

General Dental Practice Inspection Report (Announced)

Huw de Lloyd Dentist, Cardiff

Inspection date: 24 July 2026

Publication date: 23 October 2026



This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our [website](#) or by contacting us:

In writing:

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

Or Via:

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

Digital ISBN 978-1-80853-519-2

© Crown copyright 2026



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

Our Purpose

We check the safety and quality of healthcare across Wales.

Our Values

We place people at the heart of what we do.

We are:

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

Objective - we are reasoned, fair and evidence driven.

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

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

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

Our Vision

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

Our Priorities

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

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

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

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



Contents

1. What we did	5
2. Summary of inspection	6
3. What we found	12
Quality of Patient Experience	12
Delivery of Safe and Effective Care	15
Quality of Management and Leadership	21
4. Next steps	25
Appendix A – Summary of concerns resolved during the inspection ..	26
Appendix B – Immediate improvement plan	27
Appendix C – Improvement plan	41



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 Huw de Lloyd Dentist, Cardiff on 24 July 2026.

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

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. We did not receive any completed questionnaires by patients and two were completed by staff. Feedback and some of the comments we received appear throughout the report.

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

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

2. Summary of inspection

Designation as a Service of Concern

Our inspection on 24 July 2026 identified significant risks to the safety of patients and staff. Our immediate concerns were dealt with under our non-compliance process. Details of the concerns for patient safety and the immediate improvements and remedial action taken by the service are provided throughout the report and in [Appendix B](#).

Following the inspection, in line with our escalation and enforcement procedures, HIW convened a meeting on 28 July 2026 to discuss the inspection findings, during which Huw de Lloyd Dentist was designated a Service of Concern and an urgent Notice of Decision was issued to suspend the service's registration until 25 August 2026.

HIW held a further meeting on 13 August 2026 to review the progress made by the service in addressing the identified concerns. Having considered the actions taken, the decision was made to de-escalate the service from Service of Concern status and lift the suspension with effect from 14 August 2026.

Quality of Patient Experience

Overall summary:

We found the practice had arrangements in place to support a positive patient experience. A range of oral health promotion information was available, including advice on preventative care, diet, smoking cessation and oral hygiene. Information regarding private treatment charges, opening hours and out-of-hours arrangements was clearly displayed. However, the patient information leaflet was not readily available to patients.

Staff were observed treating patients with kindness, courtesy and respect, and measures were in place to maintain confidentiality and support private conversations when required. Patients were able to access routine and emergency appointments in a timely manner, and systems were in place to manage appointment delays and cancellations.

The practice demonstrated a commitment to equality and inclusion through an up-to-date equality policy. We found reasonable adjustments to support accessibility and arrangements to respect patients' preferred names and pronouns.

Immediate assurances:

- Treatment plans were not in place for patients and medical histories were not updated regularly.

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:

- The practice must ensure a patient information leaflet is available
- Clinical team names, job titles and GDC registration numbers should be available in an area easily seen by patients.

This is what the service did well:

- Maintained arrangements to protect patient confidentiality
- Offered timely access to routine and emergency dental care
- Promoted equality, inclusion and accessibility for patients.

Delivery of Safe and Effective Care

Overall summary:

We found the practice had some arrangements in place to support the delivery of safe and effective care. The premises were generally secure and accessible, with appropriate fire safety equipment, health and safety documentation, and safeguarding arrangements in place. Staff demonstrated an awareness of safeguarding responsibilities and had completed relevant training. Most clinical equipment was suitable for its intended use, and there were systems for managing medicines, medical emergencies and patient records.

However, we identified several concerns that required urgent action through our non-compliance process. Environmental cleanliness and maintenance standards required improvement, and we found shortcomings in infection prevention and control procedures, decontamination processes and waste management arrangements. Weaknesses were also identified in medicines management, including monitoring of emergency equipment and refrigerated medicines. Risk management arrangements were not always robust, with gaps in business continuity planning, fire risk assessment and equipment maintenance. Patient records lacked updated medical histories as well as documented treatment plans, and improvements were required in radiography governance and referral management.

