents contained the information required by the Private Dentistry (Wales) Regulations 2017.

Information on NHS and private treatment prices were displayed within the waiting room and within the patient information folder.

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 name and General Dental Council (GDC) registration numbers of all staff were displayed internally and externally in an area easily seen by patients.

The practice telephone number, opening hours and emergency out of hours information for registered and non-registered patients were displayed clearly

outside the practice. This information was also available within the patient information folder within the waiting area.

Dignified and respectful care
During the inspection we observed staff being friendly, polite 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 waiting area in English and Welsh.

The main reception desk was within the waiting room, and we were told staff would take confidential conversations on the phone in the room behind reception. Patients would be taken into one of the surgeries if they wanted a confidential conversation in person. There were solid doors to clinical areas and surgery doors were kept closed whilst treating patients. We saw a confidentiality agreement in place which had been reviewed by all staff.

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

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

Timely

Timely care
Patients could book examinations and emergency appointments through an online booking system. Patients could also book appointments by telephone or in person at reception. We heard the telephone lines working effectively on the day.

We were advised the current average waiting time between treatment appointments was one week. Where an appointment may be needed sooner, patients would be triaged, and appointments arranged as required. Patients are informed they can access emergency appointments by phoning the practice or booking an appointment online, and we were told they can usually be seen on the same day.

Staff working in the dental surgeries informed reception staff of any delays. We were told reception staff would then inform patients verbally in person or call the patient ahead of their appointment if they had not yet arrived. Respondents to the

HIW questionnaire said it was ‘very easy’ or ‘fairly easy’ to get an appointment when they needed one.

Equitable

Communication and language
We were told some of the staff at the practice spoke Welsh fluently and others were able to understand Welsh. We saw ‘Iaith Gwaith’ lanyards being worn by staff members to indicate they spoke Welsh. When asked, staff told us Welsh language training would be provided if requested.

We saw patient information such as the practice information leaflet, out of hours information and the complaints procedure were available in English and Welsh. We saw the registered manager had requested further information from the local health board to help further implement the ‘Active Offer’.

Staff described how it ensured information is accessible to all patients. Patient information was available in alternative formats, such as large print, on request. Patients whose first language is not English could access Language Line interpreter services when needed. Those without digital access received information by letter, and appointments were arranged by phone or in person at the practice.

Rights and equality
Staff told us preferred names and/or pronouns were recorded on patients records to ensure all patients were treated equally and with respect. We found there was no policy in place to promote equality and diversity. We advised the registered manager to implement a policy.

All respondents to the HIW questionnaire who responded to the question 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. There were two dental surgeries available on the ground floor and a portable ramp was available if required at the front entrance. We were told spare glasses were available to help patients who needed them and a hearing loop was available at the reception desk.

Delivery of Safe and Effective Care

Safe

Risk management
We saw external and most internal areas of the practice were visibly clean and tidy with no obvious hazards. However, we noted an area of discolouration on a wall within the staff toilet area and staff kitchen area. The appearance of this discolouration may indicate a potential issue with dampness or water ingress, which potentially could be a risk to staff.

The registered manager must ensure staff areas of the practice are well maintained and kept in a good state of repair.

There was one waiting area available which was of an appropriate size for the setting with a separate area available for children. A staff room was available for lunch breaks, and we were told staff used this area as changing facilities. We saw adequate storage facilities for staff to store possessions safely. Two staff toilets were available on the first floor which could also be used as changing facilities and there was a toilet available on the ground floor for patients.

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

We saw a health and safety policy in place as well as a health and safety risk assessment. However, the health and safety risk assessment had been implemented in 2021 and had not been reviewed yearly. We were assured by the registered manager the premises had not changed since the risk assessment was carried about and the document was reviewed on the day of the inspection. We also noted there was no policy in place to identify, manage and assess risks and there was no building maintenance policy in place.

The registered manager must implement a process to ensure the health and safety risk assessment is reviewed yearly.

