Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

General Dental Practice Inspection Report (Announced)

Newport Smile Centre, Aneurin Bevan 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 Vision

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

Our Values

We place people at the heart of what we do.

We are:

Independent – we are impartial, deciding what work we do and where we do it.

Objective - we are reasoned, fair and evidence driven.

Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find.

Inclusive - we value and encourage equality and diversity through our work.

Proportionate - we are agile and we carry out our work where it matters most.

Our Priorities

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

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

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

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

Contents

1. What we did

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

Healthcare Inspectorate Wales (HIW) completed an announced inspection of Newport Smile Centre, Aneurin Bevan University Health Board on 16 June 2026.

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

During the inspection we invited patients to complete a questionnaire to tell us about their experience of using the service. Patients completed a total of ten questionnaires. Feedback and some of the comments we received appear throughout the report.

2. Summary of inspection

Quality of Patient Experience

Overall summary:

Overall, patients provided positive feedback about Newport Smile Centre, with most rating the service as ‘good’ or ‘very good’. Patients reported that staff explained treatment clearly, discussed treatment options and costs, and involved them in decisions about their care.

We found arrangements in place to enable timely access to routine and urgent appointments. The practice demonstrated a commitment to equality and inclusion, including accessible facilities and staff training on equality and diversity.

However, improvements were required in several areas. The range of patient information was limited, with little oral health promotion material available for patients. Some professional information, including staff registration details and the GDC ethical principles, was not consistently displayed at the outset of the inspection. We found patient information was not available in alternative formats.

This is what we recommend the service can improve:

- To review the practice information leaflet to ensure compliance with the regulations

This is what the service did well:

- Friendly, welcoming team
- Comfortable waiting area
- Short notice list used to help fill cancelled appointments.

Delivery of Safe and Effective Care

Overall summary:

The practice provided care within premises that were reasonably well maintained and appropriately equipped, with spacious surgeries. We saw suitable systems in place for safeguarding and medical emergencies. Dental equipment, including X-ray facilities, was generally well managed. Suitable policies were in place for consent and digital records management.

Patients were actively checked for any changes in their medical history, while the practice used recommended checklists to help prevent wrong tooth extractions which we considered good practice.

However, significant concerns were found in relation to fire safety, including inadequate evidence of staff fire training and a lack of annual fire safety reviews. Infection prevention and control processes were not consistently effective, with concerns regarding cleanliness, outdated auditing and decontamination practices. Improvements were also required in the secure storage of medicines, prescription pads and substances subject to COSHH regulations. We also found numerous omissions in the patient records we reviewed.

Immediate assurances:

- Arrange for a deep clean of the surgeries including dental chairs and their attachments
- Resume the use of daily surgery checklists
- Complete a WHTM 01-05 audit as soon as practicably possible
- Implement a consistent approach to date-stamping the sterilised instrument pouches and ensure that all staff are aware of the dates that must be used
- Re-sterilise all reusable instruments that were packaged in the pouches, and ensure that the new pouches are stamped with the correct date/s
- Ensure all relevant staff completed appropriate fire safety training
- Review fire safety arrangements annually
- Provide HIW with an up-to-date written fire safety risk assessment
- Ensure all patient records are kept locked away in a secure location within the premises.

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

This is what we recommend the service can improve:

- To improve staff changing facilities
- To use ‘clean’ boxes to transport sterilised instruments from the decontamination room
- Autoclave record sheets to identify the autoclave to which it refers
- Use vacuum autoclaves to sterilize instruments with a lumen in accordance with relevant guidance
- To ensure COSHH storage is locked
- To appoint and train an additional first aid responder
- To implement a process for monitoring urgent referrals.

This is what the service did well:

- Well-equipped surgeries
- Sharps injury protocols were displayed in each surgery.

Quality of Management and Leadership

Overall summary:

The practice had a clear management structure, but leadership responsibilities were stretched across a small team. While the registered manager responded positively and addressed several issues promptly, further work was required to strengthen governance and ensure consistently safe and effective care.

We found staff absence arrangements relied on support from a branch practice, although communication of local procedures required improvement.

There was no formal process for collecting or responding to patient feedback while the complaints procedure required updating to reflect current NHS Wales requirements.

Although the practice participated in recognised quality improvement initiatives, audit activity was limited and would benefit from a structured programme to support ongoing monitoring and improvement.

Training oversight was ineffective with gaps identified in mandatory training records for the hygienist.

Immediate assurances:

- To provide up-to-date mandatory training records for the practice therapist
- Take immediate action to strengthen staff training governance arrangements.

This is what we recommend the service can improve:

- To develop and implement a suitable recruitment policy
- To review and update relevant policies as necessary
- To ensure the induction process is completed for all staff including temporary cover from the branch practice
- To develop and implement a system for regularly seeking feedback from patients
- To review and update the complaints procedure
- To implement an ongoing programme of audits.

This is what the service did well:

- Team meetings minutes recorded and shared with staff
- Good compliance with professional obligations.

3. What we found

Quality of Patient Experience

Patient feedback

Patients who completed a HIW questionnaire provided positive feedback about their care at Newport Smile Centre. Most patients who responded rated the service as 'good' or 'very good'.

