Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Dental Practice Inspection Report (Announced)

Bamboo Cosmetic Dentistry, Cardiff

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In writing:

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

Or Via:

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

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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 Bamboo Cosmetic Dentistry, Cardiff on 07 May 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 three questionnaires were completed by patients or their carers and two were completed by staff. Feedback and some of the comments we received appear throughout the report.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

The practice demonstrated a positive patient experience supported by good standards of care, communication and accessibility. Patient feedback, although limited, was consistently positive, with all respondents rating the service as ‘very good’ and reporting that they felt well informed, respected and involved in decisions about their care. Patients also reported that it was very easy to access appointments.

The practice provided a good range of patient information, including health promotion materials on oral health and smoking cessation. Key information such as treatment costs, statement of purpose and registration details were accessible both on site and online, supporting transparency and patient understanding. Patients confirmed they received appropriate aftercare advice and information about their treatment.

We observed staff interactions to be professional, respectful and patient-centred. Measures were in place to support dignity and confidentiality, including the use of private areas for telephone conversations and secure clinical environments.

Arrangements for accessing care were effective, with patients able to book appointments easily and access emergency care on the same day, where required. Communication arrangements supported inclusivity, with Welsh-speaking staff available and information provided in Welsh and English. The practice also demonstrated a commitment to equality, with policies in place and reasonable adjustments available to support access, including a ground floor surgery.

This is what the service did well:

- Patients reported very positive experiences, including being treated with dignity, respect and clear communication
- Strong access arrangements, with patients finding it easy to obtain appointments and access emergency care when needed
- Good provision of patient information and transparent communication around treatment options, risks, costs and aftercare.

Delivery of Safe and Effective Care

Overall summary:

The environment was clean, well maintained and free from obvious hazards, with suitable health and safety arrangements in place. Required documentation, including risk assessments, safety certificates and fire safety records, were up to date, and regular testing, maintenance and staff training were evident.

Infection prevention and control arrangements were generally good, with appropriate policies, cleaning schedules and decontamination processes observed. Staff had access to suitable personal protective equipment, and equipment used for sterilisation was regularly tested and appropriately documented. Patient feedback also supported these findings, with all respondents reporting that the practice was clean and that infection control measures were being followed. However, some improvements were required, including ensuring COSHH documentation was clearly organised and addressing minor infection control risks, such as the presence of sink plugs, which were removed during the inspection.

Medicines management arrangements were largely appropriate, with trained staff, emergency equipment available and systems in place to check medicines and equipment. However, improvements were identified to ensure emergency medicines were immediately accessible, including the storage of emergency drugs and Glucagon. Out-of-date items were identified and removed at the time of inspection. Additional training in the use of oxygen was also recommended to further support staff competency.

Safeguarding arrangements were appropriate, with policies aligned to national guidance, a designated lead in place and staff trained to the required level. The management of medical devices and equipment, including radiography, was also strong, with appropriate policies, quality assurance arrangements and external support in place. However, some governance gaps were identified, including the absence of an X-ray equipment inventory and limited quality assurance checks of digital viewing equipment. Similarly, while laser use was appropriately registered, a treatment register was not in place and protective equipment required replacement.

Patient records were generally well maintained, clear and comprehensive, demonstrating safe care planning. However, some areas for improvement were identified, including the recording of patient language preferences, ensuring risk-based approaches to mouth cancer screening and completing BPE assessments for children in line with current guidance.

This is what we recommend the service can improve:

- Ensure emergency medicines and equipment are stored in a way that allows immediate access and strengthen checks to prevent out-of-date items
- Improve governance systems, including COSHH documentation, X-ray equipment inventory, laser treatment register and quality assurance of imaging equipment
- Strengthen clinical record keeping and risk-based care, including recording language preferences, undertaking BPE for children and ensuring individualised mouth cancer risk assessments.

This is what the service did well:

- Maintained a clean, safe environment with robust health and safety, fire safety and infection control arrangements in place
- Staff were well trained and knowledgeable, with effective safeguarding arrangements and appropriate management of patient care and records overall.