Immediate assurances:

- Several environmental and maintenance issues were seen that required immediate attention
- The Electrical Installation Conditions Report was not satisfactory, and remedial works had not been completed
- There was no fire risk assessment available
- Numerous infection prevention and control issues had been identified
- There was no contact information available in the event of a sharps injury
- Numerous issues within radiography including X-ray units and documentation
- Patient records had areas that required improvement.

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:

- The setting must implement a business continuity plan with local contact details
- Keys for X-ray units must be stored in a secure location.

This is what the service did well:

- Had appropriate safeguarding policies and trained staff.

Quality of Management and Leadership

Overall summary:

Staff who responded to our questionnaire told us they felt the facilities and environment were appropriate to support patient care. Staff described the practice as a good place to work and said they would be happy for family members to receive care there.

The registered manager held the roles of practice manager and principal dentist and demonstrated commitment to patient care. However, the inspection identified significant weaknesses in governance, oversight and regulatory compliance, which contributed to the service being designated a Service of Concern. While improvements were subsequently made, the findings highlighted the importance of robust governance arrangements and consideration of whether additional leadership support would strengthen oversight and help sustain improvements.

Quarterly team meetings were held and documented, and systems were in place to manage risks, review policies and share safety information with staff. The practice had appropriate recruitment, induction, appraisal and training processes in place, and staff reported feeling able to raise concerns. However, gaps were identified in workforce records, including incomplete evidence relating to Hepatitis B immunity, employment history and references.

While patient feedback, complaints and incident information were used to support learning, weaknesses were identified in complaint monitoring, duty of candour arrangements and quality improvement activity, with limited evidence of clinical audit and ongoing service review.

Immediate assurances:

- Clinicians did not have the full hours of training for Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) in the five-year cycle
- Limited evidence of clinical audits being undertaken.

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:

- Evidence of employment history, two references and Hepatitis B blood results must be available for all staff
- The setting must implement a system to record, monitor and review complaints.

This is what the service did well:

- Staff felt supported and able to raise concerns when needed.
- Regular team meetings were held and documented.

3. What we found

Quality of Patient Experience

Person-Centred

Health promotion and patient information

We found oral health promotion information was available through leaflets. This covered topics such as children's teeth, diet and my teeth, smoking, preventative care and oral hygiene. Posters were also available with information on '5 steps to good oral health' and mouth cancer.

The statement of purpose was available when requested from reception. We found it contained the information required by the Private Dentistry (Wales) Regulations 2017. We requested to see a copy of the patient information leaflet; however, this was not available.

The registered manager must ensure the patient information leaflet is made available to patients.

Information about private treatment charges were displayed clearly next to the reception desk. We found the clinician names were displayed outside of the practice. However, job titles, General Dental Council (GDC) registration numbers, and other GDC registered staff information was missing.

The registered manager must ensure information for all the clinical team including names, GDC registration numbers and job titles are displayed in an area easily seen by patients.

The practice opening hours, out-of-hours telephone number, in-hours telephone number and practice email address were displayed at the entrance to the building. However, we noted a website was displayed for patients in the front window. When checking the website address it was no longer working. We advised the registered manager to remove this from the window to avoid confusion for patients.

Dignified and respectful care

During the inspection we observed staff being polite, friendly and treating patients with kindness and respect. We saw the GDC nine core principles of ethical practice were displayed in English within the waiting room.

We were told staff were able to use a dental surgery should patients request to have a conversation in private. We saw doors to clinical rooms were solid and were kept closed whilst treating patients. A confidentiality agreement was available which had been read by all staff, and compliance was monitored through a digital check sheet.

