Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Dental Practice Inspection Report (Announced)

BUPA Dental Care Cardiff Pentwyn, Cardiff and Vale University Health Board

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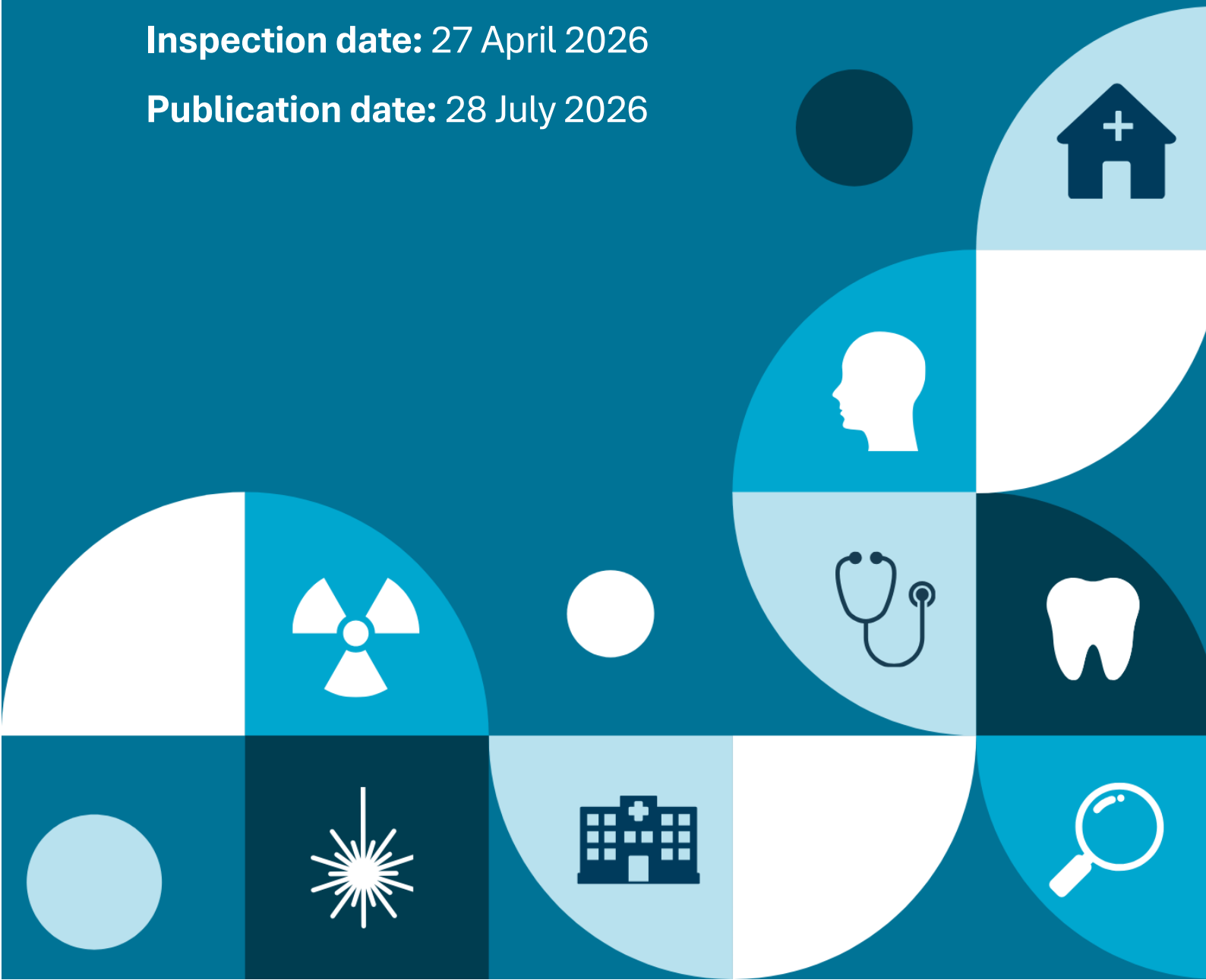

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Healthcare Inspectorate Wales (HIW) is the independent regulator and inspectorate of healthcare in Wales

Our Purpose

We check the safety and quality of healthcare across Wales.

Our 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 Vision

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

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 Pentwyn, Cardiff and Vale University Health Board on 27 April 2026.

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

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of 10 questionnaires were completed by patients and five 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:

We found that patient experience at the BUPA Dental Care Cardiff Pentwyn was positive, with strong evidence of person-centred, respectful and inclusive care. Patients told us they were treated with dignity and respect, were involved as much as they wished in decisions about their care, and were given clear information to understand treatment options, risks and benefits. Patient feedback through the HIW questionnaire was consistently positive, including reassurance that patients had not experienced discrimination when accessing services. The practice provided clear information on charges, opening hours and emergency care, and promoted health through accessible information on oral health, smoking cessation, sepsis and oral cancer.

