Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

# General Dental Practice Inspection Report (Announced)

## BUPA Dental Care Penarth, Cardiff and Vale University Health board

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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 Penarth, Cardiff and Vale University Health Board on 19 May 2026.

Our team for the inspection comprised of a HIW healthcare inspector and a 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 14 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:

Patient feedback about Bupa Dental Care Penarth was very positive. Patients reported that they found it easy to access appointments and were provided with clear information about treatment options, including risks, benefits and costs. Staff were consistently described as professional, respectful and attentive, with patients feeling listened to and involved in decisions about their care. The environment was widely regarded as clean, accessible and supportive of effective infection prevention and control. Most respondents rated the service as 'very good'.

The practice demonstrated a strong person-centred approach, with a range of health promotion materials available and clinicians actively supporting patients to maintain good oral health. Information about services, costs and the dental team was accessible, and systems were in place to ensure patients received aftercare advice where appropriate. Confidentiality and privacy were maintained, with suitable spaces available for private discussions and clear adherence to professional standards.

Patients received individualised care, supported by appropriate clinical record keeping and clear communication throughout their treatment journey. The practice also provided timely access to care, including online booking, flexible appointment times and daily emergency slots. Although private patients were generally seen promptly, some NHS patients experienced longer waiting times for routine care.

The practice demonstrated a commitment to equality and inclusivity, with arrangements in place to support patients with diverse needs, including access to translation services, alternative formats and reasonable adjustments for patients with mobility needs. Staff had completed equality and diversity training and showed awareness of supporting individual patient preferences.

## Delivery of Safe and Effective Care

### Overall summary:

The practice demonstrated strong arrangements to ensure the delivery of safe and effective care. The environment was clean, well maintained and suitable for the services provided, with appropriate facilities, equipment and accessibility arrangements in place to support patient needs. Health and safety systems were robust, supported by comprehensive risk assessments, regular servicing of equipment and clear emergency procedures. Fire safety arrangements, business continuity planning and compliance with statutory requirements were well established.

Effective infection prevention and control (IPC) systems were in place, including clear policies, defined responsibilities and regular auditing. Decontamination processes were managed in line with current guidance, supported by appropriate equipment, maintenance regimes and detailed record keeping. Medicines were generally managed safely, with secure storage, appropriate monitoring and staff awareness of procedures, including those relating to medical emergencies.

Safeguarding arrangements were effective, with trained staff, clear reporting processes and accessible guidance. Clinical equipment and medical devices were appropriately maintained, and compliance with ionising radiation regulations was robust, supported by quality assurance processes and specialist advice.

The practice demonstrated effective care delivery, with systems in place to support appropriate assessment, diagnosis and treatment. Patient records were managed securely, with strong information governance arrangements in line with data protection requirements. Systems were also in place to support efficient service delivery, including referral processes, emergency appointments and effective use of clinical resources.

This is what we recommend the service can improve:

- Ensure emergency medicines and oxygen are stored securely in locations not accessible to patients while remaining readily accessible to staff
- Strengthen training compliance by ensuring all relevant staff are trained in the safe handling and use of oxygen cylinders

This is what the service did well:

- Maintained a safe, well-equipped and compliant environment, supported by robust health and safety, fire safety and risk management arrangements
- Demonstrated strong infection prevention and control processes, including effective decontamination systems and regular auditing

- Delivered effective and well-governed care, with robust safeguarding, record keeping, radiation protection and clinical oversight arrangements.

## Quality of Management and Leadership

### Overall summary:

The practice demonstrated effective management and leadership arrangements, supported by a clear organisational structure and strong team working. Staff reported positively on their training, development and working environment, with evidence of regular appraisals, supervision and access to ongoing professional development. Staff described the practice as well resourced, with appropriate staffing levels, skill mix and access to equipment and IT systems, enabling the delivery of safe and effective care.

Governance systems were well established and proportionate to the size and complexity of the service. Regular team meetings were undertaken, with clear communication processes in place to ensure information was shared across the team. Systems for managing risks, incidents and safety alerts were effective, supported by established reporting mechanisms and the use of Datix. The practice maintained accessible and regularly reviewed policies and procedures, contributing to consistent and well governed care.