The registered manager must implement a policy for identifying, assessing and managing risks.

The registered manager must implement a buildings maintenance policy.

We saw the health and safety executive poster was displayed in the staff room.

We saw evidence of gas safety records, five yearly fixed electrical wire testing 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 checks undertaken on fire equipment. We saw evidence that all staff had up to date fire safety training certificates available.

We reviewed the fire risk assessment and found it had been reviewed yearly. However, we noted that some sections within the document were left unanswered, and in cases where responses required control measures, these had not been completed.

The registered manager must ensure a full fire risk assessment is undertaken by a competent person.

Infection, prevention and control (IPC) and decontamination
We found an appropriate infection control policy 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. We were informed there was appropriate Occupational Health support available to staff if required.

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 internal audits being completed in August 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).

All respondents to the HIW questionnaire said the practice was 'very 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 verbal 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 dental surgeries.

We found the practice had medical emergency flow charts available; however, there was no dedicated medical emergency policy in place.

The registered manager must implement a medical emergency policy and ensure it includes practice specific information and meets current national guidelines for resuscitation.

We reviewed staff training records and found all staff members had up to date training in cardiopulmonary resuscitation (CPR), and all staff members had completed first aid training. We saw a first aid kit available with all items in place and in date.

We saw evidence of regular checks being carried out on all emergency equipment and the medical emergency equipment was kept in an accessible place. However, we noted that not all items recommended by the Resuscitation Council UK were included. Issues identified were the following:

- Glucagon was not available
- Some items were not in the original packaging and therefore had no expiry date available
- Size 0, 3 and 4 face masks were not present
- Child defibrillator pads were not available.

These issues were raised with the registered manager on the day of the inspection and was resolved on the day. Further information regarding this can be found in Appendix A.

However, We noted staff had not completed BOC specific oxygen cylinder training, and 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 safeguarding policy in place which included flow charts outlining the process for staff to follow. This was in line with the Wales Safeguarding Procedures (WSP) and included the relevant safeguarding contact details for local safeguarding teams. The practice has an appointed safeguarding lead and staff were aware of the support available to them in the event of a safeguarding concern.

We reviewed safeguarding training records and found all staff had completed safeguarding adults training to the appropriate level, and all but one had completed safeguarding children training to the appropriate level.

The registered manager must ensure all staff have completed safeguarding training to the 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.

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. 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, we noted the local rules needed updating to include up to date guidance on grading of X-rays, information on a quality assurance programme and guidance for the exposure of carers and comforters.

The registered manager must update the local rules to ensure all information is correct and in line with current guidance.

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 policy in place.

We reviewed a sample of ten patient records. Each patient had identifiers, medical history updated at each visit, language preference and oral hygiene and diet advice. However, we found the following areas that could be improved:

- Reason for attendance was not routinely recorded
- Baseline Basic Periodontal Examination (BPE) was missing for 2/7 patients
- Treatment options required more detail
- Risk assessments were not available for 4/10 patients
- No consent was recorded for X-rays.

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

Efficient

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

Quality of Management and Leadership

Leadership

Governance and leadership
We found a clear management structure in place to support the running of the practice. We saw evidence the practice held formal team meetings every six months and noted suitable discussions around surgery checklists, decontamination and Continuing Professional Development (CPD). As they operate with a small team, additional informal meetings were arranged on an ad-hoc basis when needed. Staff shared that this flexible approach worked well for them and supported effective communication without the need for frequent formal meetings.

We saw staff had access to policies within a dedicated staff handbook folder. We were told they were updated annually and saw evidence of staff reviewing policies annually.

Workforce

Skilled and enabled workforce
The team comprised of two dentists, one therapist and three qualified nurses. We found an appropriate system in place to ensure a suitable number of staff were working at any time. We were told the practice rarely used agency staff, with the last instance being over a year ago.