The practice demonstrated flexibility in appointment scheduling and had effective arrangements for urgent care, helping patients access treatment in a timely way. Communication needs were well considered, with bilingual services available, translation support, alternative formats for information, and arrangements to support patients without digital access. Reasonable adjustments were made for patients with additional needs, including anxious patients and neurodiverse children.

We identified some areas requiring improvement. At the time of inspection, staff confidentiality agreements had not been signed by all staff, although this was addressed during and immediately after the inspection. While the premises were largely accessible, the patient toilet did not have an emergency pull-cord alarm or moveable grab handle, which could limit safety for some patients. In addition, although complaints information was available, improvements were needed to ensure arrangements fully reflected the new NHS Wales complaints processes. These issues required action to strengthen safety, equity and governance.

This is what we recommend the service can improve:

- Strengthen accessibility and safety within the patient toilet
- Ensure governance arrangements consistently support patient rights and confidentiality.

This is what the service did well:

- Patient-centred culture and consistently positive patient feedback
- Flexible and responsive access to care.

Delivery of Safe and Effective Care

Overall summary:

We found that BUPA Dental Care Cardiff Pentwyn had systems in place to support the delivery of safe and effective care, with many positive findings alongside some areas requiring improvement. The environment was clean, and patients and staff reported confidence in infection prevention and control arrangements. Robust systems were in place for fire safety, safeguarding, medicines management and staff training. Patients also benefited from timely access to care, including emergency appointments and efficient use of clinical time.

However, some aspects of the premises and equipment required attention, with clinical areas appearing worn and some equipment showing signs of corrosion. Issues were also identified in medicines management, including the absence of a disposal log for midazolam and incomplete training for staff in the use of oxygen cylinders. In addition, there were shortcomings in the management and documentation of X-ray use, including inconsistent recording of justification, clinical evaluation and patient information, alongside an overdue review of the radiation protection policy.

Patient record keeping was variable, with gaps in areas such as medical history review, treatment planning, risk assessment and radiographic documentation.

This is what we recommend the service can improve:

- Strengthen governance around radiography and record-keeping
- Address the condition of the premises and equipment
- Improve medicines management.

This is what the service did well:

- Strong infection prevention and control arrangements
- Robust fire safety and emergency preparedness
- A positive safety culture supported by governance systems.

Quality of Management and Leadership

Overall summary:

Leadership and management arrangements at BUPA Dental Care Cardiff Pentwyn were generally effective and well supported by clear governance and a wider corporate structure. Staff feedback was consistently positive, with all staff reporting appropriate training, regular appraisals, manageable workloads and access to suitable resources and support. Staff demonstrated a strong commitment to patient care, openness and safety, with good awareness of professional responsibilities such as the Duty of Candour, incident reporting and infection prevention and control. There were clear systems for recruitment, training and performance management, supported by effective oversight and use of digital systems.

The practice showed a positive culture of engagement, learning and improvement. Patient and staff feedback were actively encouraged, discussed in regular meetings and used to inform service improvements. A programme of audits and quality improvement activity was in place, and the practice engaged in research and partnership working with system partners, including the health board and local healthcare services.

However, we identified some areas where leadership and governance needed to be strengthened. The whistleblowing ('Speak Up') policy did not include contact details for external regulators, and complaints arrangements for NHS dental care had not been updated to reflect changes introduced under the Listening to People process in April 2026. In addition, while a wide range of audits had been completed, smoking cessation had not yet been included within the audit programme.

This is what we recommend the service can improve:

- Strengthen whistleblowing arrangements.

This is what the service did well:

- Strong staff engagement and support
- Well-established governance structures and communication
- A positive culture of learning and improvement.

3. What we found

Quality of Patient Experience

Patient feedback

Feedback from patients to the HIW questionnaires relating to patient care was highly positive. Nearly all respondents 'agreed' or 'strongly agreed' that they were provided with sufficient information to understand their treatment options, including the associated risks and benefits, and that their medical history was checked prior to treatment. All respondents reported that they were involved in decisions about their care as much as they wished to be.

Patients consistently reported positive interactions with staff. The majority 'strongly agreed' that they were treated with dignity and respect, that procedures were explained clearly, and that staff listened to them and communicated in an understandable way.

Overall, patient satisfaction was high, with all respondents rating the service as 'good' or 'very good'.

Patient comments included:

> "... I found the staff very helpful and friendly and was put at ease straight away."
>
> "We have always found the staff helpful, caring and approachable."

Person-Centred

Health promotion and patient information

We found that the practice provided a range of information to support health promotion and encourage patients to maintain good oral and general health. During the inspection, we observed patient information leaflets available within the practice promoting healthy living and good oral health. This included information on smoking cessation, healthy eating, sepsis and oral cancer awareness.

During the inspection it was identified that the complaints section of the statement of purpose did not initially include details of relevant advocacy organisations or Healthcare Inspectorate Wales (HIW). This matter was addressed promptly, with the information updated during the inspection process.

Information about NHS and private treatment charges was clearly displayed and accessible to patients. This information was available on the practice website and was also within the patient information folder in the waiting area.

We observed that required information for patients was clearly displayed in areas that were easily seen. This included the names of all dentists and members of the dental

team, along with their General Dental Council (GDC) registration numbers. The practice's opening hours were displayed, and information was available for patients on how to access emergency and out-of-hours dental care.

Dignified and respectful care

The practice had arrangements in place to support dignified and respectful care for patients. Clinical rooms provided appropriate levels of privacy for patients attending appointments and speaking with staff. We found doors to clinical areas were solid and were kept closed whilst treating patients.

During the inspection, we identified that staff confidentiality agreements had not been signed by all members of staff. This was addressed during the inspection, with most staff signing the agreement at that time. The manager subsequently confirmed following the inspection that the remaining staff had also signed the agreement.

The registered manager told us that arrangements were in place to ensure patient confidentiality when sensitive conversations were required. Staff reported that confidential discussions or telephone calls would be undertaken in the back office or in an empty surgery where necessary.

All respondents to the HIW questionnaire agreed that staff treated them with dignity and respect.

We also saw that the General Dental Council's nine principles were displayed at the front door of the practice, promoting awareness of the professional standards patients should expect from the dental team.

Individualised care

Patient feedback reflected positive experiences of individualised care at the practice. Responses to the HIW questionnaire were consistently positive, with all respondents either 'strongly agreeing' or 'agreeing' that they had been provided with sufficient information to understand their treatment options, including the associated risks and benefits. All respondents also reported that their medical history had been checked prior to treatment and that they were involved as much as they wished to be in decisions about their care.

Timely

Timely care

The practice had arrangements in place to support timely access to care and treatment. Staff told us that patients were informed verbally of any waiting times or delays to appointments. Where delays occurred and a patient was unable to wait, staff advised that they would offer to reschedule the appointment.

Staff explained how patients could access emergency dental appointments. Patients were able to contact the practice by telephone, text message or email. On contact, patients were triaged to determine whether their needs were urgent or routine. Staff confirmed that dental nurses were able to undertake triage where appropriate. Patients were also directed to contact NHS 111 for advice if they required support outside of the practice's opening hours.

We were told that time for emergency appointments was built into each dentist's daily schedule. Appointments were prioritised based on patients' symptoms and clinical need, supporting timely access to urgent care.

The manager described a flexible approach to appointment scheduling to help meet patient needs. Examples provided included offering appointments for children after 3pm, as well as early morning or lunchtime appointments for working patients where possible.

Equitable

Communicating and language

We found that the practice was able to provide a bilingual (Welsh and English) service. The practice employed two Welsh-speaking members of staff, and translation services were available to support patients when required. We also saw bilingual signs, posters and reading materials were displayed within the practice, supporting accessibility for Welsh-speaking patients.

Staff told us that they were not aware of the 'Iaith Gwaith' badge scheme or similar approaches to identifying Welsh-speaking staff. The registered manager explained that BUPA provided name badges displaying the flags of countries whose languages staff were able to speak, to help patients identify staff members who could communicate in different languages.

We found that patient information was available in alternative formats to meet individual needs. This included information available in Welsh, large print and easy-read formats. We were also told that a hearing loop was available at the practice to support patients with hearing impairments.

Staff explained how patients whose first language was not English were supported to communicate with the practice. We were told that one member of staff spoke

Portuguese. Translation services were also available where additional support was required.

We reviewed the arrangements in place to support patients who did not have digital access. Staff told us that patients were able to book appointments by telephone or by attending the practice in person. The practice also used paper appointment reminder cards, helping to ensure that patients without access to the internet or a mobile phone were still able to access care and treatment.

Rights and equality

We found that the practice had an equality and diversity policy in place. The registered manager told us that the practice aimed to welcome everyone and treat all patients equally. Language services were available, and equality, diversity and inclusion (EDI) considerations were embedded within policies and formed part of the practice's recruitment and retention arrangements. Staff also received EDI training.

We were told that patients and staff were protected from discrimination using policies and training. This included arrangements to address potential harassment and discrimination relating to protected characteristics under the Equality Act. The practice had a 'speak up' policy to support whistleblowing and a zero-tolerance policy for abusive or unacceptable behaviour from patients.

Examples of reasonable adjustments were described to support patients to access services on an equal basis. For anxious patients, end-of-day appointments could be offered when fewer people were present. Staff also advised that accommodations could be made for neurodiverse children.

