Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Dental Practice Inspection Report (Announced Focused Inspection)

Pembroke Dock Dental Care, Hywel Dda 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 focused inspection of Pembroke Dock Dental Care, Hywel Dda University Health Board on 25 November 2025.

The inspection was arranged following a separate inspection of a practice where we found significant patient safety concerns. This separate practice was owned and operated by the same responsible individual and staffed by the same employees. Both settings voluntarily suspended their registration on 13 November 2025 and notice of this inspection was sent to the setting on 19 November 2025.

Our team for the inspection comprised of a HIW healthcare inspector and a dental peer reviewer. The inspection focused on the delivery of safe and effective care and quality of management and leadership.

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

2. Summary of inspection

Designation as Service of Concern

Healthcare Inspectorate Wales (HIW) conducted an announced inspection of Huw Jones Dental practice on 12 November 2025 which found several regulatory breaches. Following this inspection, HIW issued Huw Jones Dental practice with a Non-Compliance Notice (NCN) and the responsible individual for the setting agreed to voluntarily suspend their registration on 13 November 2025.

The registered manager and the responsible individual at Huw Jones Dental practice is also the owner of Pembroke Dock Dental Care. Due to the issues identified at Huw Jones Dental, HIW was concerned that the care being provided at Pembroke Dock Dental Care may also not meet the appropriate standard expected. As such, the service agreed to voluntary suspend their registration at Pembroke Dock Dental Care on 13 November 2025, until such time as HIW could be assured it was safe for patients by means of inspection.

HIW informed Pembroke Dock Dental Care on 19 November 2025 that we would be conducting an announced inspection at Pembroke Dock Dental Care on 25 November 2025. During this inspection, we found similar regulatory breaches, among others, which resulted in the issue of a Non-Compliance Notice (NCN) to Pembroke Dock Dental Care.

Due to the number of issues identified at both practices, HIW determined both Huw Jones Dental practice and Pembroke Dock Dental Care were Services of Concern, and their registrations were suspended for one month on 27 November 2025.

Following significant improvements and satisfactory resolution of HIW's immediate concerns, the registration for both settings were reinstated on 22 December 2025. Both practices were also no longer deemed to be services of concern on this date.

Delivery of Safe and Effective Care

Overall summary:
HIW found serious lapses in the safety procedures at Pembroke Dock Dental Care, especially those pertaining to fire safety, decontamination and health and safety. HIW could not be assured the service being provided was safe for patients nor were these matters which could be readily addressed during our inspection.

We saw little to no precautions being taken for the prevention and detection of fire, decontamination procedures which did not meet the expected standards and improper arrangements for the safe use of radiographic equipment. In addition, we were not assured medicines and prescription forms were being managed in a proper manner and patient records were not to the expected standard.

Immediate assurances:

- No fire drills were documented as taking place
- A fire risk assessment from 2023 outlined several safety improvements which had not been actioned
- Safeguarding procedures were incomplete or incorrect
- Expert advice had not been sought regarding the practice radiographic equipment, meaning patients had potentially been over exposed to radiation
- Daily testing of the practice autoclave ceased in July 2025
- Staff did not appear confident with relevant disposal arrangements for hazardous waste
- Improper arrangements were in place for the drying of hands pre and post the decontamination of equipment
- Prescriptions were being held for patients who did not require them and a pre-signed prescription form was found
- Patient records omitted several key pieces of information.

Quality of Management and Leadership

While the focus of this inspection was mainly that of safe and effective care, we also explored some aspects of the leadership, governance and quality improvement at this practice. Following the inspection at Huw Jones Dental and on this inspection, we found that lapses in effective management meaning the settings were unable to maintain regulatory compliance, managers were not managing risks appropriately nor was a robust regime of quality improvement being implemented.

Immediate assurances:

- We found there was a lack of governance in place to ensure the setting maintained regulatory compliance. In addition, we found the risks relating to the health, safety and welfare of people were not being properly identified, assessed and managed.