We saw a suitable and up to date recruitment policy in place. We were told any new staff members were required to complete an induction process and are supervised by qualified staff members. 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, Disclosure and Barring Service checks and employment contracts. However, we noted the following that required improvement:

- Two staff members did not have blood results following Hepatitis B vaccination available
- None of the staff members had their previous employment history present
- None of the staff members had references available.

We were informed by the registered manager that references were gained verbally, however this was not documented.

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

We reviewed a sample of five staff training records and found all staff members had up to date certification in place for most mandatory training. As mentioned earlier in the report, one staff member did not have certification for safeguarding children training. We also found two staff members were booked onto a course for Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) training.

We were told inhouse training for some mandatory training courses was arranged by the practice.

Culture

People engagement, feedback and learning
The practice had a feedback box available within the waiting area for patients to provide feedback. We were informed patients could also provide feedback verbally in person or via Google reviews. We were told staff act on feedback when it is received. The registered manager discussed that chairs within the waiting room were changed, and the spittoon was reintroduced into the surgeries following patient feedback. We noted there was no information displayed to patients on how the practice has learned and improved based on feedback received.

We found the practice had an appropriate complaints policy in place. This was displayed within the waiting area and was available within the patient information folder. The policy included timescale for complaints, an escalation process if required and contact information for external bodies such as HIW. However, we found the timescales stated within the document was not in line with 'Putting Thing Right' information and the address for HIW was missing. We also advised the registered manager to include Llais within this document.

The registered manager must update the complaints policy and procedure to include the address of Healthcare Inspectorate Wales, Llais information and ensure timescales are in line with Putting Things Right.

We were informed the registered manager was responsible for handling complaints. If the complaint was regarding the registered manager, another clinician would take responsibility. We saw evidence of a complaints log which was reviewed regularly to identify common themes.

We found there was no policy or guidance in place for Duty of Candour, and we were told staff had not completed Duty of Candour training. We saw evidence that the registered manager had asked for this training and further information regarding Duty of Candour within the past month but had not received a response.

The registered manager must implement a Duty of Candour policy or guidance.

The registered manager must ensure staff have completed Duty of Candour training.

Information

Information governance and digital technology

The practice used an electronic system to manage patient records. A paper system was in place for staff records and all policies and procedures. We were told all accidents or incidents were reported to the registered manager who would deal with them appropriately, and information was shared with staff members in team meetings.

Learning, improvement and research

Quality improvement activities

We were told clinical staff undertook peer reviewing within the practice. We noted a policy in place for quality improvement activities. We saw appropriate audits in place such as antibiotic prescribing, record keeping, smoking cessation and WHTM 01-05. We were told audits were completed at regular intervals and outcomes were shared with staff.

Whole-systems approach

Partnership working and development

We were told the practice maintained 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 inspected the equipment in place to deal with a medical emergency and found the following: • Glucagon was not available • Some items were not in the original packaging and therefore had no expiry date available • Size 0, 3 and 4 face masks were not present • Child defibrillator pads were not available.	Individuals who experienced a medical emergency may not be given the required treatment leading to further complications.	Immediately raised to the registered manager.	The registered manager ordered all items required on the day of the inspection with confirmation sent to HIW.

Appendix B – Immediate improvement plan

Service: Deintyddfa Hapus Dental Practice

Date of inspection: 25 November 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.	There was no non-compliance issued noted.					