Person-Centred

Health promotion and patient information

We inspected the patient waiting area and saw that costs of treatment were displayed for both NHS and private patients. However, relevant dental healthcare information was limited, consisting of smoking cessation leaflets only. The practice should ensure patients have access to a broader range of current and relevant information to support preventative care and informed decision-making about their oral health. This could include information on oral hygiene, prevention of tooth decay and gum disease, healthy diet, fluoride use and oral health for children, where appropriate. We reviewed the patient information leaflet as required by the Private Dentistry (Wales) Regulations 2017. On review we noted that the contact details provided for complaints referred to NHS England and did not include the details of HIW. We were also told that the arrangements for seeking patient feedback described in the patient information leaflet were incorrect.

The registered manager must review and update the patient information leaflet to ensure it remains accurate and up to date and ensure it is reviewed on at least an annual basis.

The dental team names and General Dental Council (GDC) registration numbers that were displayed consisted of only the dentists, whilst those of the therapist and newly qualified nurse were not displayed. We raised this with the registered manager who arranged for the therapist details to be displayed during the inspection. We were told that the nurse's details would be displayed as soon as they were received.

All respondents who answered the HIW patient questionnaire told us that staff explained what they were doing throughout their appointment, had their oral care explained to them in a way they could understand and had received advice about how to maintain good oral health.

Dignified and respectful care

We were told that there were no patients booked for the day of the inspection, therefore we were unable to observe staff interactions with patients. The reception desk and waiting area were in the same room providing patients with limited privacy when reporting to reception. We were told that a spare surgery could be utilised for any confidential or sensitive discussions.

We found the GDC nine core ethical principles of practice were not displayed at the practice. We raised this with the registered manager who arranged for the principles to be displayed during the inspection.

We were told that a confidentiality agreement was provided to all staff via an external human resource provider, although we were unable to verify that staff had read and understood this document. The practice should ensure appropriate arrangements are in place to provide assurance that staff are aware of and adhere to the confidentiality requirements.

Most respondents who completed the HIW patient questionnaire felt they were treated with dignity and respect at the practice.

Individualised care

All respondents who completed a HIW patient questionnaire said that they were given enough information to understand both their treatment options and the risks and benefits associated with those options. Where applicable, all respondents agreed that the costs were made clear prior to commencing treatment.

All respondents told us they had been involved as much as they had wanted to be in decisions about their treatment whilst most confirmed that staff listened to them and answered their questions. All except one confirmed they had their medical history checked prior to treatment.

Timely

Timely care

We were told that patients were advised of any delays to appointment times by the receptionist. This was aided by an instant messaging system between the clinicians and reception. We were advised that waiting times between treatments varied between two to three weeks.

Patients who required emergency treatment would need to telephone as soon as possible with the aim to be seen on the same day, with emergency slots planned each day to help facilitate this.

The opening hours and out of hours contact details were displayed and visible from outside.

Most respondents who completed the HIW patient questionnaire said it was easy to get an appointment when they needed one. Whilst all said they had clear guidance about what to do if they had an infection or emergency, two respondents said that they did not know how to access out of hours care for urgent dental problems.

Equitable

Communicating and language

A hearing loop system was installed to aid communication with patients with impaired hearing. We found limited information in the practice that was available both in Welsh and English. We found limited bilingual information displayed within the practice. Translation services were available where required, although information about these services was not prominently displayed. Staff were initially unaware of the Welsh Language Active Offer; however, information promoting the Active Offer was displayed during the inspection following discussion with the registered manager. The practice may wish to consider reviewing how information about available communication and language support is promoted to patients.

Dental appointments could be booked by telephone or in person at reception, ensuring patients without digital access could arrange treatment.

Rights and equality

The practice had a current equality and diversity policy in place, and we found that staff had completed training on this topic. We were assured that the practice recognised the rights and needs of transgender patients, with preferred pronouns and names used as requested.

The practice was located on both the ground and first floor of the premises with the treatment rooms available on both levels. There was level access into the premises and around the ground floor enabling easy access for patients with impaired mobility and wheelchair users. An accessible toilet was available, although we found a small cupboard which needed to be relocated as it prevented the toilet door from opening fully.

All respondents who completed the HIW patient and staff questionnaires confirmed that they had not faced discrimination at the practice. Most respondents felt the practice was either fully, or partially accessible.

Delivery of Safe and Effective Care

Safe

Risk management

In general, we found the building in a reasonable state of repair, with rooms decorated and furnished to a good standard and well equipped, spacious surgeries. However, a building maintenance policy was not in place to set out how the practice would ensure the premises always remain fit for purpose. We raised this with the registered manager who created a policy shortly after the inspection.

The patient waiting area was clean, comfortable and clutter free. Whilst staff had an area to change, this was in a communal area that lacked privacy. We also noted that there was nowhere secure that staff could keep their personal belongings.

The registered manager must ensure private changing facilities and secure storage facilities are available for staff.

We found a business continuity policy in place which set out the procedures to be followed were it not possible to provide dental services due to an emergency event or disaster. This included a reciprocal arrangement with a nearby dental service to enable continuation of services following such an event. We saw an approved health and safety poster and the employer's liability insurance were displayed as required. A

current five yearly Electrical Installation Condition Report (EICR), Portable Appliance Testing (PAT) records and an annual gas safety certificate were all available.

We inspected the arrangements in place in relation to fire prevention. We saw evidence of weekly fire alarm checks and regular evacuation drills. Fire exits were clear and signposted. However, the practice was only able to provide evidence of suitable fire safety training undertaken by one staff member. In addition, the practice was unable to provide an up-to-date fire risk assessment, or evidence that annual reviews of fire safety arrangements had been conducted.