Quality of Management and Leadership

Overall summary:

Staff feedback was very positive, with respondents reporting that they felt well supported, appropriately trained and able to manage the demands of their roles. Staff were satisfied with the quality of care provided and would recommend the practice as both a place to work and receive care. There was a strong emphasis on patient-centred care, with staff confirming that patient dignity, privacy and involvement in decision-making were consistently prioritised.

The practice had a clear organisational structure, with defined roles and responsibilities understood by staff. Governance arrangements were effective for a practice of this size, with appropriate systems in place for managing risks, reviewing policies and responding to safety alerts. The use of an electronic compliance system and oversight from a compliance manager supported monitoring and assurance activities. Regular team meetings, staff appraisals and training arrangements further strengthened communication, oversight and workforce development.

Workforce arrangements were robust, with sufficient numbers of suitably trained staff employed. Recruitment processes, induction arrangements and ongoing professional development were well managed. The practice promoted a positive and open culture, with staff reporting that they felt confident raising concerns and supported to do so through established policies and processes.

The practice had several mechanisms in place to gather patient feedback and monitor patient experience, including questionnaires and online reviews. Complaints procedures were clear, accessible and well structured, with defined timescales and escalation processes. However, while feedback and complaints were collected and recorded, there was limited evidence of a systematic approach to analysing themes and demonstrating how learning was used to drive improvements.

This is what we recommend the service can improve:

- Implement a structured approach to analysing feedback and complaints, ensuring themes are identified and used to drive improvement.

This is what the service did well:

- Positive staff culture, with staff feeling supported, well trained and confident in delivering high-quality, patient-centred care.
- Clear leadership and governance structure, with effective systems for managing policies, risks and safety alert
- Strong workforce arrangements, including appropriate recruitment, training, appraisal processes and open communication.

3. What we found

Quality of Patient Experience

Patient feedback

Patient feedback from the three respondents was positive overall. All respondents rated the service as 'very good' and reported positive experiences in relation to access, care, communication and cleanliness. Respondents felt well informed, treated with dignity and respect, and involved in decisions about their care.

Person-Centred

Health promotion and patient information

We saw a good range of patient information available in the reception area and waiting room. This included information on smoking cessation, oral health and preventive care. The practice had a satisfactory patient information leaflet and statement of purpose, which were both available on the practice's website, as well as information on treatment prices.

All patients who completed a questionnaire told us that the dental team had given them aftercare instructions on how to maintain good oral health.

The names and General Dental Council (GDC) registration numbers of the clinicians and other GDC registered staff were displayed in the waiting area of the practice. We noted the practice had HIW's official registration certificates for the registered manager and setting displayed in the reception area. The practice telephone number, emergency out of hours details and opening hours were displayed clearly at the entrance to the practice.

Dignified and respectful care

During the inspection we observed staff being friendly, polite and treating patients with kindness and respect. All patients who responded to the HIW questionnaire agreed that staff treated them with dignity and respect. The GDC nine core principles of ethical practice were displayed in the waiting area.

We saw a confidentiality policy in place which had been reviewed by all staff. The main reception desk was within the waiting area; however, all phone calls were taken in the upstairs office allowing staff to have confidential conversations on the phone. There were solid doors to clinical areas and surgeries which were kept closed whilst treating patients.

Individualised care

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

Where applicable, all respondents who completed the HIW questionnaire agreed that they were given enough information to understand treatment options available to them, was given enough information to understand the risks and benefits of the treatment options available and agreed the cost was made clear to them before receiving treatment. All respondents agreed that their medical history was checked before treatment.

Timely

Timely care

The setting arranged appointments by telephone or in person at reception. We heard telephone lines working effectively on the day.

We were advised the average waiting time between treatment appointments was one to two weeks. Patients are informed they can access emergency appointments by calling the practice in the morning and we were told they can usually be seen on the day.