3. What we found

Delivery of Safe and Effective Care

Safe

Risk management
The practice was set over the ground floor of a two-storey building with a communal corridor joining the practice to the domestic property on the first floor. There were stairs leading from street level to the front door of the practice; therefore, access was restricted for those with limited mobility. The reception and waiting area were joined, providing appropriate space for the one surgery in use and for the number and flow of patients.

The building appeared to be in a suitable state of repair internally and externally. However, we noted the rear door of the setting to an enclosed yard appeared damp. We also found damp ingress in the cupboard in which the practice compressor was stored. The door to this storage cupboard appeared damaged or eroded at its base. Having areas of damp around clinical equipment and in surgeries increases the risk of spreading infections and makes areas difficult to decontaminate effectively.

The registered manager must ensure all areas of the practice are maintained to an appropriate standard.

The temperature, ventilation and tidiness of the practice all appeared to be satisfactory. The patient and staff toilets were suitable, and we were told staff changed in these areas.

During our inspection, we requested copies of the practice health and safety risk assessment. We were informed an assessor had attended the practice on 23 November 2025. However, no written assessment was available. The previous risk assessment had been conducted on 19 September 2023, valid for one year, which was therefore out of date. The November 2025 risk assessment was sent to HIW immediately following the inspection.

We did not see evidence of policies in place to ensure the premises were fit for purpose nor for identifying, assessing and managing risks. These were matters we observed during our previous inspection at the practice in October 2018, and it is disappointing to note that no action appears to have been taken by the setting. In addition to these omissions, the practice health and safety policy was missing

information such as the location of the practice defibrillator and appeared to be non-specific to this practice. Not having policies available or having in-complete policies risked staff being unable to deal with health and safety matters promptly and effectively.

The registered manager must ensure:

- **All required written policies are available at the setting in line with regulations**
- **All policies are specific for the setting and are comprehensively updated.**

The practice business continuity plan was up to date and comprehensively outlined the responsibilities of the practice in the event of business disruption. Electrical safety certificates were available for portable appliances and fixed wiring. We also noted the practice Employer Liability Insurance certificate and Health and Safety Executive poster were both on display.

On review of the fire safety measures in place at the practice we observed areas which required improvement. The records of fire drills and fire equipment testing ended in 2023. No evidence was presented to us that testing or drills had been completed since that time.

We noted the fire risk assessment was dated as completed on 19 September 2023, with an expiry noted as 19 September 2024. We did not see that this risk assessment had been reviewed since that time. The risk assessment noted the following items which required improvement:

- The practice should ensure the fire alarm system is inspected annually and tested weekly with a time frame for completion of six months
- A fire drill should take place as soon as possible
- A fire logbook should be kept and be made available whenever requested
- Install emergency lighting within six months.

The report also noted how the smoke detector in the practice reception area did not sound when activated during testing. We were presented with no evidence during our inspection that the matters outlined above from the fire risk assessment had been addressed.

It was noted during the inspection that a fire risk assessor had attended the practice on 23 November 2025, and the report was issued to HIW shortly after the inspection. However, having insufficient systems in place to monitor fire precautions increases the risk to the safety of staff and patients in the event of a fire.

Due to the increased risk of harm these matters posed to staff and patients, this matter formed part of the Non-Compliance Notice issued to the practice. The details of the actions taken by HIW and the setting are outlined in Appendix B.

We saw the practice fire extinguishers had all been recently serviced, fire safety signage was in place and fire exits were clearly signposted.

Infection, prevention and control (IPC) and decontamination
We found personal protective equipment (PPE) was available for staff and we saw staff had received appropriate training in following best practice for use of PPE. We observed the clinical areas to be in generally a good state of repair to enable effective decontamination. However, we noted the boxing of pipes and cables supplying the dental chairs did lack sealing which could make the cleaning of the floor difficult.

