Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Dental Practice Inspection Report (Announced)

BUPA Dental Care Cardiff Mermaid Quay, Cardiff

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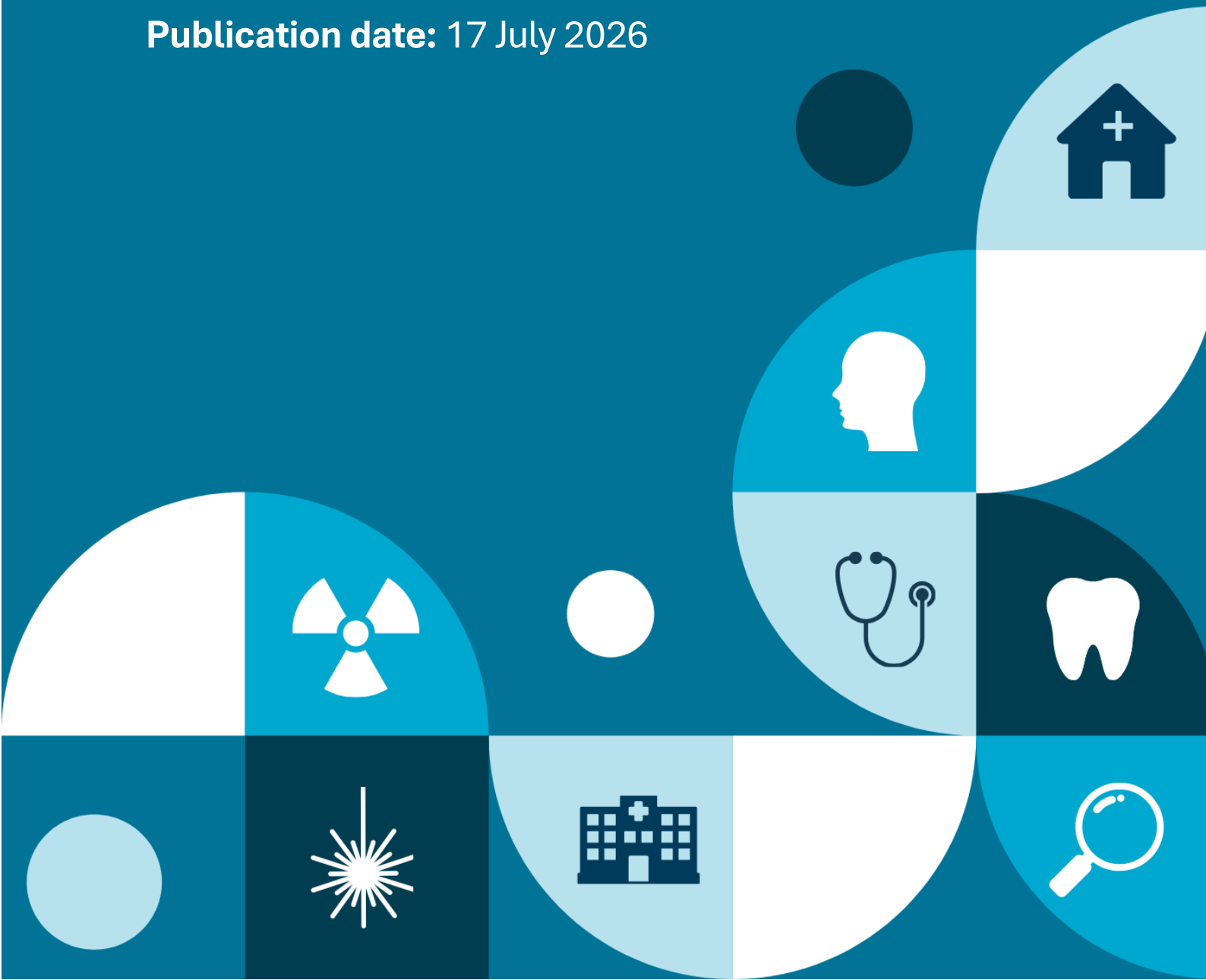

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Healthcare Inspectorate Wales (HIW) is the independent regulator and inspectorate of healthcare in Wales

Our Purpose

We check the safety and quality of healthcare across Wales.