Staff working in the dental surgeries informed reception staff of any delays. We were told reception staff would then inform patients verbally in person and would offer the option to rearrange their appointment. All respondents to the HIW questionnaire said it was ‘very easy’ to get an appointment when they needed one.

Equitable

Communicating and language

We were informed that two members of staff were fluent Welsh speakers, providing assurance that patients could communicate in Welsh if they wished. We were also informed that patients requiring communication support in other languages would typically arrange their own interpreter, for example by bringing a family member. On such occasions, the practice should assure itself that these arrangements are appropriate to support patient understanding and valid consent and consider access to professional interpreting services where required.

We saw patient information that was available in English and Welsh as well as large print. Patients without digital access would receive information by letter and contact would be made via telephone if available.

Rights and equality

The practice had an adequate and up to date policy in place to promote equality and diversity. Staff told us preferred names and/or pronouns were recorded on patients records to ensure all patients were treated equally and with respect.

We found the practice had reasonable adjustments in place to ensure the setting was accessible to all. The toilet facilities were located on the ground floor. Although most of the surgeries were located on the upper floor of the setting, the setting did have one downstairs surgery which would be used by patients with mobility difficulties.

Delivery of Safe and Effective Care

Safe

Risk management

We saw external and internal areas of the practice were visibly clean and tidy with no obvious hazards.

There was one waiting area available which was of an appropriate size for the setting. A staff room was available for lunch breaks and staff had use of locker facilities to store their possessions.

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

We saw a health and safety policy in place as well as a health and safety risk assessment. The health and safety executive poster was displayed in the downstairs office, upstairs office and the kitchen and the key details had been completed on each poster.

We saw evidence of gas safety records, five yearly fixed wire testing and portable appliance testing (PAT).

We examined fire safety documentation and found adequate maintenance contracts in place. Fire extinguishers were available around the premises and had been serviced within the last year. We saw appropriate signage displayed and evidence was available of routine fire drills. Fire alarm tests were documented, and emergency lighting was being tested on a regular basis. Signs were displayed notifying patients and visitors to the practice that smoking was not permitted on the premises, in accordance with current legislation.

We reviewed the fire risk assessment and found that it had been reviewed on an annual basis. We also found that all staff had up to date fire safety training certificates available for review.

There was a business continuity plan in place to ensure continuity of service provision and safe care for patients.

Infection prevention and control (IPC) and decontamination

We found an appropriate infection, prevention and control policy in place to maintain a safe and clean clinical environment. Cleaning schedules were available to support the effective cleaning of the practice.

We saw personal protective equipment (PPE) was readily available for all staff. The practice had suitable hand hygiene facilities available in each surgery and in the toilets. We were informed there was appropriate Occupation Health support available to staff if required.

The practice had a designated room for the decontamination and sterilisation of dental instruments. We found appropriate processes and equipment in place to safely transport instruments around the practice.

We found the decontamination equipment was regularly tested and was being used safely. We saw evidence of daily logs documented within logbooks and we were told information from the autoclaves were downloaded regularly.

We saw evidence of staff IPC training and the practice had an IPC audit action plan within the last year.

We found that the practice had an appropriate contract in place for the handling and disposal of waste, including clinical waste. The practice made use of a clinical waste bin located to the rear of the premises.

We saw appropriate arrangements in place for the safe handling of substances subject to the Control of Substances Hazardous to Health (COSHH) regulations. However, the COSHH folders did not include an index, making it difficult to locate specific materials or products. While the folders were colour coded, they were not clearly labelled.

The practice must ensure that COSHH folders are clearly labelled and include an up-to-date index to enable staff to quickly and easily locate relevant safety information for all substances.

Respondents to the HIW questionnaire said the practice was ‘very clean’ and all felt that infection prevention and control measures were being followed.

During the inspection, we found that sinks in Surgeries 4 and 5 still had plugs in place, which can present an infection prevention and control risk as they may allow water to pool and harbour bacteria. These were removed on the day of the inspection.

Medicines management

There were suitable procedures in place showing how to respond to patient medical emergencies. All clinical staff had received cardiopulmonary resuscitation (CPR) training. The practice displayed clear signage indicating the location of emergency equipment throughout the premises.