We were therefore not assured that adequate precautions were being taken against the risk of fire. This issue was addressed under our immediate assurance process at Appendix B.

Infection prevention and control (IPC) and decontamination

On reviewing the IPC processes and procedures at the practice, we found an appropriate IPC policy was in place, the provision of personal protective equipment was appropriate, and surgeries were suitably furnished to enable effective cleaning. However, the practice had ceased completing daily surgery checklists, which may have contributed to a significant accumulation of dust, dirt and debris that was found in the first-floor surgery. This included inside cupboards, on dental chairs and on equipment. To a lesser degree, dust and dirt were also found in the ground floor surgery. We also noted that the last Welsh Technical Health Memorandum (WHTM) 01-05 IPC audit had been completed in 2024 and was therefore out of date. This meant we were not assured that robust IPC systems were in place at the practice. This issue was addressed under our immediate assurance process and further information on the remedial actions taken by the practice can be found at Appendix B.

The practice had a sharps injury protocol displayed in each surgery while we saw that sharps bins were safely stored. Occupational health support was available for vaccinations and sharps injuries advice.

We inspected the decontamination arrangements at the practice. There were two non-vacuum autoclaves in use, and we saw evidence that the decontamination equipment was checked and maintained as required. Staff demonstrated arrangements for the decontamination of reusable dental instruments. However, while ‘dirty’ boxes were used to transport used instruments from the surgeries to the decontamination room, the practice did not have separate ‘clean’ boxes to transport the sterilised instruments back to the surgeries. We also found that autoclave cycles were recorded on individual record sheets but did not indicate which autoclave they referred.

The registered manager must:

- **Implement the use of 'clean' boxes to transport sterilised instruments from the decontamination room to the surgeries**
- **Ensure autoclave cycle records clearly indicate the autoclave to which they refer.**

We found that date stamping of sterilized instrument pouches was inconsistent; some bags were marked with the date they were decontaminated, some bags were marked with the expiry date and some bags had no dates. This meant we were not assured that decontamination processes were suitably robust. This issue was addressed under our immediate assurance process at Appendix B.

We saw that the practice provided dental implant services which required the use of dental instruments featuring a lumen. However, we found that the practice was using two type N non-vacuum autoclaves to clean such instruments. The Welsh Technical Health Memorandum (WHTM) 01-05 indicates that type N non-vacuum autoclaves are not considered appropriate for reprocessing instruments with a lumen, and that, as best practice, a type B vacuum autoclave should be used for this purpose.

The registered manager should ensure instruments with lumens are sterilised using equipment suitable for that purpose and in accordance with relevant decontamination guidance.

We saw that contracts were in place to safely transfer waste from the practice with clinical waste stored appropriately while awaiting collection. However, we found substances subject to Control of Substances Hazardous to Health (COSHH) to be stored in an unlocked cupboard which was accessible to patients and other visitors to the practice.

The registered manager must ensure hazardous substances which are subject to COSHH regulations are stored securely.

Medicines management

We saw that the practice had a medicines management policy in place. Suitable processes were in place for ordering and checking stocks of medicines, while those administered were clearly recorded within patient records. We were told that patients received both online reminders and were prompted by the receptionist to update clinicians about their medical history prior to each appointment. However, we found that prescription pads and emergency drugs were not being stored securely. We also found food belonging to staff was being stored in the medicine fridge.

Our concerns regarding these matters were dealt with during the inspection. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix A.

The practice had an appropriate policy for managing medical emergencies at the practice. We found a suitable system for checking that emergency equipment was available and in date. We confirmed that all staff had completed resuscitation training.

We found the first aid kit was suitably stocked with all items in date. Whilst one staff member was appointed and trained as a first aid responder, there was no one suitably trained to cover during leave and absence.

The registered manager must ensure sufficient staff are trained and appointed as first aid responders to ensure continuous cover when practice is in operation.

Management of medical devices and equipment

We found all surgeries were suitably equipped to provide effective dental treatment with clinical equipment generally well maintained. We were provided with documentation which indicated safe arrangements were in place for the use of X-ray equipment at the practice. Local rules, radiation risk assessment and X-ray maintenance records were up to date. However, we found that required signage warning visitors of the presence of X-ray equipment was not displayed on each surgery door, while advice about the risks and benefits of dental X-rays was not displayed in written form where patients could see it. Both matters were resolved during the inspection. In addition, we found X-ray barrier envelopes were stored loose and open to contamination.

Our concern regarding this matter was dealt with during the inspection. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix A.

All staff who were involved in the use of X-rays had completed the necessary training and we saw evidence of this within the staff files we reviewed.

Safeguarding of children and adults

The practice had an appropriate safeguarding policy in place which included the contact details for the local safeguarding team. A safeguarding lead was appointed and had access to the latest guidelines. Support for staff in the event of a safeguarding concern was available from the practice lead. We saw that all staff had completed child and adult protection training although the practice lead was unable to confirm that this

was to the appropriate level. We raised this immediately with the registered manager and evidence that this training was completed was supplied to HIW immediately following the inspection.

Our concern regarding this matter was dealt with during the inspection. Further information on the issues we identified, and the actions taken by the service, are provided in Appendix A.

Effective

Effective care

We found recommended checklists were in use to help minimise the risk of wrong tooth extractions. While staff were aware of their roles and responsibilities and were able to obtain relevant professional advice where necessary.