Our Vision

A future where healthcare in Wales is safe, effective, and high-quality for everyone.

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 Priorities

Putting People First - We will focus on the biggest risks facing people and communities as they access healthcare services now and in the future.

Learning and Working Together - We will collaborate with partners to share learning and drive lasting improvements.

Investing in Our People - We will ensure our people feel supported, valued, and empowered.

Taking Action That Matters - We will take action to improve the quality and safety of healthcare for the future of Wales.

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an announced inspection of BUPA Dental Care Cardiff Mermaid Quay, Cardiff on 16 April 2026.

Our team for the inspection comprised of two HIW healthcare inspectors and one clinical peer reviewer.

During the inspection, we invited patients (or their carers) and staff to complete questionnaires to gather their views on using and working within the service. A total of 10 questionnaires were completed by patients and 10 were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Feedback from the HIW patient questionnaire was positive, with all respondents rating the service as ‘very good’.

We found a range of patient information available in reception and waiting areas, including oral health promotion and lifestyle advice. A patient information leaflet and statement of purpose were available in practice which met regulatory requirements. We found the statement of purpose was available in Welsh on the practice website; however, English versions of both documents and the Welsh version of the patient information leaflet were not available.

Information on treatment prices, opening times, emergency contact arrangements and GDC registration details of the dentists were clearly displayed. However, details for other GDC registered clinical staff were not available.

Staff were observed treating patients with dignity and respect. Arrangements were in place to support privacy and confidentiality. Patient records demonstrated that individual needs, treatment options and costs were appropriately recorded and explained.

The practice ensured patients had access to timely care, with flexible appointment options and staff communicated effectively with patients regarding delays. The practice demonstrated a commitment to equality, bilingual provision and reasonable adjustments to support inclusive access for all patients.

This is what we recommend the service can improve:

- Ensure the statement of purpose and patient information leaflet are available on the practice website
- Display names of all GDC registered clinical staff.

This is what the service did well:

- Provided a wide range of health promotion information
- Offered timely and flexible appointments
- Treated patients with dignity, kindness and respect.

Delivery of Safe and Effective Care

Overall summary:

We found the premises to be clean, secure and well maintained, with suitable facilities to support the services provided. Infection prevention and control arrangements were robust, with effective decontamination processes in place. Equipment was appropriate for the intended use and staff demonstrated good awareness of protocols.

Medicines management and medical emergency arrangements were in line with national guidance, supported by regular checks and staff training. However, staff had not completed BOC specific oxygen cylinder training.

We found appropriate arrangements in place for health and safety, fire safety and safeguarding, and staff demonstrated clear understanding of their responsibilities. However, we found the patient toilet door lock could be easily opened from the outside, which could compromise patient dignity.

Radiation protection arrangements largely complied with regulations, however some documentation required improvement. Patient records were mostly well maintained; however, some gaps were identified which included 2/9 records missing grading for X-rays, 1/7 records did not have clinical findings and language preference not being recorded within patients notes.

Immediate assurances:

- The five-year Electrical Installation Conditions Report (EICR) highlighted issues with the electrical installation and no evidence was seen to show this had been addressed.

This is what we recommend the service can improve:

- Ensure flammable COSHH materials are stored securely
- Ensure all clinicians are aware and using new grading system for X-rays
- Add contingency plans to local rules.

This is what the service did well:

- Implemented effective infection control and decontamination processes
- Staff demonstrated awareness of safeguarding procedures
- Secure storage and management of medicines.

Quality of Management and Leadership

Overall summary:

We found the management and leadership structure was appropriate to the size and complexity of the service. The practice had suitable arrangements to oversee safety and quality, with risks recognised, recorded and managed appropriately. Team meetings were held monthly, with information shared with staff who were not present. Digital systems were used to manage incidents, complaints, patient records and audits, allowing the practice to monitor performance and support continuous improvement.