The practice had robust workforce arrangements in place, including effective recruitment processes, structured induction programmes and ongoing monitoring of staff training and professional registration. Staff reported feeling supported and able to raise concerns through established ‘Speak Up’ arrangements, contributing to a positive and open culture.

The practice demonstrated a proactive approach to gathering and responding to feedback, with patient and staff feedback used to inform discussions and support service improvement. Complaints processes were in place and aligned with national requirements, with appropriate systems for recording and learning from concerns and incidents.

However, there were areas where further improvements were required to strengthen governance and quality assurance processes. In particular, evidence of consistent staff understanding and application of the Duty of Candour was limited, and quality improvement processes would benefit from greater use of peer review.

This is what we recommend the service can improve:

- Ensure all staff receive Duty of Candour training and fully understand their roles, with consistent application and clear evidence in practice

- Strengthen quality improvement processes through increased peer review and clearer demonstration of how audit and learning result in measurable improvements

This is what the service did well:

- Maintained a well-supported and skilled workforce, with appropriate training, supervision and a positive, open culture for raising concerns
- Used feedback and incident reporting systems effectively to promote learning and continuous improvement.

# 3. What we found

## Quality of Patient Experience

### Patient feedback

Overall, patient feedback was very positive. All respondents reported that it was either ‘very easy’ or ‘fairly easy’ to obtain an appointment when needed. Patients indicated they were given clear and sufficient information about their treatment options, including the associated risks, benefits and costs. They also reported that staff treated them with dignity and respect, explained procedures clearly and listened to their concerns.

Most respondents confirmed they were provided with aftercare advice and felt involved in decisions about their treatment. However, fewer respondents reported receiving clear information about who to contact in the event of an infection or emergency, or how to raise a concern or complaint.

The majority of patients described the environment as accessible and ‘very clean’ and were confident that appropriate infection prevention and control measures were in place.

Almost all respondents rated the service as ‘very good’.

## Person-Centred

### Health promotion and patient information

The practice promoted oral health through a range of information and resources available to patients. Health promotion materials, including leaflets on topics such as smoking cessation and gum disease, were available in the reception area and displayed on walls. We were told that additional information could be printed or emailed to patients on request. Dentists also supported patients to maintain their oral health through discussions during appointments, using an electronic system and a traffic light approach to guide and encourage good oral hygiene practices.

Patients were provided with relevant information about the cost of treatment, with a price list displayed in the waiting area for both NHS and private services. This information was also available on the practice website.

Information about the dental team, including dentists and dental hygienists, was displayed within the practice. Further details about the wider team were accessible within patient information folders located in the waiting area. Opening hours were clearly displayed on the front door, and information about accessing emergency or out

of hours care was available via the telephone answering service and at the practice entrance.

### Dignified and respectful care

The practice had appropriate arrangements in place to ensure patients' dignity and privacy were maintained. All staff had signed confidentiality agreements, which were retained in their personnel files, demonstrating an understanding of their responsibilities in handling sensitive patient information.

Private areas were available to support confidential conversations and telephone calls, with patients able to speak with staff in a vacant surgery room or in a separate office away from the main reception area where required.

Clinical rooms and reception areas were arranged to provide suitable levels of privacy for patients during consultations and interactions with staff.

Information relating to the General Dental Council (GDC) 'Standards for the Dental Team', including the nine principles, was displayed in the waiting area on the patient information board, making this accessible to patients.

### Individualised care

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

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 practice had appropriate systems in place to support patients in accessing care and treatment in a timely manner. Patients were kept informed of any delays, with clinical staff or reception staff communicating waiting times and reasons for delays. Patients were given the option to wait or rearrange their appointment where necessary.

The practice offered online appointment booking for both NHS and private patients, including routine and hygiene appointments, providing additional flexibility for accessing care. Patients could access emergency appointments by contacting the practice directly or through NHS 111.

Urgent care needs were prioritised through the provision of daily emergency appointment slots for each dentist, typically scheduled at the end of each session.