The registered manager must ensure all areas of the practice can be effectively cleaned.

Appropriate occupational health arrangements were in place for staff, and the practice sharps protocol was on display in the decontamination room. We heard how the practice was not currently using safety plus syringes but that these had been recently purchased with the view of operationalising their use. We did not see a current risk assessment in place to reduce the risk of needlestick injuries.

The registered manager must ensure all appropriate measures are in place to mitigate and record the risk of needlestick injuries.

Within the designated practice decontamination room, we saw a currently un-used washer-disinfector which was awaiting spare parts for a repair. The room was set up correctly to allow for a natural flow of equipment from the dirty to clean areas, enabling instruments to be decontaminated in a sterile environment. However, we found areas for improvement in the decontamination process which did not meet the expected standard of the Welsh Health Technical Memorandum 01-05:

- We noted that the manual cleaning of dental instruments was being undertaken using a product that is not designed for dental instrument decontamination.
- The ultrasonic cleaner being used at the practice was not a validated medical-grade ultrasonic cleaner designed for dental instruments. In addition, we were provided with no evidence that this machine had been tested nor calibrated. The cleaning solution used in this ultrasonic cleaner did not appear suitable for its purpose

- We were not provided with maintenance certificates for the practice autoclave machine, and we noted daily testing of the machine had not taken place since July 2025. Cycle records were also unable to be downloaded / printed off due to faulty equipment. In addition, we did not see any evidence these documents had ever been downloaded / printed for review
- The hand hygiene sink in the decontamination room did not have a paper towel holder. Therefore, when staff went to dry their hands at the start / end of a decontamination process they picked a paper towel from a stack on the worktop. This meant that water from their hands soiled the towels left on the stack. The principal dentist attempted to install a dispenser on the day of our inspection, but this was not fit for purpose.

Due to the potential risk of harm to patients, these matters formed a part of the Non-Compliance Notice issued to the practice. The details of the actions taken by HIW and the setting are outlined in Appendix B.

During our inspection, we requested a copy of the practice waste disposal contract. However, this could not be provided. In discussion with staff regarding the means of disposing patient teeth and, especially, amalgam waste, we were informed these were kept in a storage cupboard. When we asked to see the items, staff were unable to locate these items in a timely manner. We could not establish whether amalgam waste was included on the practice waste disposal contract as a copy could not be provided. We could not be assured that amalgam waste was being handled appropriately and risked potential harm coming to a patient, staff or the environment. These matters formed a part of the Non-Compliance Notice issued to the practice. The details of the actions taken by HIW and the setting are outlined in Appendix B.

Medicines management

We found the fridge designated for the storage of medicines was appropriate, had a temperature check log in place and staff had a suitable system in place to respond to temperature concerns.

During our inspection, we reviewed the arrangements in place for the safe storage, handling and disposal of medicines. While reviewing the box file being used to store patient prescriptions, we found approximately 10 prescriptions which had been made out to patients. We were told these patients had either refused them or were already being prescribed the medications so could not take them. The box was disorganised and had no clear system for recording any prescriptions being made nor stored. We were provided with no evidence as to why unused prescriptions were being kept and why these had not been disposed of securely. Within this box file we also located a pre-signed and populated NHS prescription

form made out for Amoxicillin. The form had no patient name nor date. This meant any person could use this form to prescribe Amoxicillin without oversight from a medical practitioner. Blank named and dated prescription forms must not be pre-signed under any circumstances as these could lead to improper use.

Private prescriptions were fulfilled by the surgery using their own stock of medicines. However, we saw no evidence of a stock control system in place for these medicines, nor of any records being kept for dispensing and disposal.

Due to the risk posed by the potential mismanagement of medicines and prescription forms which were open to misuse, these matters formed a part of the Non-Compliance Notice issued to the practice. The details of the actions taken by HIW and the setting are outlined in Appendix B.

