

General Dental Practice Inspection Report (Announced)

Huw Jones Dental Practice

Inspection date: 12 November 2025

Publication date: 18 March 2026



This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our [website](#) or by contacting us:

In writing:

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

Or via

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

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	5
2. Summary of inspection.....	6
3. What we found	10
• Quality of Patient Experience.....	10
• Delivery of Safe and Effective Care.....	13
• Quality of Management and Leadership	22
Appendix A - Summary of concerns resolved during the inspection	27
Appendix B - Immediate improvement plan.....	28
Appendix C - Improvement plan	43

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 Huw Jones dental practice on 12 November 2025.

Our team for the inspection comprised of two HIW healthcare inspectors 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. A total of 25 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

Designation as a Service of Concern

Our inspection on 12 November 2025 identified significant risks to the safety of patients and staff. As a result, in line with our escalation and enforcement procedures, HIW convened a service of concern meeting to discuss the inspection findings. As a result, and after working closely with the setting, Huw Jones dental practice voluntarily suspended their registration on 13 November 2025 until such time that HIW could be assured patients would be safe. In addition, HIW wrote to Hywel Dda University Health Board regarding our findings due to the safety concerns within a building shared with health board services.

Our concerns following this inspection were dealt with under our non-compliance process and memorandum of understanding with the local health board. Details of the concerns for patient safety and the immediate improvements and remedial action taken by the dental practice are provided throughout the report and in [Appendix B](#).

In addition to the areas for improvement we identified at this setting, HIW were aware the registered manager and the responsible individual at Huw Jones dental practice were also employed and operated out of a separate setting in Pembroke Dock. On 25 November 2025, HIW conducted an announced inspection at Pembroke Dock dental care where we found similar regulatory breaches, resulting in the issue of a Non-Compliance Notice. The findings at Pembroke Dock dental care also triggered the issues of a further Non-Compliance Notice for Huw Jones dental practice. Both notices were issued on 27 November 2025.

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.

Other improvements identified during the inspections, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas, are detailed in [Appendix C](#).

Quality of Patient Experience

Overall summary:

We found patients were treated with dignity and respect throughout the patient journey at Huw Jones dental practice. Overall, patients provided positive feedback regarding their treatments and the service provided. All patients rated the service they received as 'very good'. We saw evidence of how the setting supported and upheld the individual rights of patients, including adjustments for those with disabilities.

We saw suitable arrangements in place to enable effective communication between clinicians and patients, including evidence from patients regarding Welsh language provision. We also found the processes to manage appointments and to triage patients requiring urgent care were satisfactory.

All patients told us their oral health was explained to them in a manner they could understand, and all patients said they were involved as much as they wanted to be in the decisions about their treatment. We saw a suitable amount of oral health promotion information on display, and patients told us they were given clear aftercare advice.

This is what the service did well:

- All patient feedback we received was positive
- All patients said they were involved as much as they wanted to be in the decisions about their treatment.

Delivery of Safe and Effective Care

Overall summary:

The building appeared to be in a satisfactory state of repair internally and externally. The size and layout of the waiting room was appropriate for the one surgery in use and for the number and flow of patients. All patients who responded to the HIW questionnaire said the practice was 'very clean'. All patients also said IPC measures were being followed by staff.

However, HIW found a significant number of concerns relating to the safe and effective delivery of care at this setting. This meant we were not assured that adequate measures were in place to maintain patient safety.

Immediate assurances:

- The premises did not provide a clean, safe and secure environment, and effective systems were not in place to prevent and control the spread of infection

- Processes to clean and disinfect re-usable medical devices were not sufficiently robust
- We could not be assured that equipment used in and for the purposes of the private dental practice was safe nor appropriate for the task
- The equipment to deal with medical emergencies was stored inappropriately and some items were not fit for purpose
- Adequate measures were not in place to ensure the safe handling of medicines
- Comprehensive dental care records were not being kept for patients in line with best practice standards
- Adequate measures were not in place against the risk of fire.

This is what we recommend the service can improve:

- A review is completed of the practice medicines management policy and a robust audit trail of medicines introduced
- Ensure all areas of the practice can be effectively decontaminated
- Review the current arrangements in place for the safe handling of sharps in order to prevent needlestick injuries.

This is what the service did well:

- Personal protective equipment for staff was readily available and used appropriately
- Patient-facing clinical areas of the setting were kept clean and patients agreed they felt the setting was ‘very clean’
- The size and layout of the waiting room was appropriate for the one surgery in use and for the number and flow of patients.

Quality of Management and Leadership

Overall summary:

We found staff employment records were broadly complete, including Disclosure and Barring Service Enhanced checks, GDC registrations and Hepatitis B documentation. However, some recruitment information was missing from records we reviewed, and staff folders were difficult to follow and to locate documents.

Our announced inspection also identified several regulatory breaches which resulted in the decision to suspend the registration of this setting and another setting managed by the same staff. Effective governance and management should have identified these areas and addressed these, so it was not clear these arrangements were suitably robust.

Immediate assurances:

- HIW was not assured that the registered manager has evidenced the necessary skills to carry on and manage a private dental practice.

This is what we recommend the service can improve:

- A thorough review of all current policies and procedures must be completed
- Full employment records must be kept and a robust system to monitor compliance with staff training should be implemented
- Update and make available the patient complaints procedure
- Ensure all quality improvement activities take place.

This is what the service did well:

- Induction procedures looked to be managed in a supportive manner for new starters.
- Patient feedback forms were routinely available.

3. What we found

Quality of Patient Experience

Patient feedback

Overall, the responses to the HIW patient questionnaire were positive. All respondents rated the service they received from the practice as 'very good'. Patient comments included:

"Always excellent service."

"[Staff member] is pleasant, friendly at reception and [Staff member] is humorous and friendly."

"Always a friendly and efficient service."

"Staff are friendly, gentle and knowledgeable."

Person-centred

Health promotion and patient information

Patient information and posters containing advice and guidance were available regarding maintaining good oral health, caries and gum recession advice alongside oral cancer checks and smoking cessation guidance. The practice statement of purpose and patient information leaflet were available for patients to review on request. The fees for private services were displayed in reception, alongside the names and General Dental Council (GDC) registration numbers of practitioners. The opening hours and emergency contact details were clearly displayed outside of the practice for patients. While this contact information was routinely available, some patients (7/18) who responded to the HIW questionnaire said they would not know how to access the service out of hours if they had an urgent problem. The practice should consider how it can further improve this communication to its patients.