Individualised care

We reviewed a sample of five patient records and confirmed appropriate identifying patient information and medical histories were recorded at the first visit. However, we found medical histories were not updated regularly, and there was no treatment planning noted. Our concerns regarding this were dealt with under our non-compliance notice process. This meant that we wrote to the service immediately following the inspection requiring that urgent remedial actions were taken. Further information on the issues we identified, and the actions taken by the service, are provided in [Appendix B](#).

Timely

Timely care

Patients could access appointments by telephone or in person at the reception desk. We were told that the average waiting time between treatment appointments was approximately one week. A waiting list was maintained to offer patients earlier appointments should they become available.

Patients requiring emergency care were advised to contact the practice by telephone and were usually offered an appointment within 24 hours, with emergency appointment slots available each day.

Clinicians communicated delays to an appointment time to the reception team, either in person or via an internal instant messaging system. Patients were then informed of waiting times and any delays verbally by staff.

Equitable

Communicating and language

We found patient information was available in Welsh within the waiting area. The practice should consider how patient information could be made available in alternative formats if required to meet the needs of individual patients.

We were told that if a patient did not speak English as their first language, the practice would ask them to bring a translator with them or use online translation tools. The practice should consider access to independent interpreting services where required, as interpreters provided by patients may not always provide assurance regarding confidentiality, accuracy of communication and informed consent.

We were told patients without digital access would have all appointments communicated by telephone and that appointment cards would be provided.

Rights and equality

We found the practice had an up-to-date equality policy in place. The practice ensured the equality rights of transgender patients were upheld by recording preferred pronouns and names on patient records.

Measures were in place to protect patients and staff from discrimination and harassment. A zero-tolerance and discrimination policy was in place and available to staff.

We found reasonable adjustments were in place to ensure the setting was accessible to all. These included ground floor access to the practice.

Delivery of Safe and Effective Care

Safe

Risk management

We found the practice was generally secure, and the size and layout of the premises were suitable for the services provided. The practice comprised of two dental surgeries, a reception area and a separate waiting room, which provided enough seating for patients. The premises was located on the ground floor, supporting accessibility for patients with mobility difficulties. Toilets were clearly signposted and equipped with appropriate handwashing, drying and sanitary disposal facilities. Staff had access to changing facilities and secure lockers for storing personal belongings.

However, we identified several environmental and maintenance issues requiring attention. We found areas of the practice were not consistently maintained to an appropriate standard. We observed chipped paintwork, stained skirting boards and doors, and ceiling tiles in the waiting area that appeared loose. An adjoining room previously used as a dental laboratory was untidy and appeared unfinished. We also found the staff changing area was cluttered and being used to store dental models and cleaning products. Whilst lighting, heating and ventilation were generally appropriate, we found cleanliness standards required improvement. Dust was present in several non-clinical and clinical areas, including one dental surgery. We observed dust on work surfaces, drawer ledges and other fixtures, and some cleaning products were stored within the patient toilet. We also noted fabric chairs within clinical areas and the waiting room, with no cleaning arrangements in place to support effective cleaning and infection prevention and control of these items. Further information on the issues we identified, and the actions taken by the service, are provided in [Appendix B](#).

We saw evidence that health and safety assessments had been undertaken within the last year. Relevant policies and procedures were in place, including health and safety and risk management. However, when we asked to see the practice business continuity plan, we were provided with a document which directed you to the Health and Safety Executive (HSE) document, which was not practice specific.

The registered manager must implement a business continuity plan and ensure it is practice specific with relevant contact details.

We also requested to see a copy of the practice Electrical Installation Condition Report (EICR). When receiving this, we found it had been completed in 2021, and the outcome was classified as unsatisfactory. The practice was unable to demonstrate that the remedial works identified had been completed. Further information on the issues we identified, and the actions taken by the service, are provided in [Appendix B](#).

We saw evidence of valid employer's liability insurance, a health and safety poster, gas

safety certification and Portable Appliance Testing (PAT) which were all up to date.

We found fire safety arrangements were generally appropriate. Fire extinguishers were available throughout the practice and were maintained through a service contract. Fire alarm testing was undertaken regularly, and records showed a fire drill had been completed in February 2026. Fire exits were clearly signposted and fire action notices were displayed. Staff had completed fire safety training appropriate to their roles through the practice. However, the practice was unable to provide a copy of its current fire risk assessment during the inspection, and therefore we could not fully assure ourselves that all identified fire safety risks were being appropriately monitored and managed. Further information on the issues we identified, and the actions taken by the service, are provided in [Appendix B](#).

Infection prevention and control (IPC) and decontamination

The practice had a designated infection prevention and control lead, and staff had access to personal protective equipment (PPE). Dedicated decontamination facilities were available in a separate decontamination room. We requested to see evidence of an infection control policy; however, this was not available on the day.

We requested to see evidence of a cleaning schedule, however there was no documented cleaning schedule in place. Due to this and other cleaning issues previously mentioned within the report, we were not assured that effective cleaning arrangements were being maintained consistently.

Arrangements were in place for the management of sharps injuries, with staff directed to the local hospital in the case of an injury. Staff were aware of the practice's sharps injury procedures, and information was displayed within the decontamination room. However, the information available did not include details of where staff should seek medical advice following an injury.

We found several weaknesses within the decontamination process. Instruments were manually cleaned prior to sterilisation, but cleaning products were not measured in accordance with manufacturers' instructions, meaning the effectiveness of the cleaning solution could not be assured. In addition, the thermometer used to monitor water temperature was not functioning. Autoclaves were available with start of the day and end of the day checks being completed. However, cycle records had not been downloaded or reviewed regularly, with the most recent download completed in January 2026. We did not see evidence of routine infection control audits being undertaken, daily surgery checklists or a documented maintenance programme being completed in accordance with Welsh Health Technical Memorandum (WHTM) 01-05 guidance. We also noted where instruments had been through the decontamination process, instrument sterilisation bags were not consistently dated and signed by staff.

We noted instruments were transported in lidded containers; however, these were not

labelled to distinguish between clean and used instruments, creating a risk of confusion. Dental impressions were disinfected using a spray system and we advised the practice to consider the use of a dedicated disinfectant bath to strengthen the process.

The practice held contracts for the disposal of clinical waste and sharps, and arrangements were in place for the disposal of expired medicines. However, evidence was not available for all waste streams, including amalgam, extracted teeth and dental models. We were therefore not assured that all waste was being managed and disposed of appropriately.

All concerns identified within infection prevention and control were dealt with under our non-compliance notice process. Further information on the issues we identified, and the actions taken by the service, are provided in [Appendix B](#).

Medicines management

The practice had processes in place for the ordering, recording, handling, administration and storage of medicines. We noted that medicines requiring disposal were being placed within a sharps container; however, medicines should be disposed of through an appropriate pharmacy or authorised waste disposal route. This was discussed with the registered manager on the day of the inspection. We also found numerous dental materials within the medical fridge, stock cupboard and surgeries were out of date.

A designated medicines refrigerator was available. However, temperatures were not being routinely monitored or recorded, and therefore the practice could not provide assurance that medicines requiring refrigeration were being stored within the recommended temperature range.

We saw a policy in place for medical emergencies which had been reviewed within the last year. When checking the medical emergency equipment and drugs, we found most items were in place in line with national guidance. However, some emergency medicines were unavailable or not readily accessible. We noted needles and syringes associated with the administration of adrenaline were out of date. The registered manager rectified this on the day of the inspection. More information on this can be found in [Appendix A](#). Midazolam and an automated external defibrillator (AED) were shared with another dental practice located within the same building.

Whilst a weekly emergency drugs checklist was available, it was undated and no historical records were available to demonstrate that regular checks were being undertaken. As a result, the practice could not provide assurance that emergency medicines and equipment were consistently monitored and maintained.

All concerns identified within medicines management were dealt with under our non-compliance notice process. Further information on the issues we identified, and the

actions taken by the service, are provided in [Appendix B](#).

Safeguarding of children and adults

The practice had a safeguarding policy in place which covered both adults and children. However, we found the policy did not initially include local contact details for reporting safeguarding concerns. These were added on the day of the inspection. More information on this can be found in [Appendix A](#).

Staff told us they accessed safeguarding guidance through regular training, and we were told some staff had access to the Wales Safeguarding Procedures application. Staff were able to describe the actions they would take to identify, respond to and report safeguarding concerns and told us they would raise any concerns with the practice lead and seek support from colleagues where required.

We found staff had completed safeguarding training for children and adults to an appropriate level.

Management of medical devices and equipment

We found most clinical equipment was safe, in good condition, and suitable for its intended use. Staff had received appropriate training to ensure they could safely use all equipment. However, we noted the compressor had not been serviced within the previous year as we were told it could not be serviced by the dental engineering company used by the practice.

We reviewed radiation protection arrangements and found they partially complied with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) requirements. We found the practice had appropriate support from a Medical Physics Expert (MPE) in place, as well as Radiation Protection Adviser (RPA) and Radiation Protection Supervisor (RPS) information. Staff were aware of their duty holder roles and responsibilities, exposures for X-rays were justified and appropriately clinically evaluated, and three yearly maintenance had been completed on X-ray units.

However, we found the following that required improvement:

- There were no risk and benefits of X-rays information available to patients
- There was no radiograph audit completed
- There was no evidence of registration with the Health and Safety Executive (HSE) to carry out work involving ionising radiation
- Annual servicing had not been completed on X-ray units
- Local rules were out of date in surgery one and were not available in surgery two.

All issues identified were dealt with under our non-compliance notice process. Further information on the issues we identified, and the actions taken by the service, are

provided in [Appendix B](#).

We also noted that the key to operate the X-ray unit for surgery one was left within the machine at all times. This was accessible to patients at the entrance.

The registered manager must ensure keys for X-ray units are removed from the machine when not in use and are kept in a secure location.

Effective

Effective care

We were informed that the practice did not use Local Safety Standards for Invasive Procedures (LocSSIPs) checklists. LocSSIPs are recognised best practice and can help reduce the risk of wrong-site extractions by supporting consistent pre-procedure safety checks. The practice should consider whether adopting LocSSIPs would enhance its existing arrangements for invasive procedures.

Patient records

We saw a suitable system in place to ensure the safety and security of patient records. The practice had an appropriate records management and consent policy in place. Paper records were stored securely, and electronic records were held on a secure cloud-based system. Records were retained in accordance with appropriate retention guidance.

We reviewed a sample of five patient records during the inspection. We found records contained some of the information required to support patient care, such as patient identifiers, reason for attendance, initial medical history, baseline charting, soft tissue examinations, and intra oral examinations. However, we identified the following improvements were required:

- None of the patient notes had updated medical histories recorded
- None of the patient notes had their language preference recorded
- Periodontal treatment was not prescribed when required for two out of four patient records
- No evidence of six-point pocket charting where required
- None of the patient notes had evidence of extra oral examinations taking place
- No evidence of smoking cessation advice being provided
- No treatment options were being recorded
- None of the patient records had evidence of informed consent recorded
- Four out of five records reviewed did not have any risk assessments for cavities,

periodontal disease, tooth wear and oral cancer

- Grading of radiographs were not consistent

We also found there was no formal process in place for managing referrals, including those that had been referred for suspected oral cancer.

All issues identified were dealt with under our non-compliance notice process. Further information on the issues we identified, and the actions taken by the service, are provided in [Appendix B](#).

Quality of Management and Leadership

Staff Feedback

Staff who completed a HIW questionnaire felt the facilities and environment were appropriate to ensure patients received the care required. Staff felt patient care was a top priority and patients were informed and involved with care decisions. All those who responded agreