

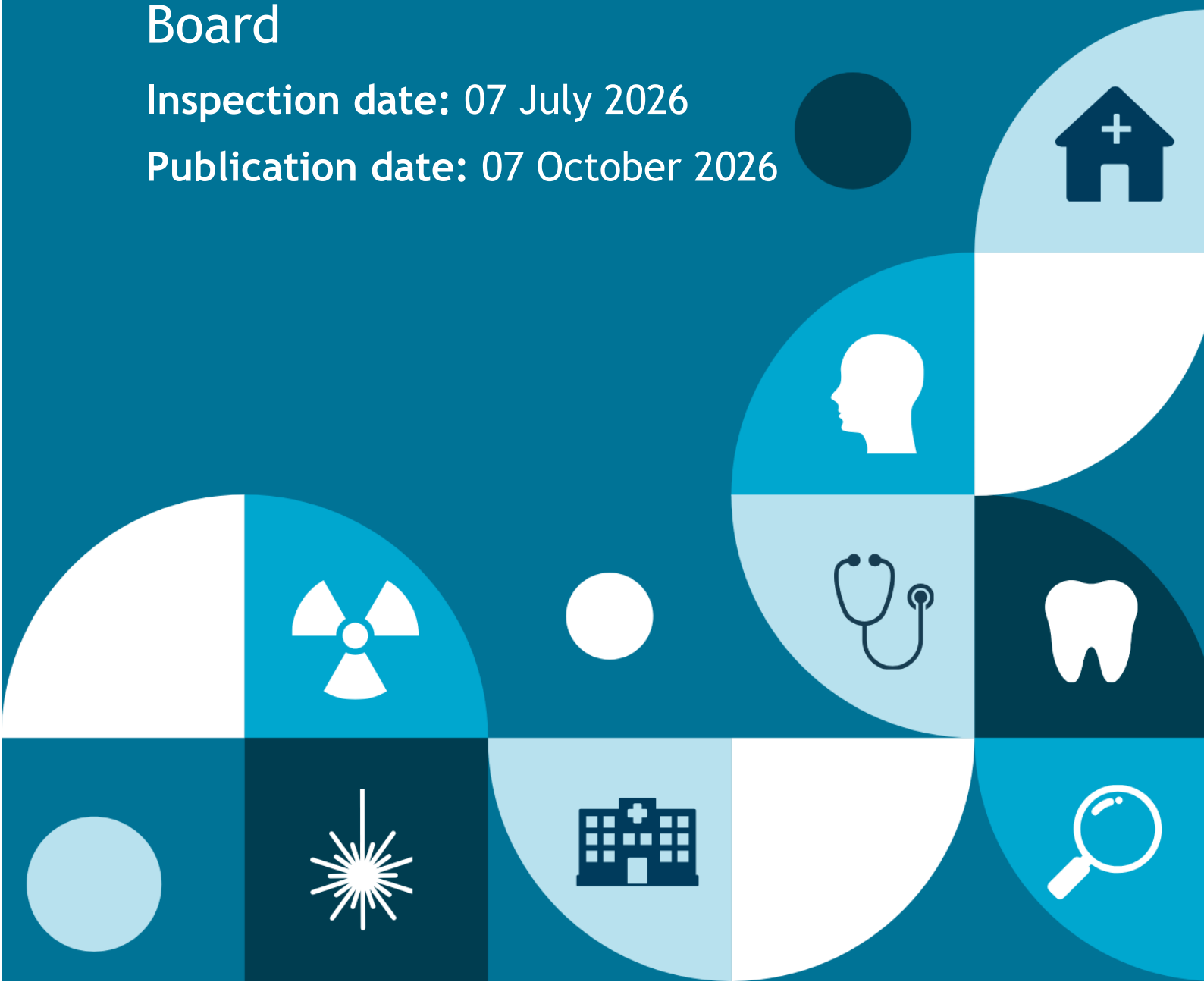
# General Dental Practice Inspection Report (Announced)

Super Smile Dental (PD Care Ltd),  
Pontprennau

Cardiff and Vale University Health  
Board

Inspection date: 07 July 2026

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

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## 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.



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# 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 Super Smiles Dental (PD Care Ltd), Pontprennau on 07 July 2026.

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

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. A total of four questionnaires were completed by patients. Feedback and some of the comments we received appear throughout the report.

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

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

## 2. Summary of inspection

### Quality of Patient Experience

#### Overall summary:

The practice demonstrated a positive, person-centred approach, with arrangements that supported patients to receive dignified, timely and equitable care. Patients had access to relevant oral health promotion materials and clear information about charges, the dental team, opening hours and emergency arrangements. Staff provided tailored oral health advice, maintained privacy and confidentiality, and supported patients to understand treatment options and participate in decisions about their care.

Questionnaire feedback was consistently positive. All respondents rated the service provided by the dental practice as 'very good'. All patients confirmed that they were treated with dignity and respect, felt listened to, received clear explanations and found appointments easy to book.

The practice also offered daily emergency appointments for registered patients, appropriately triaged urgent referrals and provided accessible booking options for people without digital access. Equality, diversity and inclusion were well supported through staff awareness, training, reasonable adjustments and accessible premises. Bilingual information, interpreting services and Welsh language support were available, alongside provision for easy-read information. Some improvements were required relating to the capturing of patients' preferred language in patient records.

This is what we recommend the service can improve:

- Routinely record patients' preferred language in patient records.

This is what the service did well:

- A wide range of oral health promotion materials was available
- Patient privacy, dignity and respect were consistently maintained
- A good range of bilingual and easy-read materials was available.

# Delivery of Safe and Effective Care

## Overall summary:

Care was provided in a clean, secure and accessible environment that was generally fit for purpose. The recently renovated premises, effective fire and health and safety arrangements, well-maintained clinical equipment and staff awareness of business continuity all supported safe service delivery.

Infection prevention and control arrangements were broadly appropriate, with relevant policies, trained staff, suitable hand hygiene and personal protective equipment (PPE) facilities and generally effective decontamination processes. We found that the Welsh Technical Health Memorandum (WHTM) 01-05 audit was out of date with outstanding actions. Evidence subsequently provided through HIW's immediate assurance process demonstrated that systems had been introduced to strengthen compliance.

Medicines and emergency arrangements were also largely suitable, supported by regular expiry checks, appropriate equipment and trained staff. Safeguarding arrangements were effective, with clear procedures, appropriately trained staff and strong leadership support. The practice demonstrated a positive approach to radiation safety, secure electronic patient records, appropriate consent processes and efficient use of appointments, including daily urgent care capacity.

Some improvements were required to strengthen governance and assurance. These included making information about limited toilet facilities clearly available, reviewing changing and storage arrangements, providing a dedicated medicines refrigerator, reviewing the medical emergencies policy and fully documenting X-ray quality assurance and equipment surveillance. Additionally, a log of private referrals was to be put in place.

There was inconsistent use of the Local Safety Standards for Invasive Procedures (LocSSIPs) checklists which was raised under HIWs immediate assurance process and we were subsequently assured this would be improved and monitored.

Immediate assurances:

- LocSSIPs checklists were available but not consistently used
- There were outstanding actions from the 2023 WHTM 01-05 audit
- The WHTM 01-05 audit for 2024, 2025 and 2026 were incomplete.

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:

- Provide a dedicated medicines refrigerator to separate medicines from food

- Fully documenting X-ray quality assurance.

This is what the service did well:

- Positive safeguarding arrangements and training
- Clean, secure and accessible environment
- Efficient use of appointments, including daily urgent care capacity.

## Quality of Management and Leadership

### Overall summary:

The practice demonstrated clear and effective management arrangements, supported by an appropriate leadership structure, established accountability and leaders with the necessary skills, knowledge and experience. Governance was strengthened through regularly reviewed policies, staff awareness of key requirements and participation in recognised development tools, including the British Dental Association (BDA) Good Practice Scheme and Maturity Matrix Dentistry. Suitable staffing arrangements, comprehensive induction, competency checks and oversight of professional registrations, training and appraisals helped ensure the workforce remained skilled and supported. Staff understood how to raise concerns and described an open culture in which learning was shared. Patients were offered a range of accessible ways to provide feedback, with outcomes communicated through the “You said, we did” approach.

Duty of Candour arrangements were understood, and appropriate systems were in place to record incidents, protect confidentiality and use learning to improve care. Partnership working through the local cluster supported referral pathways, shared training and coordinated patient care.

This is what we recommend the service can improve:

- Establish a regular programme of formal team meetings.

This is what the service did well:

- Clear and effective management arrangements
- Suitable staffing and robust recruitment processes
- Positive partnership working.

## 3. What we found

### Quality of Patient Experience

#### Patient feedback

The feedback we received from respondents to the HIW questionnaire was all positive. All respondents rated the service provided by the dental practice as 'very good'.

One patient commented:

*" I was always treated with utmost respect. The staff are helpful and friendly."*

#### Person-Centred

##### Health promotion and patient information

The practice provided a range of information to support patients in looking after their oral health, including health promotion materials displayed in the reception area, such as smoking cessation information. Staff provided tailored oral health advice to patients during consultation appointments, which supported individualised patient care. Information about charges, the dental team, GDC numbers, opening hours and emergency/out-of-hours arrangements was displayed and available to patients. The statement of purpose and patient information guide were available in paper format and published on the practice website. These ensured patients had access to relevant and up-to-date information.

All patients who completed the relevant questions in the HIW questionnaire confirmed that the dental team discussed how to keep their mouth and teeth healthy.

##### Dignified and respectful care

The practice had arrangements in place to support patient confidentiality and privacy. Staff confirmed that confidentiality agreements had been signed and the General Dental Council (GDC's) nine principles were displayed within the practice. Clinical rooms provided appropriate privacy through lockable doors and window blinds. Whilst telephone calls were answered in an open reception area which could potentially be overheard, staff advised that sensitive conversations could take place in one of the surgeries to protect patient privacy if needed.

All patients who completed the questionnaire confirmed that staff treated them with dignity and respect.

##### Individualised care

All the patients who completed the HIW questionnaire confirmed that the dental team explained what they were doing throughout the appointment. They felt listened to and

had any questions answered where asked. All patients felt that treatment options were explained to them during their appointment in a way they could understand and participated in decisions about their care enabling them to make an informed choice on their care and treatment plan. However, one patient felt unsure of who to contact for post-treatment care.

## Timely

### Timely care

The practice had arrangements in place to support patients to access care and treatment in a timely way. Patients were allocated appointment times and were informed by reception, dental or nursing staff if delays exceeded ten minutes. Patients were able to request appointments online or by telephone, with follow-up appointments offered at times suitable to them. Emergency appointments were available for registered patients daily and health board referrals for patients with urgent care needs were available three times a week and were triaged by a dentist.

The responses from the HIW questionnaire indicated that patients felt appointments were 'very easy' or 'fairly easy' to book and most patients knew how to access the out of hours dental service.

## Equitable

### Communicating and language

The practice provided a bilingual service through access to Wales Interpretation and Translation Service (WITS) and an online Welsh translation provider. Staff at the practice spoke a variety of languages, including one Welsh speaking dentist. Staff were supported by the health board to offer a bilingual service and had access to Welsh language training, although there were no current learners. Bilingual patient information was available and easy read information could be provided if required.

Staff demonstrated an understanding of the importance of communicating with patients in their preferred language. However, we noted in the patients records that language preference was not always captured and identification badges were not worn.

**The registered manager must ensure patients' language preferences are routinely identified and recorded within patient records to support effective communication and person-centred care, including delivery of the Active Offer where appropriate.**

Arrangements were in place to support patients without digital access to make appointments, including a dedicated telephone booking system and patients encouraged to book their next appointment in-person during their appointment. This approach ensured that everyone, regardless of their access to or familiarity with digital technology, could access the services they needed.

## **Rights and equality**

The practice had positive arrangements in place to support equality, diversity and the rights of individuals. Staff had read and signed to confirm their understanding of the equality, diversity and inclusion (EDI) policy. The practice was accessible via a ramp or steps. Wheelchair users could access the reception and surgery areas easily as both surgeries were located on the ground floor.

Staff were able to describe how patients and staff were protected from discrimination, including through relevant policies, training and management support. Reasonable adjustments had been made to support access to services including examples within the workplace and offering appointment times that suited patients' needs.

The practice also demonstrated awareness of the rights of transgender and non-binary patients with staff using correct pronouns, recording relevant information on the system and completing specific training.

All patients who completed the questionnaires indicated they were able to access the right healthcare at the right time and all respondents answered that they had not faced any discrimination when accessing or using this practice.

## **Delivery of Safe and Effective Care**

### **Safe**

#### **Risk management**

The practice environment was found to be clean, safe, secure and generally fit for purpose. The premises had been recently renovated and were in a good state of repair with a suitable layout that supported access for patients including those using wheelchairs. Floors were of a durable wipe clean material in all areas. Taps on sinks in treatment areas were elbow operated.

General conditions were satisfactory, with good lighting, ventilation and cleanliness, and the waiting area was appropriate for the number of surgeries. Telephone and internal communication arrangements were effective and the practice was accessible for people with mobility difficulties.

There were comprehensive risk assessments in place for fire safety, health and safety, and the environment. Annual checks of fire extinguishers were carried out by a professional company and regular fire drills were taking place at the practice. All staff were trained in fire safety with additional fire warden training.

Clinical equipment was in good condition with sufficient items available to support effective decontamination. Single-use items and safer sharps were in use where appropriate. Staff were aware of business continuity and health and safety

arrangements, which supported the safe running of the service. The employer and public liability insurances were also in place with acceptable cover.

The practice did not have a dedicated patient toilet, but patients could use the staff toilet in exceptional circumstances. The practice may wish to consider making it clear to patients that toilet facilities are only available on request.

The staff toilet was also used by staff to change. However, we noted that cleaning equipment was currently being stored within the toilet.

**The registered manager should review the storage arrangements for cleaning equipment and materials and ensure they are stored securely in a suitable location separate from facilities used by staff and patients.**

We were told the practice had limited storage. This meant that there were no dedicated storage facilities for staff personal belongings.

**The registered manager must ensure suitable facilities are available for staff to store personal belongings securely in accordance with the Private Dentistry (Wales) Regulations.**

## **Infection prevention and control (IPC) and decontamination**

The practice had appropriate arrangements in place to support IPC, with evidence of relevant policies, accessible hand hygiene facilities, appropriate use of personal protective equipment (PPE) and a suitable environment for effective cleaning. There was a designated infection control lead, occupational health support and staff training in place.

Decontamination arrangements were generally positive, with daily maintenance programmes, surgery checklists, periodic testing, appropriate pre-sterilisation cleaning methods, safe transportation of instruments and separate processing of instruments. Safety syringes were available and in use and clear sharps injury information displayed. Storage of materials subject to the Control of Substances Hazardous to Health (COSHH) was supported by appropriate signage.

Waste management arrangements were largely established, with contracts in place for several waste streams and secure separation and storage of clinical waste. However, we identified shortcomings in infection prevention and control governance, including incomplete cleaning records, outstanding actions from the most recent annual WHTM 01-05 audit, inconsistencies in autoclave validation records, and gaps in waste documentation. **This was dealt with under the HIW immediate assurance process and further details of the issues and actions taken by the service are provided in [Appendix B](#).**

## **Medicines management**

The practice had suitable arrangements in place to support the safe management of medical emergencies. We were provided with an up-to-date copy of the practice medicines management policy and policy for the disposal of midazolam.

We saw records of drugs expiration dates being checked monthly. Emergency drugs and resuscitation equipment were available and staff had completed basic life support and first aid training which included anaphylaxis training and oxygen cylinder maintenance. However, the medical emergencies policy appeared to be out of date, as the last recorded review was 01 December 2023.

**The registered manager must undertake a review of the medical emergencies policy and share with staff once completed.**

Medicines were stored away from patients, prescription pads were secured and adverse drug reactions were reported via the Yellow Card scheme. Controlled drug disposal arrangements included the use of a denaturing kit or return to the dedicated pharmacy. There were also suitable arrangements in place for incident reporting.

Improvements were required in relation to medicines management governance. Whilst we found fridge temperatures were being checked and recorded daily with clear actions in place if temperatures fell outside the acceptable range, the practice needed to ensure a designated medicines fridge was available so that medicines requiring refrigeration were not stored alongside food.

**The registered manager must ensure medications requiring refrigeration are stored separately from food and in accordance with recognised medicines management guidance.**

## **Safeguarding of children and adults.**

The practice had appropriate and effective safeguarding arrangements in place. A safeguarding policy was available which included correct local contact details for reporting concerns and staff were able to access the Wales Safeguarding Procedures electronically. Staff maintained up-to-date knowledge of child and adult protection matters through regular training. Discussions with staff demonstrated they knew who to contact locally and understood the steps to take to identify, respond to and report safeguarding concerns. Staff were supported by three safeguarding leads within the practice, who in turn felt well supported by the registered manager, practice manager and the local authority safeguarding team. All staff had completed child and adult safeguarding training to an appropriate level.

## **Management of medical devices and equipment**

The practice had arrangements in place to support the safe use and maintenance of clinical equipment and ionising radiation, including access to a Medical Physics Expert,

Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) (2017) employer's procedures, staff training, equipment inventories, local rules and radiation protection documentation. Staff were aware of their roles and responsibilities and records showed that key areas such as justification, clinical evaluation, patient information, radiation risk assessment, maintenance and testing arrangements had been considered. Overall, the practice demonstrated a positive approach to managing radiation safety.

However, we identified several areas where governance and quality assurance arrangements required strengthening. Records did not consistently demonstrate that quality assurance checks for digital X-ray equipment had been completed, routine equipment surveillance undertaken by local staff had not been fully documented, and arrangements relating to carers and comforters, including dose constraints and associated records, were not clearly evidenced.

**The registered manager must ensure governance and quality assurance arrangements for the use of ionising radiation are strengthened and are supported by complete and contemporaneous records. This should include appropriate quality assurance checks, routine equipment surveillance and clear documentation relating to carers and comforters.**

Given the issues we identified during the inspection, the practice may wish to consider using the Health Education and Improvement Wales (HEIW) Quality Improvement Tool, or an equivalent quality assurance tool, to further support ongoing monitoring and promote good practice.

## Effective

### Effective care

The practice had made safe and effective arrangements for the acceptance, assessment, diagnosis and treatment of patients. Professional, regulatory and statutory guidance had been followed where appropriate, and staff had obtained relevant professional advice when required. The implementation of a Local Safety Standards for Invasive Procedures (LocSSIPs) checklist was identified as an improvement required during the previous inspection in November 2023. At this inspection, we found no evidence that the checklist was being used when treating patients. Consequently, we were not assured that adequate measures were in place to mitigate the risk of wrong-site tooth extraction. **This was dealt with under the HIW immediate assurance process and further details of the issues and actions taken by the service are provided in [Appendix B](#).**

## Patient records

The practice had systems in place to support safe records management. Patient records were held electronically and protected by passwords, with remote back-up arrangements in place. Appropriate consent arrangements were in place, and information was managed in a way that supported compliance with data protection requirements. A clear policy and process was in place for consent and to ensure the rights of patients who lacked capacity were upheld, including appropriate reference to mental capacity requirements.

The practice demonstrated awareness of the need to follow up suspected oral cancer referrals, with this process discussed with the dentist. However, we found some improvements were required to strengthen governance arrangements in relation to private referrals and discharge correspondence.

**The registered manager must introduce a tracking log for private referrals and follow-up or discharge correspondence, to provide assurance that all referrals and related outcomes are monitored and acted upon appropriately.**

## Efficient

### Efficient

Overall, the service operated efficiently and supported timely access to care. The practice had arrangements in place to manage urgent dental care. This included dedicated emergency appointments each day and provision for patients from health boards three times a week, which helped reduce the need for patients to access urgent or out-of-hours services. The facilities and premises were appropriate for the services delivered and clinical sessions were used efficiently with sufficient clinicians available. The practice also had a system to offer cancelled appointments to other patients, supporting effective use of appointment capacity. Where treatment could not be provided on site, patients were referred to another practice.

# Quality of Management and Leadership

## Leadership

### Governance and leadership

There was a clear management structure in place with evidence of effective governance, leadership and accountability appropriate to the size of the service. Leaders had the necessary skills, knowledge and experience, and the practice had engaged positively with team development tools, including the British Dental Association (BDA) Good Practice Scheme and the Maturity Matrix Dentistry, which had been helpful in supporting ongoing improvement.

Policies and procedures were maintained, reviewed and updated regularly, with all staff having signed to confirm they had read and understood key policies including whistleblowing, health and safety, and EDI. Safety notices were also shared with staff in both paper and electronic formats. We saw that team meetings were minuted and shared with staff who were unable to attend. However, team meetings had been held on a sporadic basis rather than as part of a regular programme, limiting opportunities for staff to share information, discuss issues and support effective governance arrangements.

**The registered manager must introduce a more regular programme of formal team meetings to further strengthen governance arrangements.**

## Workforce

### Skilled and enabled workforce

There were appropriate arrangements in place to ensure sufficient numbers of suitably trained and qualified staff were employed at the practice. Staff rotas had been used to support safe staffing levels, with cover available from the second branch, part-time staff taking additional hours, or where necessary, use of agency staff. All temporary and agency staff used were familiar with the practice and had completed role-specific induction. Additionally, they had their competency assessed and completed relevant training for the role and had their disclosure and barring service (DBS) information checked before employment.

The practice manager had maintained oversight of professional registrations, training and appraisal dates, whilst staff had retained responsibility for completing their continuing professional development requirements. A comprehensive induction pack was available, with competencies assessed and signed off before staff took up their posts.

Staff demonstrated an understanding of how to raise concerns and had felt able to do so, supported by an established escalation process and whistleblowing policy.

Recruitment procedures were also in place to help ensure staff were fit to work and the practice manager described how any performance concerns would be managed.

The practice manager discussed how they intended to introduce a documented central monitoring system with timely reminders for registration, training, continuing professional development and appraisal renewals, providing clear assurance that all requirements remained current.

## **Culture**

### **People engagement, feedback and learning**

The practice manager described the arrangements in place for seeking feedback from patients about their experiences of using the practice and the procedure for dealing with complaints. This included multiple channels for feedback, including a feedback box in reception and quick response (QR) codes, telephone and email options, as well as providing translation services for non-English speakers to feedback.

Reception and clinical staff told us they had remained attentive to patients' needs and encouraged them to share any concerns. We were told feedback and learning had been communicated across the team through practice meetings or email where appropriate. A "you said, we did" board and the complaints procedure had been displayed prominently in reception and information relating to the NHS Wales 'Listening to People' process was also available.

The practice had a Duty of Candour policy in place for which staff had received relevant training and had demonstrated an understanding of their roles and responsibilities. Staff had been encouraged to raise concerns and communicate openly with patients when something had gone wrong. No incidents had met the Duty of Candour threshold. However, the practice had considered the duty in all relevant cases and had indicated that patient or family support would have been considered where required.

To strengthen the arrangements further, the practice advised how they have considered introducing a documented, routine process for reviewing patient feedback. This included how the needs of vulnerable patients were supported, any actions needed and how resulting learning was shared with the wider team.

## **Information**

### **Information governance and digital technology**

The practice had appropriate arrangements in place to record and respond to patient safety incidents, including an accident book and a supporting policy, although no incidents had been reported. Staff explained that relevant information would be discussed at team meetings and shared with appropriate professionals or NHS bodies, maintaining confidentiality and limiting disclosure during any investigation. Learning

from incidents would be communicated to the team and used to inform improvements to the quality and safety of the service. To further strengthen these arrangements, the practice manager described how they maintained a central incident log and periodically reviewed its policy and reporting processes to ensure that learning, actions and outcomes were consistently recorded and monitored.

## **Learning, improvement and research**

### **Quality improvement activities**

The practice had arrangements in place to support quality improvement and maintain standards. Complaints and resulting actions had been recorded and investigations, reports and incidents had been monitored. The registered manager had completed an annual quality assurance survey to inform the annual return to HIW.

A programme of clinical audit included smoking cessation, prescribing, radiography and clinical records, with clinician-specific record and antibiotic-prescribing audits undertaken in January 2026. Dentists had also participated in peer review and had access to BDA resources via the sister practice.

Further to the non-compliance notice issued to the practice, we were provided with a copy of the newest WHTM-01-05 IPC audit and other clinical audits which had been completed. Actions from those audits were completed or underway and learning was said to be shared with staff.

## **Whole-systems approach**

### **Partnership working and development**

There were sufficient arrangements in place for the practice to engage with system partners, although this engagement was said to be limited. The practice formed part of a local cluster led by the principal dentist. The practice manager explained how being part of the cluster had strengthened their interaction and collaboration with system partners such as GPs, secondary care providers and pharmacies.

The engagement ensured streamlined referral processes and shared training opportunities which contributed to cohesive and comprehensive patient care within their community. Referrals for urgent suspected cancers had all been recorded in patient records and followed up as expected. The practice staff felt fully supported and well informed, with learning being shared throughout.