Emergency medicines and equipment were stored in a locked cabinet in a non-clinical area of the practice. Staff advised that the cabinet was kept locked due to its location, as it could potentially be accessed by patients and was not within direct sight of reception staff. We advised that, while security is important, emergency medicines

should be stored in a way that ensures they are immediately accessible in the event of a medical emergency. This matter was addressed during the inspection, with the emergency medicines and equipment relocated to a more suitable location. All relevant signage was updated, and staff were informed of the revised storage arrangements.

The medical emergency bag was complete and contained the appropriate range of equipment. There was a system in place to check the emergency drugs and equipment to ensure they remained in date and ready for use. However, we identified out of date glucose tablets within the emergency bag and in Surgery 1. These were removed immediately.

The practice must ensure that all emergency medicines are routinely checked and that any expired items are promptly identified and removed. Regular stock checks should be strengthened to prevent out of date items, such as glucose tablets, from being stored within emergency kits and surgeries.

We found that Glucagon was stored in a locked refrigerator. We advised the practice that this arrangement could delay access in an emergency.

The practice should ensure that Glucagon is stored in a manner that allows immediate access in an emergency. This could include keeping the refrigerator unlocked or storing the medication outside of the fridge, in line with manufacturer guidance and best practice.

We were informed that all staff received appropriate training in the use of oxygen cylinders as part of their annual CPR training. However, we recommended that staff also complete the BOC online training to further strengthen their knowledge and competency.

The practice must ensure that all relevant staff complete the BOC online oxygen training, in addition to existing CPR training, to enhance their competence and confidence in the safe use of oxygen equipment.

Staff were able to demonstrate their knowledge of the procedures to follow in the event of a medical emergency and the setting had a medical emergencies policy in place.

Safeguarding of children and adults

We saw evidence the practice had an up-to-date safeguarding policy in place. This was in line with the Wales Safeguarding Procedures and included the relevant external contract details for local safeguarding teams. The setting had an appointed safeguarding lead. Staff were aware of the support available to them in the event of a safeguarding concern.

We reviewed safeguarding training records and saw all staff had up to date safeguarding training to an appropriate level.

Management of medical devices and equipment

Staff confirmed they had received appropriate training to ensure they could safely operate equipment. Arrangements were also in place to respond promptly to equipment failure, and maintenance and servicing schedules, including for the compressor, were up to date.

The practice demonstrated appropriate arrangements to support the safe use of ionising radiation. There was evidence of Medical Physics Expert (MPE) support, and comprehensive employer's policies, procedures and protocols were in place. These covered key requirements such as patient identification, entitlement of duty holders, justification and authorisation of exposures, clinical evaluation, communication of risks and benefits, and the management of unintended exposures.

Staff were aware of their duty holder roles and responsibilities, with dentists and appropriately trained nurses undertaking radiography duties. Staff competency and scope of practice were reviewed annually, and entitlement was confirmed on an individual basis. Clinical evaluation of X-rays was completed appropriately, and incidental findings were managed through established internal processes.

There were quality assurance arrangements in place for radiation safety, including equipment testing, image quality review and audit processes. The practice had implemented recognised quality improvement tools to support good practice.

Although quality assurance processes were in place, these did not include checks on viewing facilities (for example, monitor screen performance checks using recognised diagnostic test patterns).

The practice must strengthen its quality assurance programme by including routine checks of digital viewing facilities, such as monitor screen performance, to ensure consistent diagnostic image quality.

The practice had registered with the Health and Safety Executive (HSE) and had completed a radiation risk assessment. Supporting documentation, including local rules, details of the Radiation Protection Adviser (RPA) and Radiation Protection Supervisor (RPS), and equipment testing records, were available and accessible to staff.

While the overall management of radiation safety was good, we identified that an inventory of X-ray equipment, including key details such as manufacturer, model number, serial number and dates of manufacture and installation, was not available at the time of inspection.