We found the recruitment process to be effective. The practice had procedures in place for induction and staff had access to mandatory and additional training. Staff records were well maintained and senior management had oversight of training compliance.

Systems were in place to receive and respond to patient feedback and complaints.

This is what we recommend the service can improve:

- Ensure evidence was available to confirm staff had reviewed policies and procedures
- Introduce process to assure staff are fit for employment between DBS renewals.

This is what the service did well:

- Staff were aware and could describe the duty of candour
- Undertook a range of clinical and non-clinical audits to support improvement
- Held regular, well-documented team meetings.

Details of the concerns for patient's safety and the immediate improvements and remedial action required are provided in Appendix B.

3. What we found

Quality of Patient Experience

Patient feedback

Overall, the responses to the HIW questionnaire were positive. We asked patients how they would rate the service provided by the setting. All respondents rated the service as 'very good'.

Patient comments included:

> "The staff are very welcoming and professional on all levels."
>
> "Very friendly and helpful staff."
>
> "...given a high standard of care."
>
> "... all treatments have been explained well and carried out efficiently."

Person-Centred

Health promotion and patient information

We found a range of patient information available within the reception and waiting areas. This included information on smoking cessation, diet and various oral health promotion information provided through leaflets and posters.

The practice had a patient information leaflet which was readily available within the waiting areas, and a statement of purpose which was displayed in an area easily seen by patients. We found both documents contained the information required by the Private Dentistry (Wales) Regulations 2017. We noted the statement of purpose was available in Welsh on the practice website; however, English versions of both documents and the Welsh version of the patient information leaflet were not available.

The registered manager must publish the patient information leaflet and statement of purpose on their website.

The practice telephone number, opening hours, emergency out of hours number, and website address was displayed outside the practice. Information on private treatment prices were displayed in the waiting area. The names and General Dental Council (GDC) registration numbers of the dentists were also displayed outside the practice. However, the names and GDC registration numbers of other registered clinical staff were not available as required by the GDC standards.

The registered manager must display the names and GDC registration numbers of all GDC registered clinical staff working at the practice.

Dignified and respectful care

During the inspection we observed staff being polite, friendly and treating patients with kindness and respect. All respondents to the HIW questionnaire agreed that staff treated them with dignity and respect.

The reception desk was located away from the two waiting areas available. We were told staff were able to use the office should patients request to have a conversation in private, and confidential telephone calls could be taken in the office or a dental surgery if required. We found doors to clinical areas were solid and were kept closed whilst treating patients ensuring conversations could not be overheard. We saw evidence that staff had signed a confidentiality agreement which was within their employment contract.

We saw the GDC nine core principles of ethical practice were displayed within the waiting areas.

Individualised care

We reviewed a sample of seven patient records and confirmed appropriate identifying patient information, medical histories and treatment options were being recorded.

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

Timely

Timely care

Patients could book appointments in person at the reception desk and by telephone. An online booking system was also available for patients to book exams and hygiene appointments. We found the telephone lines were working effectively on the day of the inspection.

We were told patients could be seen as soon as the next day for treatment appointments. Patients were able to choose an appointment time that suited them with Saturday appointments available and late-night opening times. Patients were informed they can access emergency appointments by phoning the practice, and we were told patients were typically seen within 24 hours.

In the event of a delay to an appointment time, clinicians communicated with reception via an internal messaging system. Staff would then inform patients verbally in person or ring the patient ahead of their appointment and offer an alternative time if preferred.

All respondents to the HIW questionnaire said it was ‘very easy’ to get an appointment

when they needed one.

Equitable

Communicating and language

We found the practice provided a bilingual service, with information such as the patient information leaflet being available in both Welsh and English.

Patient information was available in alternative formats such as large print or via email when requested. The practice had access to Language Line and Wales Interpretation and Translation Services (WITS) to enable them to treat patients whose first language was not English or had other translation needs. Staff understood the importance of communicating with patients in their preferred language to support the delivery of good health care.

Printed appointment details or letters were provided when needed.

Rights and equality

We saw an appropriate inclusion and diversity standards policy in place which had been reviewed within the last year. We were told staff had completed equality and diversity training.

The practice ensured the rights of transgender patients were upheld by recording preferred names and pronouns. We were told by staff that all patients were treated the same.

All respondents to the HIW questionnaire told us they had not faced discrimination when accessing the services provided by the practice.

We found reasonable adjustments were in place to ensure the setting was accessible to all. All facilities were located on the ground floor, with an accessible toilet available.

Delivery of Safe and Effective Care

Safe

Risk management

We found the practice was visibly clean, secure and decorated to a good standard. The premises were in a good state of repair both internally and externally, and the size and layout were suitable for the service provided. There were two waiting areas which were appropriate for the three dental surgeries. Staff had use of a decommissioned surgery where they had lockers to store their personal items. A separate kitchen area and toilet facilities were available which could be used for changing.

Lighting, heating and ventilation appeared appropriate. We found signage was clear, including dental surgery and toilet facilities. Toilet facilities were equipped with sanitary disposal, handwashing and drying facilities and baby changing facilities. However, we noted the lock on the patient's toilet could be easily opened from the outside, which could compromise patient dignity.

The registered manager must ensure that the lock on the patient's toilet is secure and cannot be opened from the outside.

We found dental equipment to be in good condition, and appropriate items were available to enable effective decontamination between uses. Single-use items were in place where appropriate. However, during the inspection we identified that a dental chair was being used for a patient whose weight exceeded the manufacturer's recommended limit. This presented a potential risk to patient safety and indicated that equipment was not always used in line with manufacturer guidance. This was raised to the practice manager and clinicians during the inspection.

The registered manager must ensure all equipment is used in line with manufacturer guidance, including adherence to weight limits for dental chairs, to maintain patient safety.

We found a health and safety risk assessment was in place which had been completed within the last year. Relevant policies were in place, including health and safety, risk management standards, and business continuity. We saw employer's liability insurance information displayed behind the reception desk, and a Health and Safety Executive (HSE) poster which was accessible to staff.

We were told the practice worked solely off electric and therefore there was no requirement for a building gas safety certificate. We saw evidence of Portable Appliance Testing (PAT) which had been completed within the last year. We requested to see evidence of the five-yearly electrical installation condition report. When this was provided, we noted the report stated it was unsatisfactory. The registered manager was not able to provide a more up-to-date report, or evidence of actions being taken to address the issues. Our concerns regarding this were dealt with under our non-

compliance notice process. This meant that we wrote to the service immediately following the inspection requiring that urgent remedial actions were taken. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix B.

We found fire safety arrangements at the practice were appropriate. A fire risk assessment had been completed and reviewed annually. Fire extinguishers were available throughout the setting with evidence seen of servicing completed in October 2025. We saw evidence of fire safety equipment maintenance contracts which had been completed in the last year. Weekly fire alarm tests were undertaken with documented evidence seen. Fire exits were clearly signposted, and instructions in the event of a fire were on display.

Fire drills took place at appropriate intervals, with the last drill completed in January 2026. We saw evidence that all staff had completed fire safety awareness training.

Infection prevention and control (IPC) and decontamination

We found the practice had an appropriate infection control policy and procedure in place to maintain a clean and safe clinical environment. Hand hygiene facilities were suitable, and personal protective equipment (PPE), including gloves and masks were accessible and used appropriately.

The practice had a designated decontamination room available which was equipped with appropriate facilities for the decontamination and sterilisation of dental instruments. A dedicated decontamination lead was in place, and suitable equipment and processes were in place to safely transport instruments around the practice.

We found decontamination processes were appropriate. Pre-sterilisation cleaning methods were effective, and autoclaves were in use with cycle records maintained. Daily maintenance checks and start/end of day protocols were followed. Periodic tests were completed in line with Welsh Health Technical Memorandum (WHTM) 01-05 guidance.

Occupational health support was available to all staff through BUPA services. Staff were aware of the needle stick protocol, which was accessible in all clinical areas. We were told clinicians used safety plus needles to ensure the use of safer sharps.

We saw most Control of Substances Hazardous to Health (COSHH) materials were stored securely; however, we noted flammable items were not stored within a metal cupboard.

The registered manager must ensure any flammable COSHH items are stored in a metal cupboard or container to maintain safety.

Waste disposal arrangements were suitable, with contracts in place for clinical waste, amalgam, sharps, and other hazardous materials. Clinical waste was stored securely,

and expired medicines were disposed of appropriately.

Medicines management

We saw an appropriate medicines management policy in place, supported by procedures for ordering, safe handling, and disposal of medicines. A designated medical fridge was available for items that required temperature control. Medicines were also stored securely in a locked safe within a designated room where staff monitored access through a log. Patients were provided with information about prescribed medicines, and the staff were aware of the Yellow Card scheme for the reporting of adverse effects if required.

We found a medical emergency policy in place which was based on current national guidelines. We saw evidence that all staff had completed cardiopulmonary resuscitation (CPR) training within the last year. All emergency drugs were available, in date, and met national guidelines. Systems were in place to replace expired items and record checks. We noted the medical emergency bag was located within the Orthopantomogram (OPG) room. We advised the setting to reconsider the location of the medical emergency bag to ensure quick access in the event of an emergency and reduce the risk of accidental exposure.

Resuscitation equipment that is recommended by the Resuscitation Council UK was available and in date, and oxygen cylinders were serviced annually. However, we noted staff had not completed BOC oxygen cylinder training.

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

We saw a first aid kit was available with all items in place and in date. Two staff members were trained first aiders, providing full time cover.

Safeguarding of children and adults

We saw a suitable safeguarding policy in place. The policy included local contact details for safeguarding teams, including names and telephone numbers, this information was also available within each dental surgery.

The staff were able to access up-to-date guidance on child and adult protection matters through safeguarding training. We were also told updates were provided to managers from higher management within BUPA. All staff had completed safeguarding training to the required level. Staff at the practice were aware of how to raise a safeguarding concern and the process to follow.

Management of medical devices and equipment

We found clinical equipment at the practice was in good condition and suitable for its

intended use. A maintenance and inspection schedule was in place for the compressor. Staff had received appropriate training to ensure they could safely use all equipment, and arrangements were in place to promptly deal with any device or system failure.

Radiation protection arrangements mostly complied with Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) requirements. Staff were aware of their duty holder roles and responsibilities, which were reviewed regularly. Patients were provided with information about the benefits and risks of X-rays, and pregnancy enquiries were made in line with practice policy. However, we noted the practice did not have employer's procedures available. This was raised to the practice manager, and the employer's procedures were provided to HIW shortly following the inspection. Further information regarding this can be found in Appendix A.

Radiation protection documentation included local rules, risk assessments, and arrangements for maintenance and incident reporting. Radiation Protection Adviser (RPA) and Radiation Protection Supervisor (RPS) information was available, and X-ray equipment and maintenance records were seen. We found contingency plans in the event of equipment malfunction or accidental radiation exposure were available within the radiation protection folder. However, this was not available within the local rules.

The registered manager must ensure contingency plans are available within the local rules.

Effective

Effective care

There was evidence that professional, regulatory, and statutory guidance was followed when providing treatment. The practice used Local Safety Standards for Invasive Procedures (LocSSIPs) checklists to help prevent wrong-site tooth extractions.

Patient records

We reviewed a sample of seven patient records. Each patient had patient identifiers, reason for attendance, risk assessments, soft tissue examinations, oral hygiene and diet advice, and treatment options. However, we found the following that required improvement.