## 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:** PD Care, Cardiff

**Date of inspection:** 7 July 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 was not assured robust infection prevention and control (IPC) systems were in place.                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                   |
|                    | The last IPC audit was undertaken in 2024 and there was no evidence that some actions had been carried out. There had not been an IPC audit since then. The last annual Welsh Technical Health Memorandum (WHTM) 01-05 IPC audit was completed in 2024 and was therefore out of date. The WHTM 01-05 is intended to progressively raise the quality of decontamination work in primary care dental services by covering the decontamination of reusable instruments within dental facilities. |                                                                                                   |
|                    | This was reported as an improvement required in the previous inspection in November 2023 and we were told that this would be actioned.                                                                                                                                                                                                                                                                                                                                                        |                                                                                                   |
|                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |
| Improvement needed |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Standard / Regulation                                                                             |
| 1.                 | The registered provider must: <ul style="list-style-type: none"><li>• Immediately undertake an IPC audit and ensure that these are completed on a regular basis</li><li>• Immediately update the WHTM 01-05 and ensure this is completed annually</li><li>• Provide evidence of this to HIW, along with any action plan for improvement</li><li>• Ensure a range of clinical audits are undertaken as soon as possible</li></ul>                                                              | The Private Dentistry (Wales) Regulations (2017) - Regulation 16(1)(a), 16(1)(b) and 16(2)(d)(ii) |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Draft a regular schedule of clinical audits as part of a programme of ongoing clinical governance.                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Service Action:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                      | Responsible officer                                                                                                                                                                                                                                                                                        |
| <ul style="list-style-type: none"> <li>• Comprehensive Infection Prevention and Control (IPC) audit completed in accordance with current guidance and an action plan developed to address all identified areas for improvement.</li> <li>• Annual Welsh Technical Memorandum (WHTM) 01-05 audit completed and all recommendations implemented.</li> <li>• Infection Prevention and Control Policy reviewed and updated.</li> <li>• A rolling programme of clinical audits has been established, including annual IPC and WHTM 01-05 audits together with regular audits of radiography, decontamination, waste management, record keeping, prescribing and other clinical governance topics.</li> <li>• Cleaning logs, decontamination records, equipment maintenance records and infection control documentation have been reviewed and updated where required.</li> <li>• Staff have been reminded of their responsibilities regarding infection prevention and control procedures and compliance will be monitored through regular audit.</li> <li>• A documented annual clinical governance audit schedule has been introduced to ensure audits are completed and reviewed within the required timescales.</li> </ul> |                                                                                                                                                                                                                                                                                                                                                                                                      | <p>Ali EL Maadarani<br/>Registered Manager</p> <p>Karen Poole<br/>(Infection Prevention and Control Lead )</p> <p>Fawaz Abbas<br/>(Audit and Clinical Governance Lead)</p>                                                                                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                      | <p><b>Completed – July 2026</b></p> <p>Ongoing monitoring:</p> <ul style="list-style-type: none"> <li>• Cleaning logs – Daily</li> <li>• Decontamination records – Daily</li> <li>• Clinical audit programme – Quarterly</li> <li>• IPC audit – Annually</li> <li>• WHTM 01-05 audit – Annually</li> </ul> |
| Findings                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <p>HIW found the practice were not utilising the Local Safety Standards for Invasive Procedures (LocSSIPs) checklists to help prevent wrong site tooth extractions. This was reported as an improvement required in the previous inspection in November 2023 and we were told that this would be actioned.</p> <p>HIW were therefore not assured that the associated risks were being mitigated.</p> |                                                                                                                                                                                                                                                                                                            |

| Improvement needed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                           | Standard / Regulation                                                 |                                                                                                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 2.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <p>The registered provider must:</p> <ul style="list-style-type: none"> <li>• Ensure LocSSIPs checklists are utilised by all dentists to help prevent wrong site tooth extractions</li> <li>• Regularly audit tooth extractions to ensure that the LocSSIPs are being completed appropriately.</li> </ul> | <p>The Private Dentistry (Wales) Regulations 2017 - Regulation 13</p> |                                                                                                                                                                                 |
| Service Action:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                           | Responsible officer                                                   | Timescale                                                                                                                                                                       |
| <p>Local Safety Standards for Invasive Procedures (LocSSIPs) have been implemented for all dental extractions.</p> <ul style="list-style-type: none"> <li>• All clinicians have been instructed to complete the LocSSIPs checklist before every extraction procedure.</li> <li>• The LocSSIPs policy and checklist have been reviewed with all clinical staff.</li> <li>• A regular audit programme has been introduced to monitor completion of LocSSIPs documentation and compliance by all clinicians.</li> <li>• Audit findings will be reviewed as part of the practice clinical governance programme and any learning points discussed with staff.</li> </ul> |                                                                                                                                                                                                                                                                                                           | <p>Fawaz Abbas (Audit and Clinical Governance Lead)</p>               | <p><b>Completed – July 2026</b></p> <p>Compliance audit:</p> <ul style="list-style-type: none"> <li>• Monthly for the first 3 months</li> <li>• Quarterly thereafter</li> </ul> |

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): Ali El Maadarani**

**Job role: Responsible Officer**

**Date: 14/07/26**

## Appendix C – Improvement plan

**Service:** PD Care, Cardiff

**Date of inspection:** 7 July 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. | Staff demonstrated an understanding of the importance of communicating with patients in their preferred language. However, we noted in the patients records that language preference was not always captured and identification badges were not worn. | The registered manager must ensure patients' language preferences are routinely identified and recorded within patient records to support effective communication and person-centred care, including delivery of the Active Offer where appropriate. | The Private Dentistry (Wales) Regulations 2017 - Regulation 20(1)(a) Health and Care Quality Standards – Effective – Record Keeping | Will audit patient records in 1 week to ensure language preference recorded in patient's records | Registered Manager  | 1 week    |
| 2. | The practice did not have a dedicated patient toilet, but patients could use the staff toilet in exceptional                                                                                                                                          | The registered manager should review the storage arrangements for cleaning equipment and materials                                                                                                                                                   | The Private Dentistry (Wales) Regulations 2017 - Regulation 22(3)                                                                   | Ensure that toilet is made available for patients by removing                                    | Registered Manager  | 1 Month   |