The practice must develop and maintain a comprehensive and up to date inventory of all X-ray equipment, including manufacturer details, model and serial numbers, and installation dates, in line with regulatory requirements.

The practice confirmed the use of a Class 4 laser, which was appropriately registered with HIW. However, we found that a patient treatment register for the laser was not currently in use or maintained. In addition, protective goggles for the laser were found to be deteriorating. The practice took immediate action to address this, with replacement goggles ordered on the day of the inspection and evidence provided to HIW.

The practice must ensure that a patient treatment register is implemented and kept up to date for all laser procedures to support safe practice and compliance with regulatory requirements. The practice should also ensure that all protective equipment is regularly checked and maintained in good condition, with a system in place to routinely monitor and replace equipment where necessary.

Effective

Effective care

There were satisfactory arrangements in place for the acceptance, assessment, diagnosis and treatment of patients. These arrangements were documented in the statement of purpose and in policies and procedures.

Patient records

A sample of eight patient records were reviewed. Overall, there was evidence that clinical records were being maintained, demonstrating that care was being planned and delivered to ensure patients' safety and wellbeing. All records were individualised and included appropriate patient identifiers and reasons for attendance. The records were clear, legible, and of good quality. However, we found that language preferences were not being recorded.

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

We found that soft tissue checks were being carried out as part of routine examinations; however, these were not consistently linked to individual patient risk factors, such as smoking status. As a result, patients were not being provided with an individualised mouth cancer risk assessment.

The practice must ensure that mouth cancer screening is supported by a risk-based approach. This should include routinely identifying and recording relevant risk factors, such as smoking and alcohol use, and using this information to inform and communicate an individualised mouth cancer risk assessment to patients.

We found that Basic Periodontal Examinations (BPE) for children were not being conducted at the practice. This may limit the early identification and monitoring of periodontal health in younger patients.

The practice must ensure that BPE assessments are completed in line with current guidance, for example from the British Society of Periodontology, to support effective assessment and ongoing oral health management.

Quality of Management and Leadership

Staff Feedback

Staff who responded to the HIW questionnaire provided positive responses.

Staff who responded felt that the practice employed suitably trained staff and that they were able to manage the competing demands of their role. Staff also confirmed they had received an annual appraisal.

Staff agreed that the care of patients was a top priority and that they were satisfied with the quality of the care and support provided. Staff who responded would recommend the practice as a good place to work and agreed they would be happy for a friend or relative to receive the standard of care provided at the practice.

Staff confirmed that patient's privacy and dignity was maintained and that patients were always informed and involved in decisions about their care.

One staff member commented:

> *"The practice is very good at ensuring all relevant is obtained for patients undergoing any treatment. The staff pride themselves on our customer service provided and feel that reflects by the excellent ratings on platforms like trust pilot."*

Leadership

Governance and leadership

We found that there was a clear and effective management structure in place. Documentation outlining the structure was available, and staff demonstrated awareness of roles and responsibilities within the practice.

A written statement of purpose was in place, which included the required information and had been reviewed within the last year.

The practice had not formally adopted external team development tools such as Maturity Matrix Dentistry or the British Dental Association (BDA) Good Practice Scheme. However, we saw evidence of an internal training matrix used to support staff continuing professional development (CPD) and identify training needs.

Regular team meetings were held on a monthly basis and were documented. Staff told us that additional meetings were arranged when required to address emerging issues. Meeting minutes were recorded, and although verbal updates were typically provided to staff who were unable to attend, written minutes were available to share when required. Meetings were generally scheduled to maximise staff attendance.

We found evidence of effective governance arrangements, with appropriate leadership and accountability in place for a practice of this size and complexity. Leaders demonstrated the necessary skills, knowledge and experience to fulfil their roles.

There were clear systems in place for identifying, recording and managing risks. A compliance manager was responsible for liaising with the wider compliance team and ensuring that audits and risk assessments were completed. Safety alerts, including those from the Medicines and Healthcare products Regulatory Agency (MHRA) and Welsh Government (WG), were managed through an electronic system (iComply). Alerts were reviewed, actioned where relevant, and recorded to demonstrate acknowledgement.