All patients who responded to the HIW questionnaire said they were given clear aftercare instructions on how to maintain good oral health. All patients also stated their oral health was explained to them in a manner they could understand.

Dignified and respectful care

We found the practice provided dignified and respectful care to patients throughout their care journey. All patients who responded to the HIW

questionnaire told us staff treated with them with dignity and respect, explained what they were doing, listened to them and answered their questions.

The reception and waiting area were separated so information discussed with patients in person could not be overheard, and staff advised us that no personal information was repeated over the telephone. The practice had solid surgery doors which were kept closed during appointments which meant patients could not be seen while being treated. These measures maintained the privacy of interactions between staff and patients.

The practice had a confidentiality policy in place which outlined staff responsibilities with regards to the protection of patient information. We noted the nine core principles prepared by the GDC were on display at reception.

Individualised care

All patients responding to the HIW questionnaire stated they received enough information to understand which treatment options were available, as well as the costs, risks and benefits of treatments. Most patients (21/22) said they were given information on how the setting would resolve any post-treatment concerns. Overall, all patients said they were involved as much as they wanted to be in the decisions about their treatment.

Timely

Timely care

Arrangements were in place to utilise the time of practitioners appropriately and to see patients in a timely manner. Patients were generally seen within a week for a routine appointment. Respondents to the HIW patient survey indicated they found it 'very easy' (22/25) or 'fairly easy' (3/25) to get an appointment when they needed one. Staff told us that appointments were arranged in accordance with patient availability wherever possible.

Patients could make appointments over the telephone or in person after their appointment. Staff informed us appointments rarely ran late but should an appointment extend beyond the scheduled time, clinicians told reception of any delays. Patients would be contacted via telephone if the delays were known prior to arrival. Overall, we found the arrangements in place ensured any appointment delays would be communicated to patients in a timely manner, with alternative appointments offered, where requested.

We saw an appropriate patient telephone triage system in place to prioritise those most in need of urgent care. We saw time allocated in the practice diary each day to accommodate emergency appointments, with staff informing us that no patient

would wait over 24 hours to be seen. An out-of-hours telephone number was provided for patients to contact the practice in the event of an emergency. As mentioned elsewhere in this report, some patients said they were not aware of who to contact in the event of requiring urgent care, which the practice should consider.

Equitable

Communication and language

We saw supportive arrangements in place to help enable effective communication between clinicians and patients. The staff we spoke with were fully aware of the importance in communicating with a patient in a language of their choice. Online translation tools were used to communicate with patients when required and the sole dental clinician was a speaker of 10 languages. Some patient information was available in different formats, with more specialised information provided upon request by patients.

We found evidence the practice promoted the use of the Welsh language. Welsh speaking patients who responded to the HIW questionnaire said they were actively offered the opportunity to speak Welsh, they felt comfortable using the Welsh language and information was available in their preferred language.

Rights and equality

We saw how the rights and equal treatment of individuals were actively supported by the practice. The practice had suitable policies in place promoting the equality and rights of both patients and staff. Staff were also encouraged to undertake specific training to protect the rights of patients and the prevention of harassment or discrimination. A zero tolerance to aggression and violence policy and a harassment policy were both in place to safeguard staff from abusive behaviour.

All patients who responded to the HIW questionnaire said the building was accessible, though one patient said they were unsure. Staff provided examples where changes had been made to the environment as a reasonable adjustment for patients and employees. This included treating people in their wheelchairs and providing tailored care for the nearby older persons care home. We found the rights of patients were further upheld by allowing patients to choose their preferred pronouns, names and gender on their records.

Delivery of Safe and Effective Care

Safe

Risk management

The building appeared to be in a satisfactory state of repair internally and externally. The practice was on the first floor of a health centre alongside other healthcare partners, including a GP and the local Health Board. There was level access at the front and an elevator for patients or staff to access the setting should they have difficulty with the stairs. The health centre had disabled toilets which patients could use. Staff used a toilet to change, and personal items were stored appropriately at reception.

The size and layout of the waiting room was appropriate for the one surgery in use and for the number and flow of patients. The practice temperature, lighting and signage all appeared to be satisfactory.

On review of the health and safety measures at the practice, we noted areas of concern which posed a risk to the safety of patients and staff namely:

- We were not provided with a health and safety risk assessment which meant the practice had not been assessed by a competent person to reduce the risk of harm to staff and patients through mitigating actions
- The emergency and business continuity policy for the practice was incomplete and did not list details of persons to contact in the event of a problem. This meant in the event of an emergency, staff would be unable to operate nor contact any persons to resume operations
- The top hinge for the door of the patient / staff toilet was coming off the hinge. Should this come loose it risked causing harm to patients
- The exit area for the practice had no lighting in place. This meant any patient leaving the practice in times of darkness without the means of secondary lighting would be unable to see properly and could trip and fall.

Furthermore, the staff kitchen area for the practice was generally cluttered, including a heavy toolbox and a sharps bin stored above head height. This made the items difficult to bring down from shelves and could harm staff. High voltage plant items for the practice were kept underneath the kitchen sink and staff kettle and were uncovered. During a discussion regarding the cleanliness of the kitchen area with staff, water was seen by inspectors to be spilled directly from the tea and coffee making area onto this plant equipment. This presented the real risk of electrical fire or the potential for life changing injuries to a staff member.

Due to the issues outlined above and the increased risk these posed to patients and staff, this matter formed a part of the Non-Compliance Notice issued to the practice by HIW. The details of the actions taken by HIW and the setting are outlined in [Appendix B](#).

On review of fire safety arrangements, we found additional areas of concern which posed a risk to the safety of patients and staff.

We were provided with no documentary evidence of routine fire evacuations taking place. One staff member who had worked at the practice for 26 years explained they were aware of only one in that time, which was unplanned. We saw no evidence of regular testing of fire alarms, fire detection equipment nor call points by the practice. In discussion with the GP practice co-located in the building, they advised they do undertake testing, but no records of such were made available to us during the inspection. We saw fire extinguishers had been serviced within the last year. However, a fire equipment maintenance contract could not be provided. In addition, the latest version of the practice Electrical Installation Condition Report (EICR) was dated 18 August 2019, when this should be undertaken every five years.

Some items at the practice, including heavy plant equipment, were being powered through extension cords. One piece of plant equipment used for sterilising at the practice was on a plug extender plugged into a socket, but inspectors found this plug protruding from the socket. The overuse of extension leads presents a real risk of electrical fire, especially when used incorrectly and with heavy plant equipment.

While not immediately available to inspectors during the inspection, and after inspectors raised the issue of fire safety with the co-located GP practice, a copy of the building fire risk assessment was provided. In addition, staff were initially unaware there was gas provision at the setting until this was discussed with the practice management of the GP; and a gas safety certificate was provided dated 01 October 2022.

HIW were copied into a letter to by Mid and West Wales Fire and Rescue Service to the practice on 13 August 2024. In this letter, the fire service advised the setting and HIW of an inspection they had completed at this practice on 30 July 2024. The fire service found six items they required improvement and during HIW's inspection we found some of these matters were unresolved or actions had been continuing without intervention. One action was for the setting to take all reasonable steps to co-ordinate the fire safety measures. We saw no evidence of action being taken to resolve this matter.

The registered manager must:

- Ensure all recommendations by the fire service have been fully implemented
- Work with the building owners and other tenants to coordinate fire safety measures.

Due to the fire safety issues outlined above and the increased risk these posed to patients and staff, this matter formed a part of the Non-Compliance Notice issued to the practice by HIW. The details of the actions taken by HIW and the setting are outlined in [Appendix B](#).

We saw the practice certificate for employer liability insurance was on display. We noted Portable Appliance Testing had taken place in August 2025. The practice health and safety executive poster was also on display but the details for key contacts was in-complete. This was resolved on the date of our visit. Fire safety signage and no smoking signs were all displayed.

As outlined above, risk assessments were either not present or could not be easily located by staff. On review of the practice risk assessment policy, we found it to be unfit for purpose and did not instruct staff these risk assessments needed to be completed.

The registered manager must review the practice risk assessment policy.

We saw safer sharps devices were not currently being used by clinical staff, and we saw no risk assessment in place to mitigate any risks. Therefore, we could not be assured the risk to individuals from sharps injuries was being sufficiently controlled or assessed.

The registered manager must review the current arrangements in place for the safe handling of sharps in order to prevent needlestick injuries.

Infection, prevention and control (IPC) and decontamination

We found personal protective equipment was routinely available for staff. In addition, we saw hand hygiene procedures and signage to be appropriate. All patients who responded to the HIW questionnaire said the practice was 'very clean'. All patients also said IPC measures were being followed by staff. Overall, the cleanliness for areas where patients received clinical care were appropriate. However, we found areas which required immediate improvement outside of the patient-facing clinical spaces, including the kitchen and toilet.

On inspection of the patient / staff toilet, we found visibly dusty surfaces and flooring. The toilet roll was being kept on top of a waste bin because the holder

was not working, this waste bin had no lining bag. Additionally, in this toilet room, the brush for cleaning the toilet was sat in a holder containing black coloured water and assumed to be contaminated.

In the small staff kitchen area for the practice, we found two large sinks. Both sinks were visibly dirty, including the splashbacks, but especially in the plug hole of one sink where there were items of food and other unknown substances. In the other sink we found a cleaning mop being left to dry.

These issues meant we could not be assured the areas above were being kept clean and that staff did not have the correct level of training in cross-contamination. Due to the concerns relating to the cleanliness of these non-clinical areas, this matter formed a part of the Non-Compliance Notice issued to the practice by HIW. The details of the actions taken by HIW and the setting are outlined in [Appendix B](#).

While the areas where patients received clinical care were overall appropriate, we did note the keyboards used in the surgery room were not able to be wiped clean and as such could not be effectively decontaminated. In addition, we noted the chairs in the patient waiting room were upholstered of a material which could not be effectively decontaminated.

The registered manager must ensure all areas in the practice can be effectively decontaminated.

On inspection of the practice decontamination room, we observed the following which required improvement:

- Dirty and clean equipment was being transported to and from surgeries in unlabelled boxes
- The washing and rinsing of dental equipment was taking place in one sink
- The ultrasonic cleaner and inspection light were both incorrectly located in the dirty to clean flow of the room
- Areas of hard furnishings (cupboards and other fixtures) had broken seals which had been taped up as a temporary measure.

These concerns meant items may not be decontaminated correctly, resulting in potential cross-contamination and harm coming to a patient from the use of dirty equipment.

When inspecting the practice ultrasonic cleaner, we found the device did not appear to be of an expected dental standard. On an open-source search of the device instruction manual, namely the UKOKE Ultrasonic Cleaner 4820, it appears the primary focus of this device is for the jewellery industry. While it lists the

device uses includes dentistry, we did not see any means for servicing nor calibration. Staff were also unable to explain what cleaning solution was used during decontamination or where this was stored. Near to the end of the day a cleaning solution was found in a cupboard, however, there remained confusion as to which area in the flow of decontamination this was used.

The concerns above regarding the decontamination room, procedures and equipment had the potential to harm patients and as such this matter formed a part of the Non-Compliance Notice issued to the practice by HIW. The details of the actions taken by HIW and the setting are outlined in [Appendix B](#).

We saw the practice autoclave had been serviced in April 2025, that there was a daily programme of maintenance and daily checks also took place. However, the system for disinfecting impressions was not suitable. The practice should consider utilising a dedicated impression disinfection solution (rather than diluted household bleach) and following the manufacturer's instructions for the correct dilution and timing of immersion.

The registered manager should review the cleaning solution and protocol used for the disinfection of impressions.

Materials subject to Control of Substances Hazardous to Health (COSHH) were not stored securely and kept in a cupboard without the correct signage. In addition, on request for the means of disposing patient teeth and, especially, amalgam waste, we were informed these disposal pots were kept in a storage cupboard. When we asked to see the means for disposal, staff were unable to open the cupboard doors with the keys they had, for more than 10 minutes. Disposal pots were located and were new and sealed. Upon review of the contract from their waste disposal provider we did not see evidence these disposal pots would be taken away by the provider. We were given no suitable account as to where these pots had been disposed of previously. Due to the concerns identified, this matter formed a part of the Non-Compliance Notice issued to the practice by HIW. The details of the actions taken by HIW and the setting are outlined in [Appendix B](#).

Medicines management

We saw the practice had a medicines management policy in place which outlined the requirements for recording, storing, handling and using medicines at the practice. The practice prescription pad was stored securely, and medicines were stored in a locked cabinet.

We saw the practice fridge which was used to store household items was also being used to store medicines. We did not see a temperature reader on this fridge, nor any records of checks on the temperature. This meant medicines could become

cross-contaminated and were potentially being stored at the incorrect temperature. This matter formed a part of the Non-Compliance Notice issued to this practice. The details of the actions taken by HIW and the setting are outlined in [Appendix B](#).