Waiting times for routine treatment varied depending on the clinician, with private patients generally seen within one to two weeks, while some NHS patients experienced longer waiting times of up to two to three months.

The practice also offered a range of appointment times to meet patients' needs, opening from 8:30am (8:00am on Fridays) and providing extended hours until 6:00pm on two evenings each week.

## Equitable

### Communicating and language

The practice had arrangements in place to support patients with a range of communication needs. While there were no Welsh speakers within the staff team, translation services were available through Language Line, and the practice could also access British Sign Language (BSL) support via external services where required. Patient information was available in alternative formats, including large print, and a hearing loop was installed to support patients with hearing impairments.

Staff were provided with access to Welsh language training and were encouraged to undertake this, with one staff member currently completing training in both Welsh language and BSL. Staff were also supported to deliver the Active Offer through training opportunities provided by Health Education and Improvement Wales (HEIW), with the practice promoting and encouraging staff participation.

Although the practice did not receive direct support from the health board in implementing the Active Offer, it reported having access to relevant guidance and information to support compliance.

A range of bilingual information was available, including medical history forms, the chaperone policy, zero tolerance information and the patient information leaflet. Where materials were not available bilingually, arrangements were in place to have these translated upon request.

Staff demonstrated an understanding of the importance of communicating with patients in their preferred language to support safe and effective care.

The practice ensured that patients without digital access were able to access services through non-digital methods, including manual appointment cards, paper copies of medical histories, and written treatment plans where required. Communication preferences were discussed with patients, and correspondence could be provided by letter if needed.

### Rights and equality

The practice demonstrated a positive and inclusive culture, with a clear commitment to

equality and diversity. Staff reported that patients were treated with dignity and respect at all times. The practice had an equality and diversity policy in place, and all staff had completed equality, diversity and inclusion (EDI) training. The team reflected a diverse workforce, with a range of languages spoken, and staff were encouraged to promote inclusive care in their day-to-day interactions.

Arrangements were in place to protect patients and staff from discrimination, including a zero-tolerance policy towards inappropriate behaviour. Staff understood the importance of maintaining a respectful and inclusive environment for all individuals, including those with protected characteristics.

The practice had made reasonable adjustments to support accessibility. Patients with mobility needs could be seen in ground floor surgeries, and the practice provided ramp access at the front entrance as well as additional access via a side entrance for wheelchair users. Patients were offered choice to ensure their needs were met.

The practice also demonstrated an awareness of the needs of transgender patients, with staff treating individuals with respect and ensuring that patient preferences were recorded within clinical records to support personalised care.

# Delivery of Safe and Effective Care

## Safe

### Risk management

Overall, the practice environment was clean, safe and secure, and the premises were maintained in a good state of repair both internally and externally. The size and layout of the practice was generally suitable for the delivery of services.

Appropriate lighting, including emergency lighting, was in place, and servicing documentation for both emergency lighting and air conditioning systems was seen during the inspection.

The waiting area on the ground floor was of an appropriate size to accommodate patients attending the practice, although a smaller waiting space was also located on the middle floor. Overall, sufficient seating was available for patients.

Staff had access to suitable changing and storage facilities, with lockers provided within the staff room.

Toilet facilities were available, signposted, clean and appropriately equipped, including handwashing and drying facilities and sanitary disposal.

Clinical facilities and equipment were appropriate to support safe and effective care. Dental equipment was observed to be in good condition and available in sufficient

quantities to enable effective decontamination between uses. Where appropriate, single-use items were in place, and equipment was available to support safe clinical practice.

A business continuity plan was in place, and staff demonstrated an understanding of their roles and responsibilities in the event of an emergency. A Health and Safety policy was in place, which staff were aware of and followed.

The practice environment was observed to be safe and secure, with no immediate environmental concerns identified during the inspection. A comprehensive health and safety risk assessment was in place, supporting the ongoing management and review of risks.

A fire risk assessment was in place, supported by a maintenance contract for fire safety equipment. Regular testing of fire detection systems was undertaken and recorded, with checks completed weekly and documented within a fire log.