However, we identified a number of concerns relating to the delivery of safe and effective care, which are detailed in Appendix B of this report. Several of these issues had also been identified during the previous inspection, indicating that improvements had not been fully embedded into practice and that opportunities for learning and sustained improvement had not been consistently realised.

Despite these concerns, the registered manager responded positively to the issues raised during the inspection. We received evidence that improvements had been implemented promptly following the inspection to address the concerns identified and strengthen arrangements for the delivery of safe and effective care.

Patient records

We found an appropriate records management policy was in place, whilst suitable processes were in place for obtaining informed consent from each patient prior to treatment. There was a suitable records management system in place to ensure digital patient records were kept safe, secure and retained for appropriate periods in accordance with the regulations. However, we found older paper patient records were being stored in unlocked cupboards. These were in a room that was not fitted with a lock and was therefore easily accessible to anyone entering this area of the practice.

This meant we were not assured that paper records containing sensitive personal data were being kept securely. This issue was addressed under our immediate assurance process at Appendix B.

We reviewed a sample of ten patient records and found the overall standard of record keeping required improvement. Whilst suitable patient identifiers, medical history and medical history updates were recorded, information relating to preventative care was not consistently documented. Records of alcohol consumption, tobacco use and the provision of oral hygiene advice was sporadic.

We also identified omissions in key aspects of clinical record keeping. Treatment planning, Basic Periodontal Examinations (BPEs), and informed consent was not being consistently recorded. Where radiographs had been taken, records did not always demonstrate appropriate authorisation, dose or clinical evaluation, and radiograph quality grading was absent from all records reviewed. In addition, where antibiotics had been prescribed, the indication, dosage and duration of treatment were not consistently documented

We also found no evidence that patients' language preferences were recorded within the records reviewed. The range and frequency of omissions identified did not provide assurance that records consistently supported continuity of care, clinical decision-making and effective governance. Regular, structured audits of patient records would assist the practice in identifying and addressing these issues.

The registered manager must take action to improve the quality and completeness of patient records and provide HIW with details of the improvements implemented. Regular audits of patient records should be undertaken to monitor compliance and support sustained improvement.

Efficient

Efficient

We found that clinical sessions were being used efficiently, with a short notice list in use to help fill any cancelled appointments. However, we found there was no process in place for tracking urgent cancer treatment referrals.

The registered manager must implement a process for managing and tracking all urgent referrals.

Quality of Management and Leadership

Leadership

Governance and leadership

As a small practice, there was a clear management structure in place, although management responsibilities were shared between the two dentists rather than being undertaken by dedicated management staff. One dentist also undertook the role of practice manager in addition to their clinical responsibilities. We were told that the registered manager worked at the practice one day per week, spending the remainder of the week at another practice.

Regulation 11(4) requires registered managers to spend sufficient time at each practice they manage to ensure it is managed effectively. We identified a number of governance and compliance issues during this inspection and during our previous inspection at the practice. This did not provide assurance that there were sufficient management oversight arrangements in place to effectively monitor, review and drive improvement in the quality and safety of the service.

The registered manager must review the management and leadership arrangements at the practice to ensure there is effective oversight of the service and appropriate monitoring of the quality and safety of care provided.

We found suitable arrangements in place for sharing urgent safety notices and other valuable information with staff. We also saw that minutes of team meetings were recorded and shared with those who could not attend. However, we were told that only two or three team meetings had taken place during the previous year. This did not provide assurance that there were sufficient opportunities for staff to share learning, discuss practice issues and support effective governance arrangements.

The registered manager must ensure formal team meetings are held on a regular basis and appropriately documented to support communication, learning and the effective management and oversight of the service.

We found that the practice had access to a range of policies through a third-party resource provider. Although an appropriate recruitment process was described, the practice was unable to provide a recruitment policy. We also found that some policies had not been reviewed for several years. In addition, the practice risk management policy consisted of a checklist of risks to be considered rather than a document describing how those risks would be identified, assessed, managed and monitored within the practice.

The registered manager must:

- **Develop and implement a suitable recruitment policy in accordance with the regulations**
- **Review the risk management policy to ensure it includes greater detail about how the practice will identify, assess and manage risks**
- **Ensure policies and procedures are subject to regular review and remain current and reflective of practice arrangements.**

Workforce

Skilled and enabled workforce

In addition to the dentists, the practice team comprised of a hygienist-therapist, one newly qualified dental nurse, one trainee dental nurse and a receptionist. We were told that staffing shortages were regularly covered by dental nurses from the provider's branch practice. However, there appeared to be a lack of formal arrangements to ensure staff attending from another practice were familiar with local processes and procedures. For example, we were told that differences in working practices between the two locations may have contributed to the confusion identified in relation to the dating of sterilised instrument pouches.

Whilst we reviewed a documented induction process for the receptionist, the practice was unable to provide evidence of an induction process for dental nurses, including those attending as cover from the branch practice.

The registered manager must ensure suitable induction and familiarisation arrangements are in place for all staff, including those attending the practice on a temporary or cover basis, to provide assurance that they understand and follow local policies, procedures and working practices.

We saw all staff had valid indemnity insurance cover, Disclosure and Barring Service (DBS) certificates and had evidence of Hepatitis B immunisations.

We reviewed staff files relating to their mandatory training. In addition to a lack of fire safety training for all bar one staff member, there were no records available of mandatory training in relation to the therapist working in the practice.

We were not assured that robust systems were in place to ensure effective oversight of staff training. The mandatory training issue was addressed under our immediate assurance process at Appendix B.