- Language preference was not recorded
- 1/7 patients did not have Basic Periodontal Examination (BPE) recorded
- 2/9 records did not have grading of X-rays
- 1/7 did not have clinical finding in notes

- 1/2 did not have a copy of the referral present in notes.

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

We also noted some clinicians with the practice were using the old grading systems for X-rays, when the new 'acceptable' or 'non-acceptable' grading system should have been used.

The registered manager must ensure all staff are aware of up-to-date requirements when grading X-rays.

The practice had a suitable records management policy in place. We saw systems in place for the recording and keeping of records that supported patient care and upheld the rights of patients.

The practice appropriately managed and protected personal information in compliance with the Data Protection Act 1988 and General Data Protection Regulation (GDPR). Digital records were backed up to a secure cloud system, and records were retained in line with appropriate retention policies.

Follow up and discharge letters for referred patients were documented within patient notes and monitored on the dental referral system. For suspected oral cancer patients, a designated staff member monitored referrals.

Efficient

Efficient

The service operated efficiently to support the delivery of quality care. Patients were able to access routine hygiene appointments, with dentists referring patients as required and recording prescriptions within clinical records.

Arrangements for referral to other services were in place and operated through established systems.

The practice had processes in place to manage patients requiring urgent dental care, including designated emergency appointment slots within clinical diaries, to help reduce attendance at urgent care or out-of-hours services. The practice also kept a list of patients who were able to attend appointments at short notice to utilise diary time.

Quality of Management and Leadership

Staff Feedback –

Staff who responded to the HIW questionnaire provided positive comments. All those who responded felt the facilities and environment were appropriate to ensure patients received the care required. Staff felt patient care was a top priority and felt patients were informed and involved with care decisions. All those who responded strongly agreed the practice was a good place to work and would be happy for family to receive care at the practice.

Staff comments included:

> " Brilliant place to work and exceptional care for patients. Staff looked after well and we work well as a team."
>
> " We aim to provide excellent care for our patients and staff."
>
> "It is a supportive environment with lots of help and resources available"

Leadership

Governance and leadership

We found the practice had a clear and effective management structure in place to support the running of the practice. Team meetings were held and documented monthly. Topics included compliance information, learning and development, policies, maintenance updates and local team news. Meeting notes were displayed on the notice board in a staff area for those who could not attend.

Governance, leadership, and accountability were acceptable for the size and complexity of the service. There were clear arrangements in place for identifying, recording and managing risks. Safety alerts were received by senior management at the practice and shared with the team in meetings and verbally.

Policies were available via the BUPA intranet site and within a dedicated policy folder within the office. Policies were reviewed by BUPA on a three-yearly basis; however, we noted evidence was not available to show staff at the practice had reviewed the policies.

The registered manager must ensure evidence is available to show staff at the practice have reviewed policies and procedures.

Workforce

Skilled and enabled workforce

A rota system was in place to plan staffing levels effectively. We were told agency staff

were not used at the practice.

We were told checks were carried out online to confirm staff maintained their GDC registration; this was completed quarterly.

The practice had a speak up policy in place that was accessible to all staff. We were told staff could raise concerns to the practice manager or lead nurse. If they wanted to speak to someone outside of the practice team, they would be directed to the area manager.

A recruitment and selection standard policy was in place, and an induction handbook was provided to all new staff. We were told a working at BUPA handbook would be following during the induction process which covered practice induction and mandatory learning which lasted approximately one month. New starters would have a mentor during this time.

We were told any performance concerns were escalated to the practice manager, and the practice manager would then follow a process of informal and formal conversations. A disciplinary procedure would be followed if necessary.

We reviewed a sample of five staff member records and found evidence of GDC registration, health screening documents, Disclosure and Barring Service (DBS) checks renewed every five years, employment history, references and appraisals. However, we noted there was no system in place to ensure staff were fit for employment between the five-year DBS checks.

The registered manager must ensure a system is in place to assure themselves that staff are fit for employment in the time between DBS renewal.