The practice maintained a register of policies and procedures, which was accessible to staff electronically. Staff had access to a computer to review these documents. Policies were regularly reviewed, with a formal annual review process in place, and updated as required.

Workforce

Skilled and enabled workforce

We found that the practice had appropriate arrangements in place to ensure there were sufficient numbers of suitably trained and qualified staff to meet the needs of the service. Staffing levels were managed through the use of an electronic compliance system and oversight from a designated compliance manager.

The practice did not employ temporary or agency staff and instead relied on established team members to provide cover where required. This supported continuity of care and consistency in service delivery.

The provider ensured that staff maintained their GDC registration by funding registration fees and monitoring ongoing continuing professional development (CPD) requirements.

There was a positive and open culture within the practice, where staff told us they felt able to raise concerns. Staff could escalate issues directly to management or communicate within the wider team. A whistleblowing policy was in place to support this process.

Appropriate systems were in place to support staff training, supervision and appraisal. Annual appraisals were undertaken, and staff worked within clearly defined roles, with dental nurses supporting clinicians during procedures. Trainee staff were appropriately supervised and not left to work independently. The practice employed three trainees who were supported through an external training provider, with regular communication between the provider and the practice regarding progress.

Induction arrangements were structured, with a six-month probation period in place

and the use of an induction template. New staff were introduced to the practice environment, team members and key safety information, including emergency equipment.

The practice manager described the pre-employment checks undertaken for any new members of staff. This included checking of references and undertaking Disclosure and Barring Service (DBS) checks. We confirmed that all relevant staff had a valid DBS check in place.

Culture

People engagement, feedback and learning

The practice demonstrated that it had multiple systems in place to gather patient feedback, including patient comment forms, questionnaires and online platforms such as Google and Trustpilot. We also noted a feature on the practice website displaying patient reviews. Arrangements were in place to support access for a range of patients, with both paper-based and online options available, which may help those with differing needs to provide feedback. The practice told us that feedback from all sources was reviewed and analysed to monitor patient experience and inform service delivery.

However, we did not see information displayed within the practice to demonstrate how feedback had been used to drive improvements. Whilst the practice was able to describe examples of changes made in response to feedback, such as enhancing the waiting area environment following comments that it felt uninviting, this was not clearly communicated to patients. The practice should consider implementing a visible “You said, we did” approach to demonstrate how patient feedback is used to inform improvements and encourage ongoing engagement.

The practice reported that there had been no incidents requiring investigation or resulting in service changes

The practice had a clear and accessible complaints procedure available in both Welsh and English, displayed in the reception area and on the website, including relevant HIW information. The process was clearly described, with timescales of acknowledgement within two working days and a full response within 30 days, with any delays communicated to patients. Information also outlined routes for escalation, including the Ombudsman, and signposted external bodies such as the GDC. A named lead was responsible for handling complaints, which was advertised to patients. Complaints were recorded in a dedicated file, and informal concerns were captured through telephone records and patient notes. However, there was limited evidence that themes from complaints were routinely analysed or used to inform service improvements, and the practice should introduce a more structured approach to reviewing and learning from complaints.

The practice must implement a more structured approach to reviewing complaints, including identifying trends and documenting resulting actions. The practice should also ensure that learning from complaints is clearly evidenced and, where appropriate, shared with staff and patients to demonstrate how concerns have led to improvements.

Staff knew and understood their responsibilities under the Duty of Candour. A Duty of Candour policy was in place, and staff had received training in Duty of Candour.

Information

Information governance and digital technology

The practice had systems in place to record patient safety incidents, with all incidents documented in a physical file and recorded as events. Patient safety information was shared with staff verbally, including via a team messaging group and discussed further during team meetings.

Learning, improvement and research

Quality improvement activates

The practice demonstrated some systems to support continuous improvement by having an events register, sharing feedback with staff, and discussing issues in team meetings. There was evidence that the practice considered a range of information sources such as complaints, patient feedback, investigations and reports, and used systems such as iComply and staff meetings to support monitoring and review.

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 found that sinks in Surgeries 4 and 5 still had plugs in place. which	This can present an infection prevention and control risk as they may allow water to pool and harbour bacteria.	This was raised with the Registered Manager.	These were removed on the day of the inspection.
Protective goggles for the laser were found to be deteriorating.	Deteriorating laser protective goggles may not provide adequate protection, increasing the risk of eye injury to both patients and staff during laser procedures	This was raised with the Registered Manager.	The practice took immediate action to address this, with replacement goggles ordered on the day of the inspection and evidence provided to HIW.
We identified out of date glucose tablets within the emergency bag and in Surgery 1.	The presence of out of date glucose tablets may compromise the effectiveness of emergency treatment, potentially delaying appropriate management of patients experiencing hypoglycaemia.	This was raised with the Registered Manager.	These were removed immediately on the day of the inspection.

Emergency medicines and equipment were stored in a locked cabinet in a non-clinical area of the practice. Staff advised that the cabinet was kept locked due to its location, as it could potentially be accessed by patients and was not within direct sight of reception staff.	Emergency medicines should be stored in a way that ensures they are immediately accessible in the event of a medical emergency.	This was raised with the Registered Manager.	This matter was addressed during the inspection, with the emergency medicines and equipment relocated to a more suitable location. All relevant signage was updated, and staff were informed of the revised storage arrangements.

Appendix B – Immediate improvement plan

Service: **Bamboo Cosmetic Dentistry**

Date of inspection: **7 May 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.

Findings	No immediate non-compliance issues were found on this inspection.

	Improvement needed	**Standard / Regulation**
1.		

Service Action:	**Responsible officer**	**Timescale**

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative:

Name (print):

Job role: **Date:**

Appendix C – Improvement plan

Service: **Bamboo Cosmetic Dentistry**

Date of inspection: **7 May 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 saw appropriate arrangements in place for the safe handling of substances subject to the Control of Substances Hazardous to Health (COSHH) regulations. However, the COSHH folders did not include an index, making it difficult to locate specific materials or products. While the folders were colour coded, they were not clearly labelled.	**The practice must ensure that COSHH folders are clearly labelled and include an up-to-date index to enable staff to quickly and easily locate relevant safety information for all substances.**	Regulation 13 - (The Private Dentistry (Wales) Regulations 2017)	The COSHH file now has an index for each section of the file. Stating in order what is in each section. This was completed the day after inspection.	Danielle Love	08/05/2026

2.	Emergency medicines and equipment were stored in a locked cabinet in a non-clinical area of the practice. Staff advised that the cabinet was kept locked due to its location, as it could potentially be accessed by patients and was not within direct sight of reception staff. We advised that, while security is important, emergency medicines should be stored in a way that ensures they are immediately accessible in the event of a medical emergency.	**The practice must review the storage arrangements for emergency medicines and equipment to ensure they are both secure and immediately accessible to staff in an emergency. Consideration should be given to relocating the cabinet to a more appropriate, supervised location or implementing measures that allow rapid access without delay.**	Regulation 13 (2)(a)	Medical emergency kit was moved to a more suitable place on the day of inspection into out central staff area in the cupboards outside of our decontamination room. All signage was moved and changed as necessary.	Danielle Love	07/05/2026

3.	We found that Glucagon was stored in a locked refrigerator. We advised the practice that this arrangement could delay access in an emergency.	**The practice should ensure that Glucagon is stored in a manner that allows immediate access in an emergency. This could include keeping the refrigerator unlocked or storing the medication outside of the fridge, in line with manufacturer guidance and best practice.**	Regulation 13 (2)(a)	This was rectified in the day and staff aware that fridge remains unlocked at all times of the working day and locked on closure of the practice and reopened in the morning.	Taylor Morgan	07/05/2026
4.	We were informed that all staff received appropriate training in the use of oxygen cylinders as part of their annual CPR training. However, we recommended that staff also complete the BOC online training to further strengthen their knowledge and competency.	**The practice must ensure that all relevant staff complete the BOC online oxygen training, in addition to existing CPR training, to enhance their competence and confidence in the safe use of oxygen equipment.**	Regulation 13 (2)(b)	As recommended, staff are in the process of completing this online course	Danielle Love	1 month