Culture

People engagement, feedback and learning

We were told that the practice did not have a process in place to obtain patient feedback. As a result, the practice was unable to demonstrate how patient views and experiences were used to inform service development or improvement.

The registered manager must develop and implement a system for routinely obtaining, reviewing and responding to patient feedback as part of the practice's quality assurance and governance processes.

The practice had a complaints process on display, which included timescales for responses and contact details for other organisations that patients could approach for advocacy support if dissatisfied with the response. However, this had not been updated and was not aligned with the NHS Wales Listening to People (LtP) process. We also found that the contact details for HIW were missing from this document.

The registered manager must review and update the practice complaints procedure to ensure it is fully compliant and aligns with the NHS Wales Listening to People framework.

Learning, improvement and research

Quality improvement

The practice had an appropriate policy for governing quality improvement activities. We saw evidence that the practice engaged with recognised team development tools such as the British Dental Association (BDA) Good Practice scheme.

We were provided with a limited set of audits that included healthcare waste, smoking cessation and antibiotic prescribing. We did not see evidence of a structured programme of audits covering other key aspects of the service, such as clinical record keeping, infection prevention and control, health and safety, and accessibility. This did not provide assurance that the practice had effective arrangements in place to routinely monitor performance, identify areas for improvement and drive quality improvement across the service.

The registered manager must establish and maintain a comprehensive programme of clinical and non-clinical audits to support the monitoring, review and continuous improvement of the quality and safety of the service.

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 prescription pads and emergency drugs were not being stored securely.	Visitors to the practice could gain unauthorised access to prescription pads and emergency drugs.	We raised this immediately with senior staff.	Safe was obtained and items locked away.
We found food belonging to staff was also being stored in the medicine fridge.	Patients and staff could be at risk due to cross contamination.	We raised this immediately with senior staff.	Food was removed from medicine fridges.
X-ray barrier envelopes were stored loose and open to contamination.	Patients could be put at risk of infection from contaminated envelopes.	We raised this immediately with senior staff.	A secure, airtight storage box was obtained.
The practice safeguarding lead was unable to provide evidence that adult and child safeguarding training was to the appropriate level.	Vulnerable patients that visit the practice could be at risk, as any safeguarding concerns raised may not be managed appropriately.	We raised this immediately with senior staff.	Training was completed the day following the inspection with certificates supplied to HIW.

Appendix B – Immediate improvement plan

Service: **Newport Smile Centre**

Date of inspection: **16 June 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	HIW is not assured robust infection prevention and control (IPC) systems were in place. We found a significant accumulation of dust, dirt and debris in the first-floor surgery. This included inside cupboards, on dental chairs and on equipment. Dust and dirt were also found in the ground floor surgery. We found that the practice had ceased completing daily surgery checklists. The last Welsh Technical Health Memorandum (WHTM) 01-05 IPC audit was completed in 2024 and was therefore out of date.

	Improvement needed	**Standard / Regulation**
1.	The practice must: ● Arrange for a deep clean of the surgeries including dental chairs and their attachments ● Resume the use of daily surgery checklists ● Complete a WHTM 01-05 audit as soon as practicably possible.	Regulation 13(6)

Service Action:	**Responsible officer**	**Timescale**
Thank you for your recommendations. Please find our response below: ● Deep clean of the surgeries: A comprehensive deep clean was undertaken in all surgeries, including the dental chairs and their attachments. In addition, we have engaged a professional cleaning company that specialises in healthcare cleaning to carry out a deep clean of the entire premises.	Practice Owner	31/7/2026 audit timeframe

Photographs have been included as evidence of the completed work, and the cleaning company's confirmation email for the booking is attached. ● Daily surgery checklists: We have updated our daily cleaning checklist and reinstated its use with immediate effect. In addition, we have introduced a weekly surgery cleaning checklist to strengthen our cleaning and monitoring processes. All staff have been reminded of the importance of consistently completing these checklists. Copies of the updated daily cleaning checklist and the new weekly surgery cleaning checklist are attached. ● WHTM 01-05 audit: We have registered with HEIW to complete the WHTM 01-05 audit, and the process is already underway. We aim to complete the audit and submit the results within the next four weeks. We will implement any recommendations arising from the audit promptly.		

Findings	HIW were not assured that decontamination processes were suitably robust. We found that date stamping of sterilized instrument pouches was inconsistent with some bags marked with the date they were decontaminated, some marked with the expiry date and others with no dates. We were told that staff from the branch practice sometimes attend and use different dates.		
Improvement needed		**Standard / Regulation**	
2.	The practice must: ● Implement a consistent approach to date-stamping the sterilised instrument pouches and ensure that all staff are aware of the dates that must be used ● Re-sterilise all reusable instruments that were packaged in the pouches, and ensure that the new pouches are stamped with the correct date/s.	Regulation 13(3)(b)	
Service Action:		**Responsible officer**	**Timescale**

● **Sterilized pouch date stamping:** A uniform method for marking dates on all autoclaved packages has been introduced. Every team member has received a refresher and training regarding the mandatory data entries to guarantee regulatory alignment and uniformity. We will perform routine audits to verify strict adherence to this practice. ● **Reprocessing of reusable tools:** Each multi-use instrument previously stored in an improperly labelled bag has undergone full cycling and re-sterilization. These items were placed into fresh packaging, which features accurate chronological stamps that align perfectly with our revised protocols. Our enclosed, modernized Decontamination Protocol incorporates these adjustments to offer explicit instructions to the workforce concerning proper sterilization workflows and tool encapsulation techniques. We instituted these measures to reinforce our infection control systems and safeguard long-term conformity with clinical benchmarks.	Practice Owner	Completed