The practice premises were accessible for wheelchair users. This included a ramp from street level and a doorbell positioned at an appropriate height. The patient toilet and all clinical areas were located on the ground floor. We noted that the patient toilet was fitted with fixed grab handles. We advised the practice to consider installing a moveable grab rail adjacent to the toilet to provide greater flexibility in supporting patients with differing mobility needs. We also found that the patient toilet did not have an emergency pull-cord alarm system.

The registered manager should install an emergency pull-cord alarm system within the patient toilet to enable individuals to summon assistance in an emergency.

The registered manager told us how the practice ensured the equality rights of transgender patients were upheld. Patients were addressed using their preferred pronouns, and staff aimed to ensure everyone was welcomed and treated with respect. Relevant preferences were documented in patients' clinical records.

We were told that a chaperone service was offered to patients where required.

All respondents to the HIW questionnaire told us they had not experienced

discrimination when accessing services provided by the practice.

Delivery of Safe and Effective Care

Safe

Risk management

We found that the practice was clean, safe and secure during the inspection. The size and layout of the premises were suitable for the services provided, and sufficient changing and storage facilities were available for staff. The exterior of the building was in a good state of repair. Internally, we noted that some clinical areas appeared tired. Examples included wear and areas of corrosion affecting dental chairs, X-ray equipment and cabinetry. We also observed that some flooring, including areas behind reception, was worn or ripped and had been taped.

The registered manager must review the condition of:

- **equipment, including dental chairs and X-ray equipment, and take action to address signs of corrosion and wear**
- **internal flooring, including areas behind reception, and take action to repair or replace worn or damaged flooring.**

Dental equipment was available in sufficient quantities to enable effective decontamination between patients. Single-use and disposable items were available where appropriate.

The practice had a business continuity plan in place, together with a workplace health and safety risk assessment. A health and safety policy was also available and staff advised this was followed within the practice.

We reviewed the arrangements for the storage and handling of substances governed by the Control of Substances Hazardous to Health (COSHH) Regulations. We observed that COSHH materials were being stored in a cupboard that did not have a lock. This was raised with the registered manager during the inspection, and we were told that a request had been submitted to facilities management to address this issue. Further details of the actions taken are provided in Appendix A.

We saw evidence that statutory safety checks were up to date. This included valid annual gas safety records, Portable Appliance Testing (PAT) records, and a five-yearly electrical installation inspection and test report. Valid employers' and public liability insurance certificates were available.

We reviewed fire safety arrangements at the practice. An up-to-date fire risk assessment and action plan were in place, dated August 2025. There was evidence of regular testing of fire detection equipment, and all staff had completed fire safety training. Fire drills were carried out regularly. Fire extinguishers were available, fire exit routes were clearly signposted, and instructions to follow in the event of a fire were displayed in multiple locations. 'No smoking' signs were also clearly displayed.

Infection prevention and control (IPC) and decontamination

The practice had suitable arrangements in place for infection prevention and control (IPC) and decontamination. A cleaning schedule was in place to support routine environmental cleaning, and the environment enabled effective infection control procedures. All respondents to the HIW questionnaire told us they felt the practice was clean and that infection prevention and control measures were being followed.

Hand hygiene facilities were available, and handwashing protocols were displayed at each sink. Personal protective equipment (PPE) was available, accessible and used appropriately.

We were told that a designated infection prevention and control lead was in place. Staff explained the arrangements for managing sharps injuries. Clear flowcharts were displayed in each surgery, and staff told us they would contact a designated helpdesk in the event of a sharps injury. Occupational health support was provided through an independent system arranged by BUPA, and staff confirmed they were aware of, and able to access, this support.

The practice had systems to ensure shared equipment and reusable medical devices were decontaminated and stored appropriately. Logbooks were maintained for checks of autoclaves and the ultrasonic bath, supported by a daily maintenance programme. Daily surgery checklists were completed for each surgery. Appropriate pre-sterilisation cleaning methods were in use, and autoclaves were being operated safely and effectively. Evidence of a maintenance scheme, including an inspection certificate, was available.

We found that routine audits of infection prevention and control were undertaken in line with Welsh Health Technical Memorandum (WHTM) 01-05. Staff had received training in decontamination procedures, and we saw evidence to confirm staff competency, including training certificates.

We reviewed the arrangements for the handling and disposal of waste generated by the practice. Contracts were in place for the disposal of clinical waste, amalgam waste, sharps and domestic waste. The clinical waste bin was locked and stored securely in a courtyard area. Staff told us that the courtyard was locked outside of working hours, helping to reduce the risk of unauthorised access.

Medicines management

We found that an appropriate medicines management policy was in place. The practice had systems and procedures in place to support the safe management of medicines throughout their lifecycle, including ordering, storage, administration and disposal. However, we identified that there was no disposal log in place for midazolam to demonstrate that the disposal process had been followed and witnessed.

The registered manager must ensure that a clear and auditable disposal record is maintained for midazolam.

Systems were also in place to ensure the security of medicines and prescription pads. Medicines were stored securely and kept locked when not in use. A designated medicines fridge was available, and staff told us that fridge temperatures were checked and recorded twice daily.

Patients were prompted by email prior to their appointments to update their medical history, supporting safe prescribing and medicines management.

The practice had arrangements in place for managing medical emergencies and resuscitation. Staff training records confirmed that staff had completed up-to-date cardiopulmonary resuscitation (CPR) and emergency resuscitation training. Emergency medicines and resuscitation equipment were available, met national guidance and items checked were within their expiry dates. The practice used BOC integrated valve oxygen cylinders. During the inspection, it was noted that not all staff had completed BOC integrated valve oxygen cylinder training.

The registered manager must ensure that all staff who may be required to use BOC integrated valve oxygen cylinders complete the relevant training.

A first aid kit was available at the practice, and items checked were appropriate and in date. We were told that two members of staff were trained first aiders, and a third member of staff was booked to attend first aid training.

Safeguarding of children and adults

We found that safeguarding policies and procedures were in place. These had been reviewed in October 2025. A designated safeguarding lead had been appointed, and safeguarding policies included local contact details to enable concerns to be reported appropriately.

Staff told us how the practice ensured it had access to up-to-date safeguarding guidance. This included the use of the Wales Safeguarding Procedures application, information cascaded by BUPA, updates shared through team meetings, and information received from the health board. Staff confirmed they were aware of who to contact locally if they had a safeguarding concern.

We found that all staff had completed safeguarding training and were aware of the steps they would take to identify, respond to and report concerns or allegations of abuse involving children or adults at risk. Staff told us that support was available to them if they had safeguarding concerns.

Management of medical devices and equipment

We found no evidence to suggest that clinical equipment was unsafe or unsuitable for

use. However, we noted that the clinical surgeries appeared tired and were due for refurbishment. This included wear to cabinetry and dental chairs, and some corrosion on equipment, as described elsewhere in this report.

Staff told us that they had received appropriate training to ensure they could use equipment safely, and arrangements were in place to promptly address any equipment or system failures. A maintenance and inspection schedule was in place for the compressor.

Arrangements were in place to support the safe use of ionising radiation in accordance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017. The practice had access to a Medical Physics Expert (MPE), and employer's procedures for the use of ionising radiation were in place. However, the radiation protection policy, last reviewed in February 2024, indicated a review date of February 2026 and had not been updated at the time of the inspection.

The registered manager must ensure that policies are reviewed and updated in line with the stated review schedule.

Staff training records indicated that relevant staff were trained and considered competent to undertake their roles in relation to the use of X-ray equipment.

However, during our review of patient records, we noted inconsistencies in documentation relating to X-ray use. There was no consistent evidence that each exposure had been justified and authorised, and patients were not always provided with verbal information regarding the benefits and risks associated with ionising radiation, although supporting information was available through posters and patient information materials. In addition, clinical evaluations for some X-ray exposures were not recorded, and notes were at times limited.

The registered manager must improve compliance with IR(ME)R 2017 by:

- **Ensuring that justification and authorisation for all radiographic exposures are consistently recorded in patient records**
- **Ensuring that a written clinical evaluation is completed and recorded for every radiographic exposure**
- **Ensuring that patients are consistently provided with sufficient verbal information about the benefits and risks associated with exposure to ionising radiation, in addition to written information.**

We found that a quality assurance programme was in place. This included audits, inspections and updates cascaded from BUPA, with changes communicated through practice meetings. Arrangements for the environment, maintenance and testing of X-ray equipment were appropriate, supporting the safe use of ionising radiation.

Effective

Effective care

The practice demonstrated appropriate arrangements to support the delivery of effective care. Staff advised that professional, regulatory and statutory guidance was followed when providing treatment.

The practice used Local Safety Standards for Invasive Procedures (LocSSIPs) checklists to support patient safety, including helping to prevent wrong site tooth extractions.

Staff described a range of mechanisms through which they could obtain professional advice when required. These included access to BUPA management structures, including head office support, as well as engagement with professional groups, peer support networks and team communication platforms.

Patient records

We found that an appropriate records management policy and system were in place to ensure that patient records were managed securely. Patient records were stored electronically, and arrangements complied with the General Data Protection Regulation (GDPR). Records were retained in line with appropriate retention policies. An appropriate consent policy was also in place, which included arrangements to uphold the rights of patients who may lack capacity.

Staff explained how follow-up and discharge information for referred patients was managed. Referral information was recorded on the electronic system. During the inspection, we advised that the use of a separate action log would support clearer oversight and review of actions taken for each patient referred.