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: Deintyddfa Hapus Dental Practice

Date of inspection: 25 November 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 an area of discolouration on a wall within the staff toilet area and staff kitchen area.	The registered manager must ensure staff areas of the practice are maintained and in a good state of repair.	The Private Dentistry (Wales Regulation 22 (2)(b)	To be reviewed and painted	Lowri Leeke	6 months
2.	The health and safety risk assessment had been implemented in 2021 and had not been reviewed yearly.	The registered manager must implement a process to ensure the health and safety risk assessment is reviewed yearly.	The Private Dentistry (Wales) Regulations 16(1)(b)	Already reviewed. Process in place for annual reviews.	Lowri Leeke	Already completed
3.	We noted there was no policy in place to identify, manage and assess risks.	The registered manager must implement a policy for	The Private Dentistry (Wales) Regulations 8(1)(e)	Policy to be written	Lowri Leeke	1 month

		identifying, assessing and managing risks.				
4.	We noted there was no building maintenance policy in place.	The registered manager must implement a buildings maintenance policy.	The Private Dentistry (Wales) Regulations 8(1)(c)(d)	Policy to be written	Lowri Leeke	Already completed
5.	We found the fire risk assessment was not fully completed and lacking some information.	The registered manager must ensure a fire risk assessment is undertaken by a competent person and ensure the documents is fully completed.	The Private Dentistry (Wales) Regulations 22(4)(f)	Already completed	Lowri Leeke	Already completed
6.	There was no dedicated medical emergency policy in place.	The registered manager must implement a medical emergency policy and ensure it includes practice specific information and current national guidelines for resuscitation.	The Private Dentistry (Wales) Regulations 8(1)(q)	Already completed	Lowri Leeke	Already completed
7.	We noted staff had not completed BOC specific oxygen cylinder training.	The registered manager must ensure all staff complete BOC	The Private Dentistry (Wales) Regulations 17(3)(a)	To do online training	Lowri Leeke	3 months

		oxygen cylinder training.				
8.	We noted an oxygen cylinder policy was not in place.	The registered manager must implement an oxygen cylinder policy.	The Private Dentistry (Wales) Regulations 8(1)(o)	To be written	Lowri Leeke	1 month
9.	One staff member had not completed safeguarding children training to the appropriate level.	The registered manager must ensure all staff have completed safeguarding training to the appropriate level.	The Private Dentistry (Wales) Regulations 17 (1)(a)	Certificate of course completion sent to HIW	Lowri Leeke	Already completed
10.	We noted the local rules needed updating to include up to date guidance on grading of X-rays, information on a quality assurance programme and guidance for the exposure of carers and comforters.	The registered manager must update the local rules and ensure all information is in line with current guidance.	The Ionising Radiation Regulations 2017 18	To be updated	Lowri Leeke	1 month
11.	We found improvements were needed within patient	The registered manager must ensure that patient records	The Private Dentistry (Wales)	To do new clinical record audit	Lowri Leeke	3 months

	records in documenting reasons for attendance, baseline BPE, detailed treatment options, risk assessments, and consent for X-rays.	are complete and include all relevant information in line with professional standards and guidance.	Regulations 20(1)(a)			
12.	We noted some essential pre-employment checks were missing from staff records.	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 18(3)	Applicable when next employed a new staff member	Lowri Leeke	No timescale as no new staff needed at present
13.	We found the timescales stated within the complaints document was not in line with 'Putting Thing Right' information and the address for HIW was missing. We also advised the registered manager to include Llais within this document.	The registered manager must update the complaints policy and procedure to include the address of Healthcare Inspectorate Wales, Llais information and ensure timescales are in line with Putting Things Right.	The Private Dentistry (Wales) Regulations 21 (4)	To be updated	Lowri Leeke	1 month

14.	We found there was no policy or guidance in place for Duty of Candour.	The registered manager must implement a Duty of Candour policy or guidance.	The Duty of Candour Procedure (Wales) Regulations 2023 8	To be written	Lowri Leeke	1 month
15.	We were told staff had not completed Duty of Candour training.	The registered manager must ensure staff have completed Duty of Candour training.	The Duty of Candour Procedure (Wales) Regulations 2023 8	Already attempted to contact the LHB regarding training (inspectors were shown evidence of this – no response from LHB re training)	Lowri Leeke	Already attempted to access training (evidence was shown to inspectors on the day)

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): **Lowri Leeke**

Job role: **Principal Dentist**

Date: **09/01/2026**