Findings	HIW were not assured that adequate precautions were taken against the risk of fire. The practice was unable to provide an up-to-date fire risk assessment, or evidence that annual reviews of fire safety arrangements had been conducted. Furthermore, the practice was only able to provide evidence of fire safety training for one staff member.	
Improvement needed		**Standard / Regulation**
3.	The practice must: ● Ensure all relevant staff completed appropriate fire safety training ● Review fire safety arrangements annually ● Provide HIW with an up-to-date written fire safety risk assessment.	Regulation 22(4)(c)(e) & (f)

Service Action:	Responsible officer	Timescale
Fire safety instruction: Internal safety seminars have been organized for all appropriate personnel, finalized for July 7, 2026, at 9:00 AM. Presence is strictly required, and completions will be thoroughly documented to substantiate regulatory conformity. **Yearly fire protocol assessments:** We have instituted a structured mechanism ensuring our protective measures undergo formal re-evaluation every twelve months. This operational requirement is now embedded within our master audit calendar to ensure continuous adherence to safety benchmarks. **Fire hazard risk evaluation:** An external risk analysis has been concluded, with our management adopting every directive outlined in the text. The finalized reporting document is enclosed for your evaluation, and we pledge to execute all proposed upgrades within the mandated periods. I rewrote the selected sentence for clarity and conciseness while keeping the original meaning and formal tone: The registered manager must ensure a suitable induction process is in place to confirm all staff, including visiting staff, are competent in the practice's processes and procedures.	Practice Owner	7/7/26

Findings	HIW were not assured that patient records containing sensitive personal data were being kept securely. We found that old paper patient records were stored insecurely in unlocked cupboards. These were located in a room that was not fitted with a lock and was therefore easily accessible to anyone entering this area of the practice.

	Improvement needed	Standard / Regulation
4.	The practice must: ● Ensure all patient records are kept locked away in a secure location within the premises ● Provide HIW with evidence of these arrangements.	Regulation 20(2)

Service Action:	Responsible officer	Timescale
● **Secure storage of patient records:** All paper patient records are now stored in a locked, secure location within the practice. To further enhance security, a coded door lock has been installed on the records storage room, ensuring that access is restricted to authorised members of staff only, in accordance with our information governance and confidentiality policies. ● **Evidence of arrangements:** Please see the photograph below, which shows the newly installed coded door lock securing the records storage room. This demonstrates that patient records are kept in a secure location with access restricted to authorised personnel only. **Photographic evidence:**  These measures have been implemented to ensure the confidentiality, security and protection of patient information and to maintain compliance with the relevant regulatory requirements.	Practice Owner	Completed

Findings	HIW is not assured that robust systems were in place to ensure effective oversight of staff training. In addition to a lack of fire safety training, there were no records available of mandatory training in relation to the therapist working in the practice.		
Improvement needed		**Standard / Regulation**	
5.	The practice must: ● Provide HIW with up-to-date mandatory training records for the practice therapist ● The practice must take immediate action to strengthen staff training governance arrangements, by implementing robust systems to monitor, record, and assure compliance with staff training, including refresher training.	Regulation 14(1)(b) & 17(3)(a)	
Service Action:		**Responsible officer**	**Timescale**
Mandatory training records: Up-to-date mandatory training records for the practice therapist have been obtained and are attached for your review. "We have implemented Breathe HR as our central training management system. All mandatory training is recorded within the system, together with completion dates, expiry dates and supporting certificates. Automated reminders are used to notify staff and management of upcoming refresher training, enabling us to monitor compliance effectively and ensure all mandatory training remains up to date.		Practice Owner	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): Amrish Gupta

Job role: Practice owner **Date:** 25-06-2026

Appendix C – Improvement plan

Service: **Newport Smile Centre**

Date of inspection: **16 June 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.	On reviewing the practice information leaflet, we noted that the contact details provided for complaints referred to NHS England and did not include the details of HIW. We were also told that the arrangements for seeking patient feedback described in the patient information leaflet were incorrect.	The registered manager must review and update the patient information leaflet to ensure it remains accurate and up to date and ensure it is reviewed on at least an annual basis.	Regulation 6(1) & Schedule 2 Regulation 7(a)	The patient information leaflet has been revised to remove the NHS England complaints details, add the correct Healthcare Inspectorate Wales (HIW) contact information, and accurately describe how patients can provide feedback.	Registered Manager	Completed

2.	Whilst staff had an area to change, this was in a communal area that lacked privacy. We also noted that there was nowhere secure that staff could keep their personal belongings.	The registered manager must ensure private changing facilities and secure storage facilities are available for staff.	Regulations 22(3)(a) & (b)	Separate private changing and secure storage facilities for staff are currently being provided. The new arrangements will provide a dedicated staff-only changing area away from patients and visitors, together with secure lockable storage for staff personal belongings. Once completed, the facilities will be checked as part of the routine premises and health and safety review to ensure privacy, security and continued suitability.	Registered Manager	In progress - completion by 30 September 2026; ongoing monitoring thereafter