Staff had completed fire safety training, and regular fire drills were carried out, supporting awareness and preparedness. Fire safety equipment, including fire extinguishers, were appropriately located throughout the premises, and clear signage was in place, including fire exits, 'No Smoking' signs and instructions to follow in the event of a fire.

The practice demonstrated compliance with key safety requirements, including valid gas safety certification, portable appliance testing (PAT) and electrical installation inspection records. Required documentation, such as employers' liability insurance and health and safety information, was appropriately displayed and accessible to staff.

## Infection prevention and control (IPC) and decontamination

The practice had appropriate arrangements in place to support infection prevention and control. An infection control policy was in place, alongside an effective cleaning schedule to maintain a clean and safe environment. Hand hygiene facilities were available and used appropriately, and personal protective equipment (PPE) was accessible, used correctly and changed as required.

The environment was suitable to support effective infection control and was maintained in a good state of repair to enable appropriate cleaning. Responsibility for infection control was clearly defined, with a designated lead in place.

The practice had appropriate occupational health arrangements in place, including access to support for vaccinations and the management of sharps injuries. Staff confirmed they were aware of the sharps injury protocol and could access relevant support when required.

Effective systems were in place for the decontamination of instruments and reusable medical devices. Records demonstrated that periodic testing of decontamination

equipment, including autoclaves and ultrasonic baths, was carried out in line with relevant guidance. Daily maintenance programmes and surgery checklists were in place, and pre-sterilisation cleaning was undertaken using ultrasonic baths. Autoclaves were used appropriately, with cycle records maintained and servicing requirements met.

Arrangements for the safe transportation and processing of instruments were appropriate, including the use of secure containers and the separation of decontamination processes from clinical activities. Start and end of day checks were undertaken, and impressions were disinfected appropriately prior to processing.

Infection control audits were undertaken regularly, with the most recent completed in February 2026.

Appropriate arrangements were also in place for the management and disposal of waste, including a contract for the disposal of clinical waste.

## Medicines management

A medicines management policy was in place, supported by procedures covering the ordering, recording, handling, use, safe keeping, dispensing, administration and disposal of medicines. Records of medicines administered were maintained, and patients were provided with appropriate information about prescribed medicines.

Access to medicines and prescription pads was appropriately controlled, with secure storage arrangements in place, including the use of a locked safe and sign-in/sign-out processes. Controlled drugs were managed safely, with appropriate arrangements for denaturing and disposal observed, including the presence of two staff members during the process.

Medicines requiring refrigeration were stored appropriately within a designated medicines fridge, with temperatures monitored and recorded daily. Clear processes were in place to respond to any deviations outside the required temperature range.

Appropriate arrangements were in place for managing medical emergencies. Policies were aligned with current national guidance, subject to regular review and accessible to staff. Staff demonstrated awareness of these procedures and had received up to date training in cardiopulmonary resuscitation (CPR), including the management of anaphylaxis. Suitable emergency medicines and resuscitation equipment were available and met national guidelines.

Arrangements were in place for the maintenance and use of oxygen cylinders, including evidence of servicing and maintenance checks. A process was also in place for reporting and managing faults, with defective equipment removed from use promptly.

However, we identified some areas for improvement. We noted that emergency medicines were being stored in a location that was accessible to patients.

**The practice should ensure that emergency medicines and oxygen are stored securely in a location that is not accessible to patients, while remaining readily accessible to staff during an emergency.**

We also noted that not all staff had completed training in the safe use of oxygen cylinders.

**The practice should ensure that all relevant staff complete appropriate training to support the safe handling and use of oxygen cylinders in line with recommended guidance.**

A first aid kit was available, and appropriate first aid arrangements were in place.

## Safeguarding of children and adults

The practice had appropriate safeguarding policies and procedures in place, which included local contact details for reporting concerns. Staff had access to safeguarding information through a shared electronic system and supporting visual prompts, including posters displayed within surgeries. A designated safeguarding lead was identified, and staff were aware of who to contact locally in the event of a concern.

Staff demonstrated an understanding of the steps they would take to identify, respond to and report safeguarding concerns. They described raising concerns through the safeguarding lead and internal reporting systems, such as Datix. All staff had completed child and adult safeguarding training at an appropriate level.