5.	Although quality assurance processes were in place, these did not include checks on viewing facilities (for example, monitor screen performance checks using recognised diagnostic test patterns).	**The practice must strengthen its quality assurance programme by including routine checks of digital viewing facilities, such as monitor screen performance, to ensure consistent diagnostic image quality.**	Regulation 16	Diagnostic images are now on all surgery pcs for quality assurance	Danielle Love	08/05/2026
6.	While the overall management of radiation safety was good, we identified that an inventory of X-ray equipment, including key details such as manufacturer, model number, serial number and dates of manufacture and installation, was not available at the time of inspection.	**The practice must develop and maintain a comprehensive and up to date inventory of all X-ray equipment, including manufacturer details, model and serial numbers, and installation dates, in line with regulatory requirements.**	Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R)	We contacted Henry Schein and retrieved all the manufacture date.	Danielle Love	27/05/2026

7.	The practice confirmed the use of a Class 4 laser, which was appropriately registered with HIW. However, we found that a patient treatment register for the laser was not currently in use or maintained. In addition, protective goggles for the laser were found to be deteriorating. The practice took immediate action to address this, with replacement goggles ordered on the day of the inspection and evidence provided to HIW.	**The practice must ensure that a patient treatment register is implemented and kept up to date for all laser procedures to support safe practice and compliance with regulatory requirements. The practice should also ensure that all protective equipment is regularly checked and maintained in good condition, with a system in place to routinely monitor and replace equipment where necessary.**	Regulation 32 (2)	This has now been implemented and all clinicians that are qualified and use laser now are completing a log. Protective goggles were ordered on the day of inspection.	Danielle Love	08/07/2025

8.	Patient records were clear, legible, and of good quality. However, we found that language preferences were not being recorded.	**The registered manager must ensure that patient records are complete and include all relevant information in line with professional standards and guidance.**	Regulation 20	This had been implemented and a new tab on SOE has added, but due to the notes looked at being historic it hadn't been implemented on them.	Danielle Love	07/05/2025
9.	We found that soft tissue checks were being carried out as part of routine examinations; however, these were not consistently linked to individual patient risk factors, such as smoking status. As a result, patients were not being provided with an individualised mouth cancer risk assessment.	**The practice must ensure that mouth cancer screening is supported by a risk-based approach. This should include routinely identifying and recording relevant risk factors, such as smoking and alcohol use, and using this information to inform and communicate an individualised mouth cancer risk assessment to patients.**	Regulation 13	Dentist meeting held to discuss findings, Notes templates have now been adapted to include / prompt assessment.	Danielle Love	09/06/2026

10.	We found that Basic Periodontal Examinations (BPE) for children were not being conducted at the practice. This may limit the early identification and monitoring of periodontal health in younger patients.	**The practice must ensure that BPE assessments are completed in line with current guidance, for example from the British Society of Periodontology, to support effective assessment and ongoing oral health management.**	Regulation 13	Dentist meeting held to discuss findings, Notes templates have now been adapted to include / prompt assessment.	Danielle Love	09/06/2026
11.	There was limited evidence that themes from complaints were routinely analysed or used to inform service improvements, and the practice should introduce a more structured approach to reviewing and learning from complaints.	**The practice must implement a more structured approach to reviewing complaints, including identifying trends and documenting resulting actions. The practice should also ensure that learning from complaints is clearly evidenced and, where appropriate, shared with staff and patients to demonstrate how concerns have led to improvements**.	Regulation 21	Complaints are entered in an event register at the front of the complaints file. We will implement a written review process going forward.	Danielle Love	08/06/2026

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): Danielle Love

Job role: Compliance Manager **Date: 09/07/2026**