3.	While 'dirty' boxes were used to transport used instruments from the surgeries to the decontamination room, the practice did not have separate 'clean' boxes to transport the sterilised instruments back to the surgeries. We also found that autoclave cycles were recorded on individual record sheets but did not indicate which autoclave they referred.	The registered manager must: • Implement the use of 'clean' boxes to transport sterilised instruments from the decontamination room to the surgeries • Ensure autoclave cycle records clearly indicate the autoclave to which they refer.	Regulation 13(3)(b)	Closed-lid, lockable and clearly labelled 'clean' transport boxes have now been provided for both surgeries for the safe transport of sterilised instruments from the decontamination room back to the surgeries. The clean boxes are kept separate from the 'dirty' transport boxes to maintain separation of clean and contaminated instruments. Each autoclave will have a unique identifier and every autoclave cycle record will clearly state the relevant autoclave ID; this will be checked as part of ongoing decontamination monitoring and audit.	Lead Dental Nurse / Registered Manager	Completed; Autoclave cycles recorded separately vacuum autoclave will be installed and non-vacuum will be recorded separately; ongoing monitoring

4.	The practice provided dental implant services which required the use of dental instruments featuring a lumen. However, we found that the practice was using two type N non-vacuum autoclaves to clean such instruments. The Welsh Technical Health Memorandum (WHTM) 01-05 indicates that type N non-vacuum autoclaves are not considered appropriate for reprocessing instruments with a lumen, and that, as best practice, a type B vacuum autoclave should be used for this purpose.	The registered manager should ensure instruments with lumens are sterilised using equipment suitable for that purpose and in accordance with relevant decontamination guidance.	Regulation 13(3)(b)	One MDS 18 litre Class B vacuum autoclaves have been purchased from Bowen Dental Engineering under Quote QU-0336 dated 28 July 2026, with one autoclave allocated to Newport Smile Centre and one to the Port Talbot practice. Payment has been made and the practice is awaiting supplier installation, commissioning/validation and staff training before the Newport unit is brought into clinical use. Until the Type B autoclave has been installed and successfully validated, reusable lumened instruments will not be reprocessed in the existing Type N non-vacuum autoclaves; only an appropriate validated alternative, such as sterile single-use instruments or suitable external reprocessing, will be used. Following installation, the	Clinical Director / Registered Manager	Immediate control in place. Purchase and payment completed; awaiting supplier installation, commissioning/validation and staff training. Newport Type B autoclave to be brought into clinical use as soon as these steps are completed.

				Type B autoclave will be maintained, tested and used in accordance with WHTM 01-05. Evidence: Bowen Dental Engineering Quote QU-0336 showing two Class B vacuum autoclaves ordered.		

5.	We found substances subject to Control of Substances Hazardous to Health (COSHH) to be stored in an unlocked cupboard which was accessible to patients and other visitors to the practice.	The registered manager must ensure hazardous substances which are subject to COSHH regulations are stored securely.	Regulation 22(2)(a)	All COSHH-controlled substances will be moved to a locked, staff-only cupboard. A current COSHH inventory and safety data sheets will be maintained, and storage security will be included in the regular health and safety checks. Staff will be reminded that hazardous substances must not be left accessible to patients or visitors. Photographic evidence: COSHH cupboard secured with a locking device and warning signage. 	Lead Dental Nurse / Registered Manager	completed

6.	Whilst one staff member was appointed and trained as a first aid responder, there was no one suitably trained to cover during leave and absence.	The registered manager must ensure sufficient staff are trained and appointed as first aid responders to ensure continuous cover when practice is in operation.	Regulation 13(1)(b) & (17(3)(b)	[Staff member] has been appointed as an additional first aider and has attended the Emergency First Aid at Work (EFAW) course. This provides additional trained cover during leave and absence. First-aid cover will be checked when staff rotas are prepared, and her EFAW training/certification and renewal date will be recorded on the practice training matrix to help ensure continuous first-aid cover whenever the practice is open.	Registered Manager	Completed; ongoing rota and training-matrix checks

7.	We considered the quality of patient records required improvement with various omissions. Records of alcohol consumption, tobacco use and the provision of oral hygiene advice was sporadic. Other omissions included evidence of treatment planning, baseline basic periodontal examinations, consent, antibiotic dosage and durations. Where radiographs were taken, recording of authorisation, dose and clinical findings was intermittent while quality grading was missing from all records. We also found no evidence that patients' language	The registered manager must take action to improve the quality and completeness of patient records and provide HIW with details of the improvements implemented. Regular audits of patient records should be undertaken to monitor compliance and support sustained improvement.	Regulation 20(1)(a)(i) &(ii)			

	preferences were recorded					
8.	There was no process in place for tracking urgent cancer treatment referrals.	The registered manager must implement a process for managing and tracking all urgent referrals.	Regulation 13(9)(a)	An urgent referral tracking register has been introduced for all urgent referrals, including suspected cancer referrals. It will record the patient, referral date, destination, reason/urgency, confirmation of receipt, appointment or outcome where known, and follow-up actions. The register will be reviewed at least weekly, with overdue or unconfirmed referrals escalated promptly and the review documented.	Clinical Director / Registered Manager	Completed; weekly review ongoing