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; this included the controlled drug, Midazolam. Staff told us that they received no receipts when disposing of these controlled drugs and we saw no evidence of the disposal on file. In addition, we did not see a means of stock control for the practice anti-biotics.

The registered manager must:

- **Review their medicines management policy**
- **Maintain a robust audit trail for all medicines.**

On inspection of the emergency equipment, we found:

- Equipment was stored in different locations, without signage, making them difficult to access in an emergency. We requested to see the practice ventilator bags, but these were not located for over 3 hours
- The self-inflating bags for the bag valve mask had perished and had visible cracks. The bags had no expiry dates. This item would be ineffective where needed in an emergency
- There were an insufficient number of face masks for the bag valve mask in the correct sizes to treat different patient groups
- The battery for the defibrillator was not inserted into the device and was missing the pads for paediatric patients.

These issues presented a risk to a patient who may experience a medical emergency. The management of the practice emergency kit formed a part of the Non-Compliance Notice issued to the practice by HIW. The details of the actions taken by HIW and the setting are outlined in [Appendix B](#).

Safeguarding of children and adults

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. However, we could not be assured of the practice safeguarding responsibilities for children and vulnerable adults. On review of the practice safeguarding policy, we found the contact telephone numbers for social services and the out of hours contact telephone number were either incorrect or did not connect. The Wales Safeguarding Procedures were also not readily available. In addition, the practice safeguarding policy was appended by a safeguarding flowchart for Swansea Bay

University Health Board, when this setting was based in the Hywel Dda University Health Board area. Following the procedures in this flowchart would lead staff to contact the incorrect partners involved in the safeguarding process, ultimately delaying the report of 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 by HIW. The details of the actions taken by HIW and the setting are outlined in [Appendix B](#).

Management of medical devices and equipment

As outlined elsewhere in this report, we found issues pertaining to the power supply and general appropriateness of medical devices and equipment at this practice. Overall, the management of clinical devices at the practice needed to be improved, especially a detailed schedule of servicing for equipment.

The registered manager must ensure all medical devices and equipment are maintained to an appropriate standard.

One review of the practice radiographic equipment 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 dose limits for patients had been flagged as a matter to be explored with the RPA by the RPS but that this had not occurred
- Calibration for the screen used to inspect radiographs had not taken place
- We did not see a contingency plan included in the documents we reviewed
- Dose meters had not been used to measure the radiation exposures to staff from the records we reviewed.

During the inspection, we instructed the practice to add radiation signage on to the three doors leading into the room where radiographs were performed. The absence of these signs would have risked a staff member or patient inadvertently coming into contact with radiation not knowing it was taking place in the room.

Due to the risk from mis-managed radiographic equipment to patients and staff, this matter formed a part of the Non-Compliance Notice issued to the practice by HIW. The details of the actions taken by HIW and the setting are outlined in [Appendix B](#).

We found limited evidence that patients were given sufficient information about the risks and benefits of exposure to ionising radiation. In addition, there was no

quality assurance programme in place nor quality improvement tools being used to routinely check X-ray equipment, audit dose levels, review image quality, processes and incidents.

The registered manager must ensure:

- Patients are provided with information about the risks and benefits of exposure to ionising radiation.
- An appropriate programme is put in place to regularly check equipment used for X-ray imaging
- Audits are undertaken to check that ionising radiation is used safely and effectively.

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 information. In addition, some of the issues identified throughout this report did bring about concerns with regards to staff understanding of the need to be aware of and to seek relevant professional advice, where necessary.

We did not see clinical checklists, such as the Local Safety Standards for Invasive Procedures (LocSSIPs), being used to prevent wrong tooth site extractions.

The registered manager must ensure robust systems are in place to prevent wrong tooth site extractions.

Patient records

We reviewed a total of six patient records during our inspection. The records were being held in a secure digital system, in line with the General Data Protection Regulations. Some records were still on paper, and these were stored appropriately.

The records we reviewed did not provide us suitable assurance that the records of patients were being comprehensively completed. Our concerns in this regard were as follows:

- One record did not have the name, address or date of birth of the patient recorded
- Four records did not have the patient previous detail history available, while another two did not have the patient social history noted

- We did not see smoking cessation advice offered to any of the applicable patients
- Four records did not note oral hygiene and diet recorded nor any advice provided
- One record did not state the reason for attendance while four other records did not record patient symptoms
- Two records did not have their initial medical history signed and dated by the patient and dentist; three records did not have these updated at each course of treatment
- One record did not have full base charting nor updated charting at each course of treatment
- Four records did not have a basic periodontal examination recorded, any notes on soft tissue examinations, nor extra or intra oral checks
- None of the applicable records we reviewed had oral cancer checks noted
- Two records did not have evidence of treatment planning
- One patient record did not include evidence of informed consent, nor the treatment carried out
- Three 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.

It was disappointing to note that some of the areas we found for improvement during our inspection in December 2016 were still taking place and did not appear to have been improved.

Overall, the standard of patient records was below that expected and required improvement. The quality of patient records formed a part of the second Non-Compliance Notice issued to Huw Jones dental practice on 27 November 2025. The details of the actions taken by HIW and the setting are outlined in [Appendix B](#).

Quality of Management and Leadership

Leadership

Governance and leadership

The practice was overseen by a principal dentist, and practice owner, with two other nurses and a registered manager. We were informed the registered manager oversaw the dental nurses, but the principal dentist had overall responsibility for the practice. The team at this setting were also the same team responsible for another dental practice in Pembrokeshire. We were informed the staff held daily discussions and more formalised meetings, where needed. Notes were kept of the formal meetings.

During this announced inspection we identified urgent safety concerns which effective and proactive governance arrangements would have identified. Therefore, HIW were not assured that the governance and leadership levels were suitable for the effective operation of a dental service. Upon request by HIW, the practice voluntarily suspended their registration at this practice and their sister practice on 13 November 2025, until such time as HIW could be assured these settings were safe for patients. The setting was issued a Notice of Decision to temporarily suspend their registration on 27 November 2025.

Our concerns in relation to the management of this setting formed a part of the second Non-Compliance Notice issued to the setting on 27 November 2025. The details of the actions taken by HIW and the setting are outlined in [Appendix B](#).

We saw all practice policies had been signed and dated to say they had been reviewed by staff every year since their creation. However, as outlined elsewhere in this report, HIW identified several omissions from practice policies and incorrect procedures being implemented during the inspection. Therefore, we could not be assured practice policies were being effectively reviewed and kept up to date with policy changes nor changes in clinical practice.