We reviewed a sample of seven patient records. Patient identifiers were recorded in all records. Social history, including alcohol and tobacco use, was generally recorded. Oral hygiene and diet, including advice given, were documented in six records; however, in some cases the level of detail was limited due to the use of unmodified templates. Full base charting was present in all records reviewed, with updated charting recorded at each course of treatment. Where applicable, extra-oral and intra-oral examinations and oral cancer screening had been completed.

There were areas where record keeping was inconsistent. Previous dental history was recorded in one record. Medical histories were completed by patients prior to appointments; however, there was limited evidence that these had been consistently reviewed and countersigned by the dentist, with this clearly recorded in only two records. Patients' language preferences had not been documented. Six-point pocket charting was not completed in two records where this was indicated, and soft tissue examinations were not recorded in two records. Evidence of treatment planning was not present in three records where applicable. Risk assessments, including those

relating to caries, periodontal health, tooth wear and oral cancer, were recorded inconsistently across the records reviewed.

The registered manager must:

- **Strengthen the consistency and completeness of clinical record keeping ensuring alignment with current best practice guidance**
- **Strengthen arrangements for tracking and following up patient referrals, particularly for suspected oral cancer**
- **Ensure that patients' language and communication preferences are recorded within patient records.**

Efficient

Efficient

Staff explained how services were organised to support efficient movement through treatment pathways. We were told that the practice employed a hygienist who was working on a direct access basis. However, we did not see clear evidence within patient records to demonstrate referrals to or from the hygienist.

The registered manager must strengthen the documentation of referrals to and from the hygienist.

We found that arrangements were in place to support patients who required urgent dental care and to help avoid unnecessary attendance at urgent care or out-of-hours services. Staff told us that emergency appointment slots were built into each day for both new patients with urgent needs and existing patients.

We were also told that a short-notice cancellation list was used. This enabled the practice to offer newly available appointments to other patients, supporting efficient use of clinical time.

Quality of Management and Leadership

Staff Feedback

Staff survey responses were consistently positive, with all staff reporting appropriate training, regular appraisals and a suitable working environment. Staff felt able to manage their workload and had access to adequate resources, equipment and support. All respondents expressed confidence in the quality of care provided, stating that patients are treated with dignity and involved in decisions about their care, and that patient care is the practice's top priority. There was strong awareness of professional responsibilities, including the Duty of Candour and incident reporting, and infection prevention and control arrangements were viewed positively.

Leadership

Governance and leadership

Clear management structures were described, with day-to-day operations overseen by the practice manager and supported by a wider corporate structure. Staff told us about the arrangements in place to support team development. This included access to mandatory training provided by BUPA and relevant health board training, such as infection prevention and control and radiography. Regular one-to-one meetings and staff appraisals were also used to support performance management and professional development.

We found evidence that regular team meetings were held. Monthly practice meetings took place and covered a range of governance and quality topics, including complaints, incident reporting, property updates, patient feedback, quality improvement activity, sustainability and new standard operating procedures. Monthly nurses' meetings were also held and included discussions on policy updates, audits, COSHH folder reviews and key reminders. We saw that meetings were minuted, providing a record of discussions and actions agreed.

Arrangements were in place to ensure that safety information and updates were communicated effectively. Safety notices from external organisations, including the Medicines and Healthcare products Regulatory Agency (MHRA) and Welsh Government, were monitored by the registered manager and practice co-ordinator and shared with staff as appropriate.

We found that the practice maintained a comprehensive range of policies and procedures. These were available to staff via the intranet.

Workforce

Skilled and enabled workforce

We found that the practice had suitable recruitment arrangements in place. Policies and procedures described the recruitment process and the checks required for prospective employees. This included verification of identity, qualifications and vaccination status. Recruitment processes were supported by a corporate recruitment team, providing additional oversight and consistency.

We reviewed five staff records out of a total of 15 staff working at the practice. We found full compliance across all records reviewed. This included evidence of appropriate recruitment checks, professional registration documentation and training certification.

Staff training was monitored using an electronic system. Staff told us they had good access to learning and development opportunities through the corporate group. We found there was good compliance with mandatory training requirements, and the systems in place were effective in supporting oversight and assurance.

Culture

People engagement, feedback and learning

We found that there were multiple ways for patients to provide feedback about their experience of the service. This included feedback via the practice website, surveys sent by text message or email, online reviews, and paper feedback forms available in reception.

The registered manager told us that patient feedback was reviewed regularly and discussed at monthly practice meetings. Feedback and concerns were also logged on the incident reporting system (Datix), which supported oversight and provided a record of actions taken in response to issues raised. We saw evidence that learning from incidents had resulted in changes being made within the practice. Information was also available within the patient information folder to demonstrate how feedback had been used to inform improvements.