9.	The registered manager worked at the practice one day per week, spending the remainder of the week at another practice.	The registered manger must review the management and leadership arrangements at the practice to ensure there is effective oversight of the service and appropriate monitoring of the quality and safety of care provided.	Regulation 11(4)			
10.	We were told that only two or three team meetings had taken place during the previous year.	The registered manager must ensure formal team meetings are held on a regular basis and appropriately documented to support communication, learning and the effective management and oversight of the service.	Quality Standard – Leadership and Governance	Formal whole-team meetings will be held monthly using a standing agenda covering patient safety, incidents/complaints, safeguarding, infection prevention and control, audits, training, staffing, policies and service improvements. Minutes will record attendees, decisions, named action owners and deadlines; outstanding actions will be reviewed at the next meeting. Minutes will be retained as governance evidence.	Registered Manager	Monthly from August 2026; ongoing

11.	The practice was unable to provide a recruitment policy. We also found that some policies had not been reviewed for several years. In addition, the practice risk management policy consisted of a checklist of risks to be considered rather than a document describing how those risks would be identified, assessed, managed and monitored	The registered manager must: • Develop and implement a suitable recruitment policy in accordance with the regulations • Review the risk management policy to ensure it includes greater detail about how the practice will identify, assess and manage risks • Ensure policies and procedures are subject to regular review and remain current and reflective of practice arrangements.	Regulations 8(1)(e), (h) & (6)	A recruitment policy has now been developed and implemented. The Gupta Dental Recruitment Policy is dated 17 July 2026, with a review date of 18 July 2027. It sets out a consistent recruitment process including up-to-date job descriptions and person specifications, equal-opportunities monitoring, structured shortlisting and interviews, and conditional offers subject to appropriate pre-employment checks. These include satisfactory references, proof of the right to work in the UK, GDC registration where applicable, health screening and immunisation evidence for dentists and DCPs, and criminal-record checks where relevant. The risk management policy will also be revised to describe how risks are identified, assessed, controlled,	Registered Manager	completed; annual policy review ongoing

				recorded, escalated, reviewed and closed. A policy software will identify the owner, version and review date for each policy, with policies reviewed at least annually and sooner following regulatory or practice changes. Evidence: Gupta Dental Recruitment Policy Risk management Policy		

12.	The practice was unable to provide evidence of an induction process for dental nurses, including those attending as cover from the branch practice.	The registered manager must ensure suitable induction and familiarisation arrangements are in place for all staff, including those attending the practice on a temporary or cover basis, to provide assurance that they understand and follow local policies, procedures and working practices.	Regulation 17(3)(a)	A documented induction and local familiarisation checklist will be introduced for all staff, including temporary and branch-cover dental nurses. Before undertaking duties, staff will be orientated to local emergency arrangements, fire safety, medical emergencies, safeguarding, infection control/decontamination, COSHH, equipment, incident reporting and key local procedures. The checklist will be signed by the staff member and supervisor and retained in the training/personnel record for future employees and existing employee have been reinducted and training needs identified.	Lead Dental Nurse / Registered Manager	completed; for every new/cover staff member thereafter

13.	We were told that the practice had no process in place to obtain patient feedback.	The registered manager must develop and implement a system for routinely obtaining, reviewing and responding to patient feedback as part of the practice's quality assurance and governance processes.	Regulation 16(2)(c)	A routine patient-feedback system will be implemented using working feedback website and integrating it with PMS Dentally .	Registered Manager	By 30 September 2026; monthly review ongoing

14.	The practice complaints procedure had not been updated and was not aligned with the NHS Wales Listening to People (LtP) process. We also found that the contact details for HIW were missing from this document.	The registered manager must review and update the practice complaints procedure to ensure it is fully compliant and aligns with the NHS Wales Listening to People framework.	Regulation 21	The practice complaints procedure has now been reviewed and updated. The Gupta Dental Surgery Complaints Policy, dated 30 July 2026, includes routes for NHS complaints and specifically provides the Aneurin Bevan University Health Board Listening to People Team contact details for Newport. It also includes support information for Llais and escalation/contact details for the Public Services Ombudsman for Wales, General Dental Council, Dental Complaints Service and Healthcare Inspectorate Wales (HIW), including HIW telephone, email, postal and website details. The procedure will be reviewed annually and sooner if national or local complaints arrangements change. Staff will receive a documented briefing so that complaints are	Registered Manager	Complaints policy updated 30 July 2026; staff briefing and patient-facing information check annual review due 30 July 2027

				received, recorded, acknowledged, investigated, escalated and responded to consistently. The patient information leaflet and other public-facing complaints information will be checked to ensure they match the updated procedure. Evidence: Complaints Policy dated 30/07/2026.		

15.	We did not see evidence of a structured programme of audits covering key aspects of the service, such as clinical record keeping, infection prevention and control, health and safety, and accessibility.	The registered manager must establish and maintain a comprehensive programme of clinical and non-clinical audits to support the monitoring, review and continuous improvement of the quality and safety of the service.	Regulation 16(1)(a)	A formal Dental Practice Audit Policy and structured annual audit programme has now been developed and implemented. The programme includes WHTM 01-05 decontamination, smoking cessation, clinical record keeping, radiography, antibiotic prescribing, complaints, health and safety, and accessibility. Each audit has a defined frequency, suggested sample, named lead, expected output, action-plan process and re-audit arrangements. Audit results and outstanding actions will be reviewed through formal governance/team meetings and retained as evidence of continuous improvement. Evidence: Dental Practice Audit Policy (Wales), Version 1.0, issued 2 September 2026.	Clinical Director / Registered Manager	Audit policy and programme completed 2 September 2026; audits to be undertaken in accordance with the annual programme; actions and re-audits ongoing

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): Amrish Gupta

Job role: Registered Manager

Date: 03/09/2026