We found appropriate measures in place to ensure medical emergencies were safely and effectively managed. Staff records evidenced satisfactory qualifications in cardiopulmonary resuscitation for all staff and there was one first aider. Oxygen cylinders were appropriately serviced, and staff had been trained in their use. On inspection of the emergency equipment, we found all items were present, easily accessible and within their expiry dates. We noted routine checks took place on all emergency equipment. Medicines used in the event of an emergency were within their expiry dates and stored appropriately. However, we were told expired emergency medicines were disposed of at a local pharmacy without a receipt; this included the controlled drug, Midazolam.

The registered manager must maintain a robust audit trail for the disposal of controlled drugs.

Safeguarding of children and adults

On review of the safeguarding arrangements in place at this setting, we could not be assured the practice was discharging their safeguarding responsibilities appropriately. We found the emergency contact telephone numbers for social services listed in the policy did not connect and there were no contact details in the safeguarding flowchart for staff to follow in the event of identifying a concern. The Wales Safeguarding procedures were also not readily available, and it appeared the policy had not been reviewed since 28 February 2021. Following the practice procedures would ultimately delay staff being able to report any concerns.

Due to the issues outlined above and the increased risk these posed to any vulnerable adult or child needing referral, this matter formed a part of the Non-Compliance Notice issued to the practice. The details of the actions taken by HIW and the setting are outlined in Appendix B.

From the sample of staff records we reviewed, we found all staff at the practice were trained to a suitable level in adult and child safeguarding.

Management of medical devices and equipment
We found the medical devices and clinical equipment available at the practice were in good condition. We saw the staff at the setting were all trained in the effective use of this equipment and all devices we inspected appeared to be disinfected appropriately.

On review of documentation for the practice radiographic equipment and patient records we observed the following areas which required improvement:

- There was limited engagement between the Radiation Protection Advisor (RPA) and the Radiation Protection Supervisor (RPS)
- We noted skin dose levels for patients were reported as being too high in the critical exam report for one radiograph machine and which should have been formally explored with the RPA by the RPS. We were told this happened over the telephone, but no documentary evidence was presented of this consultation
- Calibration for the screen used to inspect radiographs had not taken place
- Dose meters had not been used to measure the radiation exposures to staff from the records we reviewed
- Clinical evaluation and grading of exposures were inconsistent or infrequent with no evidence presented of a robust quality assurance programme being in place for radiograph imaging.

We did not see evidence of a programme for the review of the local rules nor the arrangements for reporting incidents. In addition, we did not see a copy of the radiation risk assessment nor the programme of review of this assessment.

Failure to maintain radiographic equipment, safety documentation and not having a robust quality assurance programme in place could pose a significant risk of harm to patients or staff.

The registered manager must:

- **Ensure robust procedures are in place to effectively manage radiographic treatments to meet regulatory requirements**
- **Provide a copy of the practice radiation risk assessment to HIW.**

As outlined above, HIW determined there was a potential risk of harm to patients or staff by inappropriately managed radiographic equipment. As such, some of these concerns outlined above formed a part of the Non-Compliance Notice issued

to the setting. The details of the actions taken by HIW and the setting are outlined in Appendix B.

Effective

Effective care

Overall, we saw evidence treatments were being provided according to clinical need, and in accordance with professional, regulatory and statutory guidance. However, some patient records were missing relevant information which meant we could not be assured that this was always the case. In addition, some of the issues identified throughout this report brought about concerns with regards to staff understanding of the need to be aware of and to seek relevant professional advice, including radiographic treatments. In line with our memorandum of understanding, HIW brought our concerns regarding clinical practice at this setting and Huw Jones dental practice to the attention of the General Dental Council (GDC).

We saw appropriate use of clinical checklists to prevent wrong tooth site extractions on the wall in the surgery.

Patient records

We reviewed a sample of four patient records during our inspection and saw they were being held in line with the General Data Protection Regulations. The records we reviewed did not provide sufficient assurance that the records of patients were being comprehensively completed. Our concerns in this regard were as follows:

- Three records did not have the patient previous detail history available
- We did not see smoking cessation advice offered to any of the applicable patients
- One record did not note oral hygiene and diet recorded nor any advice provided
- Two records did not have their initial medical history signed and dated by the patient and dentist; one record did not have these updated at each course of treatment
- Two records did not have a basic periodontal examination recorded, any notes on soft tissue examinations
- None of the records we reviewed contained information on any extra or intra oral checks taking place
- None of the applicable records we reviewed had oral cancer checks noted
- None of the records we reviewed had evidence of treatment planning
- None of the patient records we reviewed included evidence of informed consent
- Two records did not include risk assessments based on cavities, perio, tooth wear and oral cancer

- Radiographic records for all patients were difficult to follow, and some records were missing information, such as clinical findings and quality grading.

Omissions from patient records occur on occasion. However, our review at this practice suggested significant gaps in documentation and clinical practice. Patient records are designed to formally record symptoms, medical history, treatments and other checks completed on a patient. Not capturing this information can compromise safe and effective care, continuity of care, regulatory compliance and raises legal and ethical concerns. The quality of patient records formed a part of the Non-Compliance Notice issued to this setting. The details of the actions taken by HIW and the setting are outlined in Appendix B.

Efficient

Efficient

We found clinicians were committed to delivering as efficient a service as possible that met the needs of their patients within suitable premises. However, as outlined elsewhere in this report, we were not assured this service was being delivered as effectively as it should.

Quality of Management and Leadership

Leadership

Governance and leadership
During our inspection of this setting and its sister practice of Huw Jones dental practice, HIW could not be assured that robust governance and management arrangements were in place.

As is outlined elsewhere in this report, we found several urgent safety concerns which effective and proactive governance arrangements would have identified. Our concerns in relation to the management of this setting formed a part of the Non-Compliance Notice issued to the setting. The details of the actions taken by HIW and the setting are outlined in Appendix B.

We found that practice policies were inconsistently updated or had not been reviewed within expected time frames. In addition, some policies and compliance documents were not available or did not exist. Therefore, we could not be assured that practice management had the correct policies and procedures in place to effectively run this practice nor the correct compliance documentation.

The registered manager must:

- **Conduct a thorough review of all current policies and procedures**
- **Ensure all policies and procedures are comprehensive, accurate and comprehensively reviewed annually**
- **Ensure all compliance documents are suitably stored and easily locatable.**

Learning, improvement and research

Quality improvement activities
We saw audits had taken place on smoking cessation and decontamination procedures. However, we did not see audits available covering patient records, radiographic quality, antibiotic prescribing nor healthcare waste. In addition, we did not see evidence of peer review having taken place since before 2020.

Some of the areas for improvement highlighted elsewhere in this report could have been noted earlier and action been taken sooner had audits been taking place to improve the service for patients.

The registered manager must ensure all mandatory quality improvement activities take place to drive continuous improvements.

4. Next steps

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

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

The improvement plans should:

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were able to be resolved on the day.			

Appendix B - Immediate improvement plan

Service: Pembroke Dock Dental Care

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.	The practice fire risk assessment was dated as completed on 19 September 2023, with an expiry noted as 19 September 2024. We did not see that this risk assessment had been reviewed since that time. In addition, the risk assessment noted the following items which required improvement: • The practice should ensure the fire alarm	Evidence must be submitted to HIW of an up-to-date fire risk assessment and the practice responses to the actions identified in previous and current risk assessments.	Regulation 22 of the Private Dentistry (Wales) Regulation 2017	Updated fire risk assessment carried out. Reports and certificate sent to HIW.	Diboneng Mothibi	Risk assessment completed Actions being carried out by qualified electrician by 8th December

	system is inspected annually and tested weekly with a time frame for completion of six months • A fire drill should take place as soon as possible • A fire logbook should be kept and be made available whenever requested • Install emergency lighting within six months. The report also noted how the smoke detector in the practice reception area did not sound when activated during testing. We were presented with no evidence that the matters outlined above from the fire risk					

	assessment had been addressed.					
2.	We did not find evidence of routine fire drills taking place, nor regular testing of the fire detection equipment / call points.	Fire drills and alarm testing must commence without delay.	Regulation 22 of the Private Dentistry (Wales) Regulation 2017	Fire drills and alarm testing carried out 27th November at local level with whole team present.	Diboneng Mothibi	Completed Fire training date 8th December for all staff
3.	We reviewed the practice safeguarding policy and saw the out of hours contact telephone number for social services was incorrect. The Wales Safeguarding Procedures were also not readily available. In addition, this policy was appended by a safeguarding flowchart which did not contain any contact details. We saw no evidence that a review of this policy had taken place since 2023.	The practice safeguarding policy must be updated to ensure accuracy and compliance with current Wales Safeguarding Procedures. The policy, and the appended safeguarding flowchart must include the correct contact details for social services and provide staff with clear, accessible guidance.	Regulation 14 of the Private Dentistry (Wales) Regulations 2017	Safeguarding policy updated with accurate and up to date contact details and flowchart.	Diboneng Mothibi	Completed

	Following the procedures in this flowchart could lead staff to contact the incorrect partners involved in the safeguarding process, ultimately delaying the reports of any concerns.					
4.	On review of the radiation protection documentation, we found limited or no evidence of engagement with a suitable medical physics expert. On discussion regarding a radiograph machine in an unused surgery, we were advised by the principal clinician that this machine was not being used. The critical examination report outlined that the equipment was able to be used but only after the matters outlined on the	Documentary evidence must be provided of the expert advice sought with regards to radiograph exposure levels or arrangements made to decommission the machine.	Regulation 13 (2) of the Private Dentistry (Wales) Regulations 2017	RPS site inspection booked	Diboneng Mothibi	4th December

	page overleaf had been addressed. The critical exam report then went on to outline that skin dosages for patients were too high and these needed to be addressed. The principal dentist informed us they had spoken to the radiation protection advisor over the telephone to discuss the dosage limits. However, no documented evidence was provided to HIW that this expert advice on the reduction of patient doses had been implemented.					
5.	We saw no evidence of daily autoclave testing having taken place since July 2025. In addition, the autoclave test read-out would not load on the day of our inspection, and no	Daily autoclave testing must recommence, and evidence provided of testing read-out reviews taking place.	Regulation 13 (5) of the Private Dentistry (Wales) Regulations 2017	Daily testing resumed immediately. Memory stick retrieved for autoclave log.	Decontamination lead	Completed

	print-out reports were available.					
6.	On request for the means of disposing patient teeth and, especially, amalgam waste, we were informed these were kept in a storage cupboard. When we asked to see the items, staff were unable to locate these items in a timely manner. We could not establish whether amalgam waste was included on the practice waste disposal contract as a copy could not be provided.	A copy of the practice waste disposal contract must be provided to HIW.	Regulation 13 of the Private Dentistry (Wales) Regulations 2017	Waste disposal contract attached.	Diboneng Mothibi	Completed
7.	Within the decontamination room, we saw a pile of paper hand towels being used as part of the hand washing procedure. However, these towels were not	Evidence must be provided to HIW of effective equipment being put in place for hand drying in the decontamination room.	Regulation 13 of the Private Dentistry (Wales) Regulations 2017	Hand towel dispenser purchased and in place for hand drying in decontamination room.	Decontamination lead	Completed

	being stored in a holder, and any time one paper towel was taken, the one underneath could become soiled or contaminated. Action was taken by the practice during the inspection by installing a device to store the hand towels, but we believed this device to be a glove holder and not suitable for towels.					
8.	Within the prescriptions box file we located a pre-signed and populated NHS prescription form made out for Amoxicillin. The form had no patient name nor date. This meant any person could use this form to prescribe Amoxicillin without oversight from a medical practitioner.	Any pre-filled prescription forms must be immediately and securely disposed of.	Regulation 13 (4) of The Private Dentistry (Wales) Regulations 2017	Actioned with immediate effect	Diboneng Mothibi	Completed

9.	On inspection of a box file being used to store patient prescriptions, we found approximately 10 prescriptions which had been made out to patients. We were told these patients either did not want them or were already being prescribed the medications so could not take them. The box was disorganised and had no clear system for recording any prescriptions being made nor stored. We were provided with no evidence as to why unused prescriptions were being kept and not disposed of securely.	A robust system for the effective management and disposal of medicines and prescription forms must be implemented.	Regulation 13 (4) of The Private Dentistry (Wales) Regulations 2017	Separate logbooks for medicines implemented. Robust disposal system to be implemented with pharmacy when next returning expired medicines.	Diboneng Mothibi	Completed
10.	HIW reviewed a sample of patient records and found a number of omissions. Our review suggested	The registered manager must provide assurance to HIW on how it will ensure all patient records are	Regulation 20 (1) of the Private Dentistry	Registered manager has done CPD on clinical record keeping. The knowledge will be	Diboneng Mothibi	Ongoing

	significant gaps in documentation and clinical practice. Not capturing this information can compromise safe and effective care, continuity of care, regulatory compliance and raises legal and ethical concerns.	contemporaneous, fully completed and meet the standards expected of the GDC and Faculty of General Dental Practice in future.	(Wales) Regulations 2017	implemented with immediate effect. Monthly audits of clinical records will be implemented. HIW wrote to the setting on 11 December to request additional assurance and the following was provided: Clinical record keeping course with the GDC to be attended. Clinical record keeping peer review requested from x2 local practices Daily morning and afternoon sessions allocated to undertake records review Hardware and software added to allow patients		

				to complete medical history forms.		
11.	During our inspection we found multiple examples of non-compliance with regulations suggesting that there was not an effective system in place that enables the registered manager to maintain regulatory compliance and manage risks. The inspection revealed concerning regulatory failures. The issues set out above demonstrate that there is a fundamental lack of governance in place to ensure that regulatory compliance is maintained and that risks relating to the health, safety and welfare of people are	The registered manager must demonstrate and provide assurance to HIW that they have the necessary skills, knowledge, and leadership capability to carry on and manage a private dental practice safely and in full compliance with regulations. This should include assurance on how the registered manager will ensure regulatory compliance is maintained, audits are completed, and risks to health, safety, and welfare are identified.	Regulation 12 (1) of the Private Dentistry (Wales) Regulations 2017	Registered manager has signed up for a level 3 management course to enhance current skills and leadership capabilities. Registered manager will delegate some responsibilities to employee who already holds level 3 management qualification. Employee is not ready to take on full time management position. HIW wrote to the setting on 11 December to request additional assurance and the following was provided: Company has been contracted to support	Diboneng Mothibi	Ongoing

	identified, assessed and managed.			the oversight of compliance at this setting.		

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): **Diboneng Mothibi**

Job role: **Dental service provider and manager**

Date: **1/12/2025 / 11/12/2025**

Appendix C - Improvement plan

Service: Pembroke Dock Dental Care

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 the rear door of the setting to an enclosed yard appeared damp. We also found damp ingress in the cupboard in which the practice compressor was stored. The door to this storage cupboard appeared damaged or eroded at its base. Having areas of damp around clinical equipment and	The registered manager must ensure all areas of the practice are maintained to an appropriate standard.	Regulation 22 (2) of the Private Dentistry (Wales) Regulations 2017	The door to the enclosed yard was replaced three years ago. We will get the person who installed the door to inspect and treat the door. The storage cupboard door will be replaced by a carpenter	Registered manager	31st August, weather permitting 31st August, weather permitting

	in surgeries increases the risk of spreading infections and makes areas difficult to decontaminate effectively.					
2.	We did not see evidence of policies in place to ensure the premises were fit for purpose nor for identifying, assessing and managing risks. In addition to these omissions, the practice health and safety policy was missing information such as the location of the practice defibrillator and appeared to be non-specific to this practice. Not having policies available or having in-complete policies risked staff being unable to deal	The registered manager must ensure: • All required written policies are available at the setting in line with regulations • All policies are specific for the setting and are comprehensively updated.	Regulation 8	We have started working on a full overhaul of our practice policies with the assistance off Dental Compliance	Designated staff member	30th April

	with health and safety matters promptly and effectively.					
3.	We noted the boxing of pipes and cables supplying the dental chairs did lack sealing which could make the cleaning of the floor difficult.	The registered manager must ensure all areas of the practice can be effectively cleaned.	Regulation 22 (2)	We will arrange to have the boxing around pipes and cables supplying the dental chairs sealed	Registered manager	31st March
4.	We heard how the practice was not currently using safety plus syringes but that these had been recently purchased with the view of operationalising their use. We did not see a current risk assessment in place to reduce the risk of needlestick injuries.	The registered manager must ensure all appropriate measures are in place to mitigate and record the risk of needlestick injuries.	Regulation 13 (5)	We have been using needle re-sheathing devices and have no records of needle-stick injuries to date. However, we will us safety plus syringes where we deem appropriate	Registered manager	In practice
5.	We were told expired emergency medicines	The registered manager must maintain a robust audit	Regulation 13 (4)	We are adding a blue medication unit to our	Registered manager	27th February

	were disposed of at a local pharmacy without a receipt; this included the controlled drug, Midazolam.	trail for the disposal of controlled drugs.		waste contract and will request midazolam denaturing kits as and when required		
6.	During the inspection we found several areas of improvement regarding the management of radiographic equipment which formed a part of the Non-Compliance Notice issued to the setting. We did not see evidence of a programme for the review of the local rules nor the arrangements for reporting incidents. In addition, we did not see a copy of the	The registered manager must: • Ensure robust procedures are in place to effectively manage radiographic treatments to meet regulatory requirements • Provide a copy of the practice radiation risk assessment to HIW.	Regulation 13 (2)	We will arrange a programme to review our local rules and regularly undertake radiation risk assessments to maintain management of radiographic equipment. We will update our radiation protection file and update in accordance with compliance	Registered manager	27th February 30th April

	radiation risk assessment nor the programme of review of this assessment. We require the setting to improve the procedures in place for the management of radiographic equipment.					
7.	We found that practice policies were inconsistently updated or had not been reviewed within expected time frames. In addition, some policies and compliance documents were not available or did not exist. Therefore, we could not be assured that practice management had the correct policies and procedures in place to	The registered manager must: • Conduct a thorough review of all current policies and procedures • Ensure all policies and procedures are comprehensive, accurate and comprehensively reviewed annually • Ensure all compliance documents are suitably stored and easily locatable.	Regulation 8	We have started working on a full overhaul of our practice policies with the assistance off Dental Compliance. All policies will undergo a thorough review and processes will resume to comprehensively review annually	Designated staff member	30th April

	effectively run this practice nor the correct compliance documentation.					
8.	We did not see audits available covering patient records, radiographic quality, antibiotic prescribing nor healthcare waste. In addition, we did not see evidence of peer review having taken place since before 2020. Some of the areas for improvement highlighted in this report could have been noted earlier and action been taken sooner had audits been taking place to improve the service for patients.	The registered manager must ensure all mandatory quality improvement activities take place to drive continuous improvements.	Regulation 16 (1)	Clinical records audit arranged Clinical records and radiation audit arranged We will continue to improve and take further opportunities as they arise	Registered manager	29th November 24th February

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): **Diboneng Mothibi**

Job role: **Practice Manager**

Date: **26th January 2026**