We found that there were clear arrangements in place for staff to raise concerns. Staff described a range of routes available to them, including raising concerns directly with the practice manager, using the Datix system, discussing issues in team meetings, or through one-to-one meetings. A whistleblowing policy, referred to as the 'Speak Up' policy, was in place. However, we noted that this policy did not include contact details for HIW or other external regulatory bodies.

The registered manager must ensure the 'Speak Up' policy includes clear contact details for external bodies, including Healthcare Inspectorate Wales and other relevant regulators.

We found that a complaints procedure was displayed and accessible to patients, including posters within the practice and information within the patient information

folder. A named member of staff was responsible for handling complaints. We saw evidence that complaints were recorded on the Datix system.

For NHS dental care and treatment, staff told us that the practice's complaints process was based on the previous Putting Things Right arrangements. We noted that the practice was not aware of the changes introduced in April 2026 under the Listening to People (LtP): NHS Wales Complaints, Incidents and Redress Process. We discussed the updated requirements with the registered manager and advised them to review and update the practice's complaints policy accordingly. We also suggested that the practice contact the Health Board to obtain relevant patient information and promotional materials relating to the revised process.

We found that a Duty of Candour policy was in place. Staff told us they had received appropriate training, and the policy clearly set out staff roles and responsibilities.

Information

Information governance and digital technology

We found that the practice had arrangements in place to support the secure handling and appropriate use of patient information. Staff told us that the practice had a system to record patient safety incidents.

The practice had suitable processes for managing patient information securely. Staff demonstrated an awareness of information governance requirements, including an understanding of when and how information should be shared appropriately to support patient and public safety.

Learning, improvement and research

Quality improvement activities

We found evidence that the practice routinely reviewed and responded to a range of information sources. This included complaints, patient feedback, incidents, audit findings and staff views. These mechanisms provided opportunities to identify areas for improvement and to implement changes where required.

Policies and procedures were in place to support quality improvement processes. We found evidence that the practice used both local and national reviews, clinical audits and research to inform improvements in care. The practice was participating in the INDICATE 2 study with the University of Birmingham, which focused on the diagnosis of diabetes, demonstrating engagement with research to support service improvement.

We saw evidence that a programme of clinical audits had been undertaken. This included audit relating to IPC, health and safety, radiation protection, antimicrobial

prescribing and healthcare waste management. However, a smoking cessation audit had not been undertaken.

The registered manager must ensure that smoking cessation is included in the audit programme.

Whole-systems approach

Partnership working and development

Staff told us that the practice engaged with system partners through regular attendance at quarterly health board dental meetings. This supported communication, shared learning and alignment with wider dental service priorities across the health board area.

We were also told that the practice worked closely with local community partners, including a nearby pharmacy and general practice. These relationships supported coordination of care and information sharing where required, helping to promote joined-up working and continuity of care for patients.

4. Next steps

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

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

The improvement plans should:

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

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

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

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

Appendix A – Summary of concerns resolved during the inspection

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

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
We observed that COSHH materials were stored in a cupboard that did not have a lock.	Storing COSHH materials in an unlocked cupboard increases the risk of unauthorised access or accidental exposure to hazardous substances, which could compromise the safety of patients, staff or visitors.	We raised this with the registered manager.	We were told that a request had been submitted during the inspection to facilities management to address this issue. The manager subsequently confirmed following the inspection that this issue had been addressed.

Appendix B – Immediate improvement plan

Service: **BUPA Dental Care Cardiff Pentwyn**

Date of inspection: **27 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.	There was no immediate non-compliance issues identified during this inspection.				
Findings:					

Appendix C – Improvement plan

Service: **BUPA Dental Care Cardiff Pentwyn**

Date of inspection: **27 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.	The patient toilet was fitted with fixed grab handles and did not have an emergency pull-cord alarm system.	The registered manager should install an emergency pull-cord alarm system within the patient toilet to enable individuals to summon assistance in an emergency.	The Private Dentistry (Wales) Regulations 2017 – Regulation 15.	• Source and install compliant alarm reachable from floor level. • Test post-installation and implement weekly checks. • Update risk assessments and H&S policy. • Deliver team training on use and response. Maintain records.	PM	End of June 26

2.	We noted that some clinical areas appeared tired. Examples included wear to dental chairs, x-ray machines and cabinetry. We also observed that some flooring, including areas behind reception, was worn or ripped and had been taped.	The registered manager must review the condition of: • dental equipment, including dental chairs and x-ray equipment, and take action to address signs of corrosion and wear • internal flooring, including areas behind reception, and take action to repair or replace worn or damaged flooring.	The Private Dentistry (Wales) Regulations 2017 – Regulation 22.	• Escalated to Property Team and raised up management chain for review and prioritisation.	Pm passed onto property Manager and Am and clinical lead.	On receipt of report.
3.	We identified that there was no disposal log in place for midazolam to demonstrate that the disposal process had been followed and witnessed.	The registered manager must ensure that a clear and auditable disposal record is maintained for midazolam.	The Private Dentistry (Wales) Regulations 2017 – Regulation 8, Regulation 13.	• Implement disposal log, ensure witnessed entries 2 signatures. • Reconcile stock, update procedures, and deliver staff training. • Regular review by Pm and lead	Practice Manager / Clinical Lead	By 22 June 2026