The practice had arrangements in place to ensure access to up-to-date guidance, including shared policy platforms and visible information within clinical areas.

## Management of medical devices and equipment

Overall, clinical equipment at the practice was found to be safe, well maintained and suitable for its intended use. There were clear arrangements to respond promptly to equipment or system failures. The compressor had been serviced within the last year, and staff received induction and training to support the safe use of equipment.

In relation to ionising radiation, the practice demonstrated compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017. Appropriate employer procedures and protocols were in place, covering key areas such as patient identification, entitlement of duty holders, justification and authorisation of exposures, clinical evaluation, and communication of risks and benefits to patients. Staff were aware of their IR(ME)R roles and responsibilities, supported by local rules and radiation protection documentation.

The practice had appropriate support from a Medical Physics Expert and maintained a comprehensive quality assurance programme. This included regular testing and maintenance of X-ray equipment, audit processes, and monitoring of image quality and

patient dose. Records confirmed that each exposure was justified, authorised and clinically evaluated, and that patient information was clearly documented.

Radiation protection arrangements were robust, with a current risk assessment, and appropriate consultation with a Radiation Protection Adviser. Local rules were accessible to staff and included all required information. Equipment inventories and servicing records were up to date, and digital imaging systems were supported by data back up and routine quality assurance checks.

The practice had also engaged with quality improvement activity, including use of HEIW's ionising radiation tool. We noted that no actions were identified at the most recent review.

## Effective

### Effective care

The practice had appropriate arrangements in place to support the safe and effective acceptance, assessment, diagnosis and treatment of patients. Evidence confirmed that professional, regulatory and statutory guidance was followed when providing care.

The practice used Local Safety Standards for Invasive Procedures (LocSSIPs) checklists to minimise the risk of wrong site tooth extractions. In addition, staff demonstrated that they sought and obtained relevant professional advice where required, supporting safe and informed clinical decision-making.

### Patient records

The practice had appropriate systems in place for record keeping and records management, which supported patient care and upheld patients' rights. A comprehensive records management policy was in place, ensuring that patient records were handled safely and securely. The practice also maintained appropriate policies relating to consent and the management of patients who lack capacity.

Information governance arrangements were robust, with evidence that patient information was managed in line with the Data Protection Act 1988 and the General Data Protection Regulation (GDPR). Patient records, including digital records and study models, were stored securely, with appropriate back-up systems in place for electronic data. Paper records were not held at the practice.

Records were retained in line with appropriate retention periods, and systems were in place to ensure that follow-up and discharge information for referred patients was reviewed and acted upon. The practice had a referrals policy to support the management of patients referred for suspected oral cancer, including ensuring appropriate follow-up.

## Efficient

### Efficient

The practice has arrangements in place to support the efficient delivery of care, including shared care pathways, the use of emergency appointment slots, and systems for managing cancellations. Referrals to other services are recorded within patient records, supporting continuity of care. The facilities and premises were found to be appropriate for the services provided. Clinical sessions are utilised effectively, with sufficient clinicians available to meet service demand.

# Quality of Management and Leadership

### Staff Feedback

Staff reported they had received appropriate training for their roles and had undertaken recent appraisals or development reviews.

Respondents described the facilities and environment as suitable for delivering patient care, with sufficient staffing levels, appropriate skill mix and access to necessary equipment and IT systems. Staff expressed positive views regarding patient care, reporting that patients' privacy and dignity are maintained and that patients are involved in decisions about their care.

Staff indicated that patient experience feedback is routinely collected and that the organisation encourages the reporting of incidents and learning from them.

Overall, staff reported positively on working conditions, health and wellbeing support and the standard of care provided, with all respondents indicating they would recommend the practice as a place to work and for receiving dental care.

## Leadership

### Governance and leadership

The practice has a clear and effective management structure, supported by an organisational chart displayed in the staff room, with staff demonstrating a good understanding of roles and responsibilities. Team working appeared to be well established, with regular meetings taking place at least bi-monthly. These meetings were minuted and shared with all staff to ensure effective communication, including those unable to attend.