Staff had access to online training, with evidence seen that all staff had completed the necessary mandatory training to the required levels. Senior management had oversight of staff personnel information and training matrix through the online BUPA system. The practice supported staff to undertake additional training courses, and we were told some staff members had completed radiography, fluoride varnish and leadership courses. The staff who responded to the HIW questionnaire said they felt they had appropriate training to undertake their role.

Culture

People engagement, feedback and learning

Patients were able to leave feedback online, with QR codes available around the practice. Paper feedback forms were available from the reception desk. We were told feedback was monitored monthly with outcomes shared with staff in team meetings and any relevant learnings discussed.

A complaints and compliments policy was available, and the complaints procedure was easily accessible to patients within the waiting areas. The written information set

out clear processes, timescales for acknowledgement and response, and signposting to a range of external support services including HIW, Citizens Advice, Dental Complaints Service and the GDC. The information included details of how to escalate concerns if local resolution was not achieved.

We were told the practice manager was responsible for managing complaints, and staff roles were outlined within the complaints policy. We saw a complaint log was in place on DATIX, and we were told informal or verbal concerns were also documented on DATIX.

We saw a Duty of Candour policy which had been reviewed in the last year. The policy clearly outlined staff roles and responsibilities. Staff were able to describe the principles of Duty of Candour and the process to follow.

Information

Information governance and digital technology

The practice used digital systems to manage patient records, staff records, policies and procedures, and complaints.

Any incidents were recorded on DATIX. Information relating to patient safety was shared with the team through staff monthly meetings and BUPA health and safety team would also be informed. The health and safety team would then investigate and create an action plan where required. The practice used the information from incidents to support improvements in the quality and safety of the service.

Learning, improvement and research

Quality improvement activities

Quality related activity was undertaken through the completion of a range of clinical and non-clinical audits. The practice also monitored and responded to information arising from complaints, patient feedback and regulatory reports.

We saw a range of audits were undertaken, including radiography, antimicrobial prescribing, patient records and infection control.

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
The practice did not have employer's procedures for radiography available.	Without employer radiography procedures, there was increased risk of unjustified or incorrect X-ray exposures, inadequate staff training or entitlement, errors, and insufficient protection for patients, staff and others within practice.	Raised to the registered manager on the day.	The registered manager provided employer's procedures shortly following the inspection.

Appendix B – Immediate improvement plan

Service: **BUPA Dental Care Cardiff Mermaid Quay**

Date of inspection: **16 April 2026**

The table below includes any immediate non-compliance 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.

	Improvement needed	Standard / Regulation	Service action	Responsible officer	Timescale
1.	The registered manager must ensure electrical installation and any remedial works are completed.	The Private Dentistry (Wales) Regulation 2017 Regulation 22(2)	EICR remedial work (1 'C2' action). Arranged for Parr to attend to check it had been completed and if not to carry out the remedial work stated in the EICR. This was done on Friday 24th April. Certificate attached.	Donna Lovell	Complete
Findings:	We were provided with an electrical certificate which was completed in 2023. However, the outcome of the electrical installation report stated it was 'unsatisfactory'.				

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): Donna Lovell

Job role: Practice Manager **Date: 27/04/2026**

Appendix C – Improvement plan

Service: **BUPA Dental Care Cardiff Mermaid Quay**

Date of inspection: **16 April 2026**

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 patient information leaflet and statement of purpose were not available on their website.	The registered manager must publish the patient information leaflet and statement of purpose on their website.	The Private Dentistry (Wales) Regulations 2017 5(2), 6(2)	I have checked the Website and there is a version of the Statement of Purpose in Welsh. The English Version seems to be inadvertently removed. We have requested that that the English Version is put back. We have also requested for the patient information leaflet to be added to our website.	Donna Lovell and our Website Operations Team	One Week from 18th May 2026

2.	The names and GDC registration numbers of all registered clinical staff was not available as required by the GDC standards.	The registered manager must display the names and GDC registration numbers of all GDC registered clinical staff working at the practice.	GDC Standards for the Dental Team 6.6.10	These are on Display at the back of our Reception Area. They are also in our Patient Information Booklets available in our Waiting Areas. Staff information will be moved to the front of reception.	Donna Lovell	Already in place.
3.	We noted the lock on the patient's toilet could be easily opened from the outside	The registered manager must ensure that the lock on the patient's toilet is secure and cannot be opened from the outside.	The Private Dentistry (Wales) Regulations 2017 15(1)	This is also a Disabled Toilet and we must be able to access the Toilet should the emergency arrive for us to do so. The Lock has been deemed Fit for Use by our Property Manager. New request has been raised to change the lock to ensure patient dignity.	Donna Lovell, John McManus	No action required

4.	We identified that a dental chair was used for a patient whose weight exceeded the manufacturer's recommended limit.	The registered manager must ensure all equipment is used in line with manufacturer guidance, including adherence to weight limits for dental chairs, to maintain patient safety.	The Private Dentistry (Wales) Regulations 2017 13(2), 22(2)	We have liaised with our Sister Practice, The Parade who are able to see any of our patients who exceed the manufacturers recommended weight limit	Donna Lovell	Completed 17th April 2026
5.	We noted flammable items were not stored within a metal cupboard.	The registered manager must ensure any flammable COSHH items are stored in a metal cupboard or container to maintain safety.	The Private Dentistry (Wales) Regulations 2017 22(2)(a)	These flammable items have now been removed from the Practice as were no longer needed	Donna Lovell	Completed 17th April 2026
6.	We noted staff had not completed BOC oxygen cylinder training.	The registered manager must ensure all staff complete BOC integrated valve oxygen cylinder training.	The Private Dentistry (Wales) Regulations 2017 17(3)(a)	We were not aware of this available training. We now have access via BOC and the Team carrying out the training	Donna Lovell	To be completed by end of May 2026 for relevant Team Members
7.	We noted contingency plans were not available within the local rules.	The registered manager must ensure contingency plans are available within the local rules.	The Private Dentistry (Wales) Regulations 2017 13(1), 13(3)	There was confusion on whether this form was applicable to Wales. This has now been completed.	Donna Lovell	Completed 20th April 2026

8.	We found areas within patient records that required improvement.	The registered manager must ensure that patient records are complete and include all relevant information in line with professional standards and guidance.	The Private Dentistry (Wales) Regulations 2017 20(1)	Conversations with the relevant Clinicians taking place to make the required improvements with patients records.	Donna Lovell	To be completed with relevant Clinicians by 30th May 2026
9.	We noted some clinicians were using the wrong grading system for X-rays.	The registered manager must ensure all staff are aware of up-to-date requirements when grading X-rays.	The Private Dentistry (Wales) Regulations 2017 20(1)	Conversations with the relevant Clinicians taking place to ensure use of the correct system for grading x-rays	Donna Lovell	Completed 20th April 2026
10.	We noted evidence was not available to show staff at the practice had reviewed the policies.	The registered manager must ensure evidence is available to show staff at the practice have reviewed policies and procedures.	The Private Dentistry (Wales) Regulations 2017 8	Staff were reviewing policies as required, however no signature proof evident. Forms have now been put in place.	Donna Lovell	In place 20th April 2026
11.	We noted there was no system in place to ensure staff were fit for employment between the five-year DBS checks.	The registered manager must ensure a system is in place to assure themselves that staff are fit for employment in the time between DBS renewal.	The Private Dentistry (Wales) Regulations 2017 18(3)	It is Bupa Policy that DBS Renewals are carried out 5 yearly. However annual checks will be made to ensure no changes by acquiring staff declarations	Donna Lovell	Put in place on 20th April to get declarations at the end of each year. S

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): DONNA LOVELL

Job role: SENIOR PRACTICE MANAGER **Date: 18TH MAY 2026**