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

Workforce

Skilled and enabled workforce

Induction procedures appeared to be managed in a supportive manner for new staff members and appraisals for staff took place annually. The staff we spoke with during the inspection explained they would know what to do and who to speak to in the event of a concern over service delivery, treatment or management. A whistleblowing policy was in place to provide guidance on how staff can raise concerns. However, this policy appeared to be out of date, with reference made to the 'Health Inspector for Wales' on a telephone number which did not connect. In addition, the policy referenced 'Denplan', when it was not the understanding this practice provided that service.

The registered manager must update their whistleblowing policy.

We reviewed three records of the four staff working at the practice. Overall, compliance with each staff members professional obligations appeared satisfactory, including Disclosure and Barring Service Enhanced checks, GDC registrations and Hepatitis B documentation. However, we did not see any employment history nor references stored on file. All staff members had worked at this practice for several years, but suitable checks or a risk assessment should be conducted / kept on file.

The registered manager must ensure full employment records are always kept.

Overall compliance with mandatory training was to a suitable standard. We saw one staff member had an expired certificate for fire safety; however, this was resolved during our inspection. We were told that all staff were given the time to undertake their training, and we were also told staff were supported to complete additional training relevant to their roles which was evident in the records we reviewed. While all staff were trained to a suitable level, we did not see evidence of a system in place to monitor compliance with training. During the inspection, both records of training and professional obligations were not being kept in a satisfactory order, making documents difficult to locate or certification difficult to establish.

The registered manager must

- Ensure a robust system is in place to monitor compliance of staff records
- Ensure all staff records are organised and readily available.

Culture

People engagement, feedback and learning

We saw forms were available for patients to provide feedback to the setting and were told these were reviewed routinely by the practice. We noted how feedback was discussed at staff meetings, where needed to drive improvements. Responses

to feedback from the setting were not currently being publicised to patients and we advised the setting how this could be achieved through a 'you said, we did board' at reception.

On review of the practice complaints procedure, we noted it stated an acknowledgement and response time, had a named contact for patients and there was a designated book to record complaints. However, we found the following areas which required improvement:

- The complaints procedure was not displayed nor easily accessible for patients, without them having to ask for a copy
- Limited details on sources of support and advocacy could be found within the policy
- The email address for HIW was incorrect
- The name of the lead member of staff responsible for handling complaints was not advertised where it could be easily seen for patients.

Not having the complaints policy nor key contacts readily available for patients and with missing or incorrect information would make it difficult for patients to submit a complaint with the right support if they needed to.

The registered manager must ensure the practice complaints procedure is:

- **Readily available for patients without asking**
- **Up to date and contains all the information to support patients making a complaint.**

Learning, improvement and research

Quality improvement activities

We saw regular audits had taken place on smoking cessation, antibiotic prescribing and decontamination procedures. However, we did not see audits available covering patient records, radiographic quality, nor healthcare waste. In addition, we did not see evidence of peer review having taken place since before 2020. We understood these audits stopped due to the coronavirus pandemic; however, these should have resumed without delay. It was disappointing to note that peer reviews had stopped particularly as these were noted as improvements following our previous inspection in December 2016.

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.

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
One staff member was missing a fire safety certificate.	Untrained staff on fire safety could prevent the safe management of fire.	This was raised with the practice management for the setting.	Staff member conducted the training during the day of our inspection.
The key contacts on the practice health and safety executive poster were in-complete.	Staff may be unable to contact the key health and safety contact, in the event of an issue arising.	This was raised with the practice management for the setting.	The poster was populated with the key contacts.

Appendix B - Immediate improvement plan

Service: Huw Jones dental practice

Date of inspection: 12 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
<p>1. We found decontamination procedures were not in line with the Welsh Health Technical Memorandum 01-05 and staff knowledge did not appear to be of an expected standard.</p>	<p>The registered manager must ensure that decontamination procedures are reviewed and improved.</p> <p>In line with the Welsh Health Technical Memorandum 01-05, this should include:</p> <ul style="list-style-type: none"> • Labelling of clean and dirty boxes appropriately 	<p>Regulation 13 (5) of the Private Dentistry (Wales) Regulations 2017.</p>	<ul style="list-style-type: none"> • Customised clean and dirty boxes in place • Silver stainless steel bowl in place as an interim measure for washing and rinsing. We have quotation for a supplier to remove and replace one of the sinks and replace with a double. • New ultrasonic cleaner has been purchased, awaiting delivery 	<p>Sian Wills</p>	<ul style="list-style-type: none"> • Delivery of ultrasonic by 27th November • Resealing as soon as possible • Decontamination training by 27th November

		<ul style="list-style-type: none"> • Washing and rinsing of equipment must be separated • The ultrasonic cleaner must be to a required dental standard, be calibrated and serviced • All equipment positioned to maintain the dirty to clean 'flow' • Ensure hard furnishings in the decontamination room can be effectively cleaned • Ensure all staff involved in the decontamination process are confident and competently trained 		<ul style="list-style-type: none"> • Two lights in place, one in dirty area and one in clean • Quotation in place for resealing exposed crevices or joins • Three members of staff completed IPC training and one member midway through. Once completed, a day will be set to simulate process in accordance with IPC • Current waste contract updated and amended to comply with recommendations <p>Photographs have also been sent to HIW since this improvement plan response showing improvements to the layout and cleanliness of areas.</p>		
--	--	--	--	---	--	--

		<ul style="list-style-type: none"> • Have appropriate arrangements for the disposal of waste. 				
2.	<p>We found failings in the cleanliness and general health and safety of the practice which required immediate improvement. These included the staff / patient toilet, staff kitchen area and documentation pertaining to health and safety.</p>	<p>The registered manager must review health and safety at the practice to ensure the premises are fit for purpose, and appropriate infection control measures are in place. This should include:</p> <ul style="list-style-type: none"> • The kitchen and toilet areas being deep cleaned • Cleaning schedules and audits must be implemented for all areas of the practice • Decluttering the kitchen area, including the removal of items stored above head-height 	<p>Regulation 22(2)(a) and Regulation 13(5) of The Private Dentistry (Wales) Regulations 2017.</p>	<ul style="list-style-type: none"> • Communication in place with building manager in regards to communal toilet. Shelves removed in kitchen area and everything above head height. Quote in place for materials for reflooring, replacing sinks and repositioning compressor • Cleaning schedules mid process and plans to adapt in accordance with IPC training • Appointment made with electrician to access building switchboards to isolate • Fridge purchased for medicines with thermometer 	<p>Diboneng Mothibi</p>	<ul style="list-style-type: none"> • To be confirmed • 28th November electrician • To be confirmed • 1st December • To be confirmed