There was evidence of ongoing quality improvement activity, including the use of audits such as smoking cessation. Governance arrangements were in place and considered appropriate for the size and complexity of the service, with leadership demonstrating

the necessary skills, knowledge and experience. Systems were established for managing risks and safety alerts, including the use of Datix, risk assessments and structured processes for disseminating MHRA and Welsh Government guidance.

The practice maintains a centralised system for policies and procedures, accessible to all staff, which were reviewed annually or in response to changes and communicated appropriately.

## Workforce

### Skilled and enabled workforce

The practice had appropriate systems in place to ensure there were sufficient numbers of suitably trained and qualified staff. Staffing levels are managed through forward rota planning, with at least two members of staff present on site in line with the lone working policy. The practice does not routinely rely on temporary or agency staff, supporting continuity of care, although arrangements were in place to access additional staff if required.

Systems were in place to support staff in maintaining professional registration and ongoing training, including mandatory training programmes, CPD monitoring and competency tracking. Staff were supported through regular supervision, one-to-one meetings and appraisals, alongside a structured induction programme for both clinical and non-clinical roles.

There were clear processes for raising concerns, including a ‘Speak Up’ (whistleblowing) policy, and staff reported they felt able to raise issues openly. Performance concerns were addressed promptly through established management processes. Recruitment procedures were robust, with appropriate pre-employment checks completed to ensure staff meet fitness to practise requirements.

The practice had appropriate policies and procedures in place to support the safe and effective recruitment and employment of staff. There was evidence that the practice had processes in place to undertake appropriate pre-employment checks, including Disclosure and Barring Service (DBS) checks, which were completed centrally by the organisation. DBS renewal checks are undertaken every 5 years. We suggested the practice considered additional safeguards, such as introducing an annual staff self-declaration to provide further assurance between renewal periods.

## Culture

### People engagement, feedback and learning

The practice demonstrated a proactive approach to gathering and responding to patient feedback, with multiple mechanisms in place including verbal feedback, online reviews, post-treatment surveys and feedback forms. Feedback is predominantly received through online surveys and is shared and discussed within staff meetings to support service improvement.

The practice reviews patient feedback regularly and takes action where required, with discussions held during team meetings. Systems are in place to record and share learning from incidents, including the use of Datix and team communication processes.

However, information on how the practice has used feedback to make improvements is not currently displayed for patients, which was recognised by the practice. The practice should consider how it can make information more visible to patients about how feedback is used to drive improvements, in order to encourage engagement and demonstrate responsiveness.

The practice has a complaints procedure in place which is displayed and accessible to patients and is aligned with the 'Listening to People' (LtP) process for NHS care and treatment. A named lead is responsible for managing complaints, and this information is communicated to patients.

Complaints, including verbal concerns, are recorded through an established logging system and Datix, supporting oversight and learning. Feedback from complaints and incidents is shared with staff through meetings to promote a culture of learning and improvement.

The practice is aware of its responsibilities under the Duty of Candour (DoC) and has a policy in place aligned with current guidance. Staff reported that they are encouraged to raise concerns when things go wrong and to communicate openly with patients.

However, we were not fully assured that staff understood the Duty of Candour or their roles and responsibilities in practice. Training had only been completed by two senior members of staff, which is likely to limit wider awareness across the team. While appropriate policies were in place, further work is needed to ensure all staff are trained, understand their responsibilities, and apply the Duty of Candour consistently in practice.

**The practice must ensure that all staff receive appropriate training on the Duty of Candour and have a clear understanding of their individual roles and responsibilities.**

## Information

### Information governance and digital technology

The practice had systems in place to ensure that patient safety incidents were recorded, with the use of an electronic reporting system. Information relating to patient safety was shared with staff through established communication channels, including email and regular staff meetings, supporting awareness across the team.

Where relevant, the practice used information from incidents to inform improvements to the service. For example, appropriate action had been taken in response to equipment-related issues, demonstrating the ability to implement changes when required.

## Learning, improvement and research

### Quality improvement activates

The practice had appropriate policies and procedures in place to support quality improvement activities and undertakes a range of clinical audits, including those related to antibiotic prescribing, healthcare waste, health and safety, disability access and smoking cessation. The practice primarily used an established internal audit programme to support compliance with current standards.

However, while audits were undertaken, these were largely completed as self-audits with limited evidence of peer review of clinical work. There was also limited evidence of how learning from audits, research or service reviews was consistently translated into improvements and communicated to patients, although this had been considered by the practice. Systems for auditing patient records were in place, but additional peer review would further strengthen quality assurance processes.

**The practice must strengthen its quality improvement processes by ensuring that clinical audits are supported by regular peer review, including for patient records. The registered provider should ensure that learning from audits, service reviews and research is consistently used to drive measurable improvements and is clearly communicated to patients, for example through the use of display materials.**

## Whole Systems Approach

### Partnership working and development

The practice worked with relevant system partners where required, including GPs, pharmacists and safeguarding teams. Clinicians engaged with external services appropriately to support patient care, with referrals and communication initiated based on clinical need. These arrangements supported collaborative working and continuity of care.

# 4. Next steps

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

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

The improvement plans should:

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

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

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

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

# Appendix A – Summary of concerns resolved during the inspection

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

| Immediate concerns Identified | Impact/potential impact on patient care and treatment | How HIW escalated the concern | How the concern was resolved |
|---|---|---|---|
| No immediate concerns were identified on this inspection | | | |

# Appendix B – Immediate improvement plan

**Service:** **BUPA Dental Care Penarth**

**Date of inspection:** **19 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** |
| | | | |

# Appendix C – Improvement plan

**Service:** **BUPA Dental Care Penarth**

**Date of inspection:** **19 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. | Emergency medicines were stored in a location that was accessible to patients. | The practice should ensure that emergency medicines and oxygen are stored securely in a location that is not accessible to patients, while remaining readily accessible to staff during an emergency. | The Private Dentistry (Wales) Regulations 2017- Regulation 31 (3)(b) | All emergency drugs kit, including defibrillator, oxygen cylinders and first aid box have been moved to an accessible cupboard behind the reception desk and relevant signs displayed on the cupboard | Nicola Hooper | Completed |

| | | | | | | |
|---|---|---|---|---|---|---|
| **2.** | We noted that not all staff had completed training in the safe use of oxygen cylinders. | The practice should ensure that all relevant staff complete appropriate training to support the safe handling and use of oxygen cylinders in line with recommended guidance. | Regulation 8 (1)(a) and Regulation 17 (3)(a) | All team members have now completed the BOC training | Nicola Hooper | Completed |
| **3.** | We were not fully assured that staff understood the Duty of Candour or their roles and responsibilities in practice. Training had only been completed by two senior members of staff, which is likely to limit wider awareness across the team. While appropriate policies were in place, further work is needed to ensure all staff are trained, understand their responsibilities, and apply the Duty of Candour consistently in practice. | The practice must ensure that all staff receive appropriate training on the Duty of Candour and have a clear understanding of their individual roles and responsibilities. | Regulation 17 (3)(a) | All team have been informed that the required training is to be completed. Currently around 50% of the team have completed this with the aim for the remaining team members to complete this training by the end of July 2026 | Nicola Hooper | Full team completion by end of July 2026 |

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| **4.** | While audits are undertaken, these are largely completed as self-audits with limited evidence of peer review of clinical work. There was also limited evidence of how learning from audits, research or service reviews is consistently translated into improvements and communicated to patients, although this has been considered by the practice. Systems for auditing patient records are in place, but additional peer review would further strengthen quality assurance processes. | The practice must strengthen its quality improvement processes by ensuring that clinical audits are supported by regular peer review, including for patient records. The registered provider should ensure that learning from audits, service reviews and research is consistently used to drive measurable improvements and is clearly communicated to patients, for example through the use of display materials. | Regulation 16 (1)(a) and 16(2)(d)(ii) | All clinicians have completed a peer review of their peers' clinical note taking. We will implement this to take place routinely going forward with 6 monthly auditing in place | Nicola Hooper | Completed |

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): Nicola Hooper**

**Job role: Practice Manager** **Date: 16/07/2026**