|           |                                                                                                                                                                                                                  |                                                                                                                                                                                    |                                                                                                                                   |                                                   |                    |             |
|-----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|--------------------|-------------|
|           | circumstances. The practice may wish to consider making it clear to patients that toilet facilities are only available on request. We noted that cleaning equipment was currently being stored within the toilet | and ensure they are stored securely in a suitable location separate from facilities used by staff and patients.                                                                    |                                                                                                                                   | cleaning equipment from toilet.                   |                    |             |
| <b>3.</b> | The staff toilet was used by staff to change. We were told the practice had limited storage. This meant that there were no dedicated storage facilities for staff personal belongings.                           | The registered manager must ensure suitable facilities are available for staff to store personal belongings securely in accordance with the Private Dentistry (Wales) Regulations. | The Private Dentistry (Wales) Regulations 2017 - Regulation 22(3)                                                                 | Ensure a locker is purchased for staff belongings | Registered Manager | 1 Month     |
| <b>4.</b> | The medical emergencies policy appeared to be out of date, as the last recorded review was 01 December 2023.                                                                                                     | The registered manager must undertake a review of the medical emergencies policy and share with staff once completed.                                                              | The Private Dentistry (Wales) Regulations 2017 - Regulation 13(4) Health and Care Quality Standards – Safe – Medicines management | This has been updated                             | Registered Manager | Immediately |

|    |                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                        |                    |         |
|----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|---------|
| 5. | Whilst we found fridge temperatures were being checked and recorded daily with clear actions in place if temperatures fell outside the acceptable range, the practice needed to ensure a designated medicines fridge was available so that medicines requiring refrigeration were not stored alongside food. | The registered manager must ensure medications requiring refrigeration are stored separately from food and in accordance with recognised medicines management guidance.                                                                                                                                                                            | The Private Dentistry (Wales) Regulations 2017 - Regulation 13(4) Health and Care Quality Standards – Safe – Medicines management                                                                                                                   | Purchase a fridge suitable for storage of medicines                                                                                                                                                                    | Registered Manager | 1 Month |
| 6. | Overall, the practice demonstrated a positive approach to managing radiation safety. However, improvements were required to strengthen assurance arrangements.                                                                                                                                               | The registered manager must ensure governance and quality assurance arrangements for the use of ionising radiation are strengthened and are supported by complete and contemporaneous records. This should include appropriate quality assurance checks, routine equipment surveillance and clear documentation relating to carers and comforters. | Health and Care Quality Standards – Safe – Management of medical devices and equipment<br><br>Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) (2017)<br><br>The Private Dentistry (Wales) Regulations 2017 - Regulation 13(2) and 13(3) | Ensure that All Staff read the guidance notes for the X-Ray checklist, Complete the Quality Improvement Tool for the use of Ionising Radiation. Ensure that a record is kept of the investigations and what was found. | Registered Manager | 1 Month |

|    |                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                |                                                                                                                                     |                                                                                |                    |             |
|----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------|-------------|
|    |                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                |                                                                                                                                     |                                                                                |                    |             |
| 7. | The practice demonstrated awareness of the need to follow up suspected oral cancer referrals. However, we found some improvements were required to strengthen governance arrangements in relation to private referrals and discharge correspondence.                 | The registered manager must introduce a tracking log for private referrals and follow-up or discharge correspondence, to provide assurance that all referrals and related outcomes are monitored and acted upon appropriately. | The Private Dentistry (Wales) Regulations 2017 - Regulation 20 Health and Care Quality Standards – Effective – Record Keeping       | A referral log has been set up; this is now being logged by individual dentist | Registered Manager | Immediately |
| 8. | Whilst improvements had been made as meetings were now minuted and shared with staff who had been unable to attend. Team meetings had been sporadic rather than regular, limiting opportunities for staff to share information, discuss issues and support effective | The registered manager must introduce a more regular programme of formal team meetings to further strengthen governance arrangements.                                                                                          | The Private Dentistry (Wales) Regulations 2017 - Regulation 17<br><br>Health and Care Quality Standards – Governance and Leadership | Regular meetings now in place.                                                 | Ali El-Maadarani   | Immediately |

|  |                             |  |  |  |  |  |
|--|-----------------------------|--|--|--|--|--|
|  | governance<br>arrangements. |  |  |  |  |  |
|--|-----------------------------|--|--|--|--|--|

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: Ali El Maadarani**

**Name (print): ALI EL MAADARANI**

**Job role: Registered Manager**

**Date: 29.9.26**