- Heavy plant equipment protected from exposure to liquids
- Medicines stored in a designated fridge, with daily temperature checks
- A comprehensive health and safety risk assessment must be carried out
- A Emergency and Business Continuity plan must completed
- Materials subject to the Control of Substances Hazardous to Health (COSHH) regulations must be stored securely and in a cupboard with the correct signage
- Address maintenance issues, including the toilet door and condition of hard furnishings

- Contacted a few companies in regards to Health and Safety compliance. Date to be confirmed
- Communications in place with companies for compliance documentation for business continuity
- Plans in place to purchase lockable storage containers with correct signage
- Feedback forwarded in regards to communal maintenance. Light outside and door hinge fixed. Covers purchased for six armchairs

HIW wrote to the setting on 11 December requesting further assurance and the following was provided:

- A comprehensive health and safety risk assessment

		<ul style="list-style-type: none"> • Provide appropriate external lighting. 		<ul style="list-style-type: none"> • An updated Emergency and Business Continuity plan. <p>Photographs have also been sent to HIW since this improvement plan response showing improvements to the layout and cleanliness of areas.</p>		
3.	<p>During the inspection, we did not find evidence of:</p> <ul style="list-style-type: none"> • Routine fire drills taking place • Regular testing of fire alarms, fire detection equipment nor call points • A fire equipment maintenance contract, though we did note fire extinguishers had been serviced 	<p>The registered manager must ensure appropriate fire safety measures are in place. This should include:</p> <ul style="list-style-type: none"> • Providing evidence of previous and/or planned fire evacuations • Where these are not available, a planned schedule of future fire evacuations should be provided and these must be coordinated with other tenants of the building 	<p>Regulation 22 of the Private Dentistry (Wales) Regulation 2017.</p>	<ul style="list-style-type: none"> • Our doors were already fire doors, but grading of an older format. Evidence will be provided. Planned evacuations in communication with general building, awaiting further response • Communicated with building manager and correspondence sent • Evidence of up to date testing, call points and fire detection equipment requested from landlord 	<p>Diboneng Mothibi and premises manager</p>	<ul style="list-style-type: none"> • To be confirmed • 28th November (rescheduled from 21st due to bad weather)

<p>within the last year</p> <ul style="list-style-type: none"> • A five-yearly electrical installation report. The latest version provided was dated 18 August 2019. <p>Heavy plant equipment were being powered through extension cords and plug extenders which weren't properly secured into the wall.</p> <p>Documentation pertaining to fire safety and general health and safety matters were not immediately available.</p>	<ul style="list-style-type: none"> • Evidence of up-to-date testing of the fire alarm, call points and fire detection equipment testing and call points for the last 12 months • A copy of the practice fire equipment maintenance contract, including the latest site report • Evidence of an up-to-date electrical installation certificate • Assurance from a qualified professional that heavy plant equipment is being safely powered • Assurance the recommendations of Mid & West Wales Fire and Rescue Service in their letter dated 13 August 2024 have been fully implemented. 		<ul style="list-style-type: none"> • Practice fire equipment maintenance contract, including the latest site report requested from landlord • Evidence of an up-to-date electrical installation certificate requested copies from landlord • Appointment made with qualified person for assurance that heavy plant equipment is being safely powered • Proof to be forwarded that all recommendations have been implemented <p>HIW wrote to the setting on 11 December requesting further assurance and the following was provided:</p>		
---	---	--	---	--	--

				<ul style="list-style-type: none"> • Confirmation of an upcoming fire evacuation frill and discussions with other building tenants • Evidence of testing for the fire alarm, call points and fire detection equipment • A copy of the building fire equipment maintenance contract • Confirmation from the health board fire officer that the recommendations of Mid & West Wales Fire and Rescue Service had been addressed 		
4.	<p>We reviewed the practice safeguarding policy and saw the contact telephone numbers for social services and the out of hours contact telephone number were either incorrect or did not connect. The All-</p>	<p>The registered manager must improve the safeguarding arrangements for the service. Evidence must be submitted to HIW of the following:</p> <ul style="list-style-type: none"> • The practice safeguarding policy has been reviewed and 	<p>Regulation 14 of the Private Dentistry (Wales) Regulations 2017.</p>	<ul style="list-style-type: none"> • Plans in place to amend practice safeguarding policy with up to date details • Plans in place, to be finalised <p>HIW wrote to the setting on 11 December and a copy of an</p>	Sian Wills	<ul style="list-style-type: none"> • 27th November • 27th November

	<p>Wales Safeguarding procedures were also not readily available. In addition, this policy was appended by a safeguarding flowchart for Swansea Bay Health Board, when this setting was based in the Hywel Dda University Health Board area. Following the procedures in this flowchart would lead staff to contact the incorrect partners involved in the safeguarding process, ultimately delaying the reports of any concerns.</p>	<p>updated, including up-to-date telephone contact details and flow charts</p> <ul style="list-style-type: none"> • The All-Wales Safeguarding procedures have been implemented and made available to staff at the practice. 		<p>up to date safeguarding policy was provided.</p>		
5.	<p>On review of the radiation protection</p>	<p>The service must satisfy HIW that appropriate expert advice is being</p>	<p>Regulation 13 (2) of the Private</p>	<ul style="list-style-type: none"> • Recommendations given by advisor being implemented. 	<p>Diboneng Mothibi</p>	<ul style="list-style-type: none"> • Awaiting response from Satelec supplier

<p>documentation, we found:</p> <ul style="list-style-type: none"> • Limited evidence of engagement with a suitable medical physics expert • Where advice had been given that patient doses required review this had not been carried out • Inadequate measures for evaluating radiographic images and optimising patient dose • Inadequate procedures for managing accidental or 	<p>sought and implemented, to ensure the safe use of radiographic equipment. Evidence must be submitted to HIW of the following:</p> <ul style="list-style-type: none"> • Up to date advice from a Radiation Protection Advisor and that any actions recommended by the advisor are implemented • All equipment used in the radiographic process is calibrated and optimised, including screens used to review radiographic images • A robust process is put in place to manage unintended or accidental exposures. 	<p>Dentistry (Wales) Regulations 2017</p>	<p>Email sent to Satelec, awaiting a response</p> <ul style="list-style-type: none"> • Plans in place. Staff meeting arranged after CPR to read report and implement and go through policies and make sure all are in line with recommendations. 		<ul style="list-style-type: none"> • Staff meeting being held 27th November
---	--	---	---	--	--

	<p>unintended exposures.</p> <p>The risk of harm from mis-managed radiographic equipment has potential to cause harm to both patients and staff.</p>					
6.	<p>On inspection of the emergency equipment, we found:</p> <ul style="list-style-type: none"> Equipment was stored in different locations, without signage, making them difficult to access in an emergency. We requested to see the practice ventilator bags but these were 	<p>The service must improve their management of medical emergencies. The measures should be in line with the recommendations of the Resuscitation Council UK. Evidence must be submitted to HIW of the following:</p> <ul style="list-style-type: none"> Equipment and drugs being located, with appropriate signage and staff access 	<p>Regulation 31 of The Private Dentistry (Wales) Regulations 2017.</p>	<ul style="list-style-type: none"> Self-inflating bags and all required face masks in correct sizes available Defibrillator fit for use with appropriate pads in surgery Equipment and drugs locatable with appropriate signage in place 	<p>Diboneng Mothibi</p>	<p>Already actioned</p>

- not located for over 3 hours
 - Self-inflating bag for the bag valve mask had perished and had visible cracks. The bags had no expiry dates. This item would be ineffective where needed in an emergency
 - We found there were an insufficient number of face masks for the bag valve mask in the correct sizes to treat different patient groups
 - The battery for the defibrillator was not inserted into the device and was missing the pads for
- The self-inflating bags for the bag valve mask has been replaced
 - All required face masks for the bag valve mask in the correct sizes to treat different patient groups are available
 - The practice defibrillator is fit for use, with appropriate pads available.

	<p>paediatric patients.</p> <p>The issues found indicate an increased risk to patients in the event of a medical emergency.</p>					
7.	<p>Following inspection and a comprehensive review of the patient record evidence we captured in the six records we reviewed, we found a number of omissions. Our review suggested significant gaps in documentation and clinical practice. Not capturing this information can compromise safe and effective care, continuity of care, regulatory</p>	<p>The registered manager must provide assurance to HIW on how it will ensure all patient records are contemporaneous, fully completed and meet the standards expected of the GDC and Faculty of General Dental Practice in future.</p>	<p>Regulation 20 (1) of the Private Dentistry (Wales) Regulations 2017</p>	<p>Registered manager will set aside fifteen minutes at the end of each clinical session to review records from morning and afternoon sessions accordingly to ensure they meet the required standard.</p> <p>Monthly audits of clinical records and radiographs will be carried out</p> <p>HIW wrote to the setting on 11 December requesting further assurance and the following was provided:</p> <ul style="list-style-type: none"> • Evidence the registered dentist had been enrolled 	<p>Sian Wills</p>	<p>With immediate effect once service resumes</p>

	compliance and raises legal and ethical concerns.			<p>on a clinical record taking and keeping course</p> <ul style="list-style-type: none"> • Evidence that two local practices have been contacted in regards to a clinical record peer review • Evidence that hardware has been added to the practice software to digitise consent and treatment plan forms using Pearl Pad and along with medical histories for patients to sign, and any relevant details will be uploaded. Training with PEARL has been set up for Thursday 8th January. 		
8.	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	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	Regulation 12 (1) of the Private Dentistry (Wales) Regulations 2017	<p>Registered manager has signed up to a level three management course to enhance necessary leadership and management skills.</p> <p>In the mean time, registered manager will delegate some</p>	Sian Wills	Ongoing. Course ten months alongside management duties

<p>registered manager to maintain regulatory compliance and manage risks.</p> <p>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 identified, assessed and managed.</p>	<p>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.</p>	<p>tasks to team member with existing management qualification. This will be on a limited supportive basis until registered manager has qualified.</p> <p>HIW wrote to the setting on 11 December requesting further assurance and we were informed the setting has taken up a contract with a dental compliance company. This company will facilitate the overall training and advice to ensure systems are in place to review all policies, continuous professional development and management. We were also informed compliance training has been organised with a date to be confirmed.</p>		

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: 21/11/2025 | 01/12/2025

Appendix C - Improvement plan

Service: Huw Jones dental practice

Date of inspection: 12 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
<p>1. HIW found some areas Mid and West Wales Fire and Rescue Service outlined needing improvement following an inspection in July 2024 had not been addressed.</p>	<p>The registered manager must:</p> <ul style="list-style-type: none"> • Ensure all recommendations by the fire service have been fully implemented • Work with the building owners and other tenants to coordinate fire safety measures. 	<p>Regulation 22 (4) of the Private Dentistry (Wales) Regulations 2017</p>	<p>Report and concerns have been relayed to the building owner/Landlord and other tenants will again request that the concerns be discussed at the next tenants meeting</p>	<p>Business owner</p>	<p>Ongoing</p>

2.	Risk assessments were either not present or could not be easily located by staff. On review of the practice risk assessment policy, we found it to be unfit for purpose and did not instruct staff these risk assessments needed to be completed.	The registered manager must review the practice risk assessment policy.	Regulation 8 (1)	Work with the dental compliance company to draft and review a new risk assessment policy	Responsible Person	31st March
3.	We saw safer sharps devices were not currently being used by clinical staff, and we saw no risk assessment in place to mitigate any risks. Therefore, we could not be assured the risk to individuals from sharps injuries was being sufficiently	The registered manager must review the current arrangements in place for the safe handling of sharps in order to prevent needlestick injuries.	Regulation 13 (5)	Ultra Safety Plus Twist safer sharps devices have been introduced to mitigate risk of sharps injury to individuals Sharps risk assessment carried out	Responsible Person	Introduced 21st November Risk assessment carried out 17th November

	controlled or assessed.					
4.	We noted the keyboards used in the surgery room were not able to be wiped clean and as such could not be effectively decontaminated. In addition, we noted the chairs in the patient waiting room were upholstered of a material which could not be effectively decontaminated.	The registered manager must ensure all areas in the practice can be effectively decontaminated.	Regulation 22 (2)	Hygienic keyboard introduced in surgery Suitable chair covers introduced in waiting room for six of the eight chairs	Responsible Person	Keyboard introduced on the 17th November Six of the eight covered 26th November. The other two will be upholstered by the end of April.
5.	The system for disinfecting impressions was not suitable. The practice should consider utilising a dedicated impression	The registered manager should review the cleaning solution and protocol used for the disinfection of impressions.	Regulation 13 (3)	Dedicated pre-measured bleach-based tablets for disinfecting impressions introduced due allergy related health	Practice Manager	Introduced on 17th November

	disinfection solution (rather than diluted household bleach) and following the manufacturer's instructions for the correct dilution and timing of immersion.			conditions by staff member		
6.	We were told expired emergency medicines were disposed of at a local pharmacy; this included the controlled drug, Midazolam. Staff told us that they received no receipts when disposing of these controlled drugs and we saw no evidence of the disposal on file. In addition, we did not see a means of stock control for the practice anti-biotics.	<p>The registered manager must:</p> <ul style="list-style-type: none"> • Review their medicines management policy • Maintain a robust audit trail for all medicines. 	Regulation 13 (4)	<p>Medicines Management Policy reviewed</p> <p>Incoming drugs log introduced as a means of stock control for antibiotics</p> <p>Our waste service contract has been updated to include a blue medication unit and a midazolam denaturing kit as</p>	<p>Practice manager</p> <p>Responsible person/clinician</p> <p>Responsible person</p>	<p>Reviewed 16th January</p> <p>Introduced 16th January</p> <p>Added 17th January</p>

				needed for further compliance		
7.	As outlined in our report, we found issues pertaining to the power supply and general appropriateness of medical devices and equipment at this practice. Overall, the management of clinical devices at the practice needed to be improved, especially a detailed schedule of servicing for equipment.	The registered manager must ensure all medical devices and equipment are maintained to an appropriate standard.	Regulation 13 (2)	<p>Issues pertaining to power supply rectified with additional sockets and heavy plant equipment covered</p> <p>Ultrasonic medical device replaced with one specific for dental setting. This will be serviced along with all other equipment</p> <p>The general management and servicing schedules of clinical devices will now be logged on Dental Compliance in one place</p>	Practice manager	<p>26th November</p> <p>Delivered 26th November</p> <p>Compliance training 19th January</p>

8. We found limited evidence that patients were given sufficient information about the risks and benefits of exposure to ionising radiation. In addition, there was no quality assurance programme in place nor quality improvement tools being used to routinely check X-ray equipment, audit dose levels, review image quality, processes and incidents.

The registered manager must ensure:

- Patients are provided with information about the risks and benefits of exposure to ionising radiation.
- An appropriate programme is put in place to regularly check equipment used for X-ray imaging
- Audits are undertaken to check that ionising radiation is used safely and effectively.

Regulation 13 (2)

Information about the risks and benefits of exposure to ionising radiation has been put on display in the waiting room

We have arranged a clinical records and radiograph audit with a colleague

We will upload audits of our radiographs on a six monthly basis to Dental Compliance according to recommendation

Clinical records and radiograph audit on 24th February

Audit of radiographs will take place August 2026

First training logged on 15th January with the dental compliance company

						that will support
9.	We did not see clinical checklists, such as the Local Safety Standards for Invasive Procedures (LocSSIPs), being used to prevent wrong tooth site extractions.	The registered manager must ensure robust systems are in place to prevent wrong tooth site extractions.	Regulation 13 (1)	LocSSIPs being used to prevent wrong tooth site extractions on display	Responsible Person	Actioned with immediate effect
10.	We saw all practice policies had been signed and dated to say they had been reviewed by staff every year since their creation. However, as outlined in our report, HIW identified several omissions from practice policies and incorrect procedures being implemented during the inspection. Therefore, we could not be assured	The registered manager must: <ul style="list-style-type: none"> • Conduct a thorough review of all current policies and procedures • Ensure all policies and procedures are comprehensive, accurate and comprehensively reviewed annually 	Regulation 8	Registered with Dental Compliance to ensure policies are correct and updated	Responsible Person	Ongoing, with a goal of within six months. To review during staff meetings

	practice policies were being effectively reviewed and kept up to date with policy changes nor changes in clinical practice.					
11.	A whistleblowing policy was in place to provide guidance on how staff can raise concerns. However, this policy appeared to be out of date, with reference made to the 'Health Inspector for Wales' on a telephone number which did not connect. In addition, the policy referenced 'Denplan', when it was not the understanding this practice provided that service.	The registered manager must update their whistleblowing policy.	Regulation 8	Whistleblowing policy updated with correct information	Responsible Person	Updated 19th January

12.	We did not see any employment history nor references stored on file. All staff members had worked at this practice for several years, but suitable checks or a risk assessment should be conducted / kept on file.	The registered manager must ensure full employment records are always kept.	Regulation 18	In addition to DBS checks, staff risk assessment and further checks will be carried out as per recommendation		Within three months
13.	While all staff were trained to a suitable level, we did not see evidence of a system in place to monitor compliance with training. During the inspection, both records of training and professional obligations were not being kept in a satisfactory order, making documents difficult to locate or	The registered manager must <ul style="list-style-type: none"> • Ensure a robust system is in place to monitor compliance of staff records • Ensure all staff records are organised and readily available. 	Regulation 18	All staff training records will be logged on Dental Compliance for ease of monitoring and evaluation	Responsible Person	Ongoing

	certification difficult to establish.					
14.	<p>We found the following areas in the practice complaints procedure which required improvement:</p> <ul style="list-style-type: none"> • The procedure was not displayed nor easily accessible for patients, without them having to ask for a copy • Limited details on sources of support and advocacy could be found within the policy • The email address for HIW was incorrect • The name of the lead member of 	<p>The registered manager must ensure the practice complaints procedure is:</p> <ul style="list-style-type: none"> • Readily available for patients without asking • Up to date and contains all the information to support patients making a complaint. 	Regulation 21	<p>Complaints policy will be updated with relevant contact details and sources of support available</p> <p>Complaints will be procedure put on display on reception door along with lead member of staff responsible</p>	Responsible Person	Completed by end of February

	staff responsible for handling complaints was not advertised where it could be easily seen for patients.					
15.	We did not see audits available covering patient records, radiographic quality, nor healthcare waste. In addition, we did not see evidence of peer review having taken place since before 2020. We understood these audits stopped due to the coronavirus pandemic; however, these should have resumed without delay. It was disappointing to note that peer reviews had stopped particularly	The registered manager must ensure all mandatory quality improvement activities take place to drive continuous improvements.	Regulation 16 (1)	Audits will be prioritised moving forward. Following a peer review by a colleague, we shall regularly be uploading all audits to Dental Compliance as reminded, as and when they are due	Responsible Person	1st clinical audit date Arranged for 29th January

<p>as these were noted as improvements following our previous inspection in December 2016.</p> <p>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.</p>					
---	--	--	--	--	--

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 B MOTHIBI
Job role: RESPONSIBLE CLINICIAN
Date: 22/01/2026