4.	During the inspection, it was noted that not all staff had completed BOC integrated valve oxygen cylinder training.	The registered manager must ensure that all staff who may be required to use BOC integrated valve oxygen cylinders complete the relevant training.	The Private Dentistry (Wales) Regulations 2017 – Regulation 13, Regulation 17.	80% staff trained. Remaining 4 on annual leave to complete training on return. Maintain records and run emergency drills.	PM	End of June 26
5.	The radiation protection policy, last reviewed in February 2024, indicated a review date of February 2026 and had not been updated at the time of the inspection.	The registered manager must ensure that policies are reviewed and updated in line with the stated review schedule.	The Private Dentistry (Wales) Regulations 2017 – Regulation 8.	• Policy ownership sits with the Bupa Clinical Governance Team and has escalated up the chain to compliance lead and above. • Communicate all policy updates to staff and obtain signed read-and-understood confirmation. • Monitor compliance through regular audits, spot checks and governance meetings to ensure sustained improvement.	Pm passed onto Bupa Governance team.	End of June 26

6.	During the review of records, we noted inconsistencies in documentation relating to X-ray use.	The registered manager must improve compliance with IR(ME)R 2017 by: • Ensuring that justification and authorisation for all radiographic exposures are consistently recorded in patient records • Ensuring that a written clinical evaluation is completed and recorded for every radiographic exposure • Ensuring that patients are consistently provided with sufficient verbal information about the benefits and risks associated with exposure to ionising radiation, in addition to written information.	The Private Dentistry (Wales) Regulations 2017 – Regulation 20, Regulation 13. IR(ME)R 2017	• Deliver refresher training to all clinicians on clinical record keeping standards, including risk assessments, referrals and patient communication preferences. • Area Clinical Lead will be engaged to support and deliver refresher training via team meetings, virtual sessions or in-practice support. • Implement standardised templates/prompts within patient records to improve consistency.	Pm/ Clinical area lead support	End of June 2026 ongoing.

7.	There were areas where record keeping was inconsistent. Patients' language preferences had not been documented. Risk assessments were recorded inconsistently across the records reviewed.	The registered manager must: • strengthen the consistency and completeness of clinical record keeping ensuring alignment with current best practice guidance • strengthen arrangements for tracking and following up patient referrals, particularly for suspected oral cancer • ensure that patients' language and communication preferences are recorded within patient records	The Private Dentistry (Wales) Regulations 2017 – Regulation 20.	• Deliver refresher training to all clinicians on clinical record keeping standards, including risk assessments, referrals and patient communication preferences. • Area Clinical Lead will be engaged to support and deliver refresher training via team meetings, virtual sessions or in-practice support. • Implement standardised templates/prompts within patient records to improve consistency.	Pm/ Clinical area lead support	End of June 26 on going.

8.	We did not see clear evidence within patient records to demonstrate referrals to or from the hygienist.	The registered manager must strengthen the documentation of referrals to and from the hygienist.	The Private Dentistry (Wales) Regulations 2017 – Regulation 20.	Introduce clear and auditable referral processes between dentists and hygienists. • Establish and embed a clinical audit programme, including record keeping, referrals, oral cancer pathways and smoking cessation audit, with re-audit cycle.		
9.	We noted that the 'Speak up' policy did not include contact details for HIW or other external regulatory bodies.	The registered manager must ensure the 'Speak Up' policy includes clear contact details for external bodies, including Healthcare Inspectorate Wales and other relevant regulators.	The Private Dentistry (Wales) Regulations 2017 – Regulation 21.	This Has been forwarded onto Bupa team for review and has been escalated up the chain to compliance lead and above.	Pm/ forwarded onto Compliance lead	

10.	A smoking cessation audit had not been undertaken.	The registered manager must ensure that smoking cessation is included in the audit programme.	The Private Dentistry (Wales) Regulations 2017 – Regulation 16.	• New Principal Dentist and clinicians have been signed up to the HIW smoking cessation audit • Incorporate smoking cessation into the clinical audit programme. • Complete a baseline audit to assess recording of smoking status and delivery of cessation advice. • Share findings with the clinical team and implement improvement actions. • Introduce standardised prompts within patient records to support consistency. • Practice Manager to complete spot checks to ensure compliance is maintained. • Discuss outcomes and improvements	Pm, clinical team.	End of June 26

				within team meetings and clinical 1:1s. • Monitor compliance through governance meetings.		

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): Gemma Roberts

Job role: PM **Date: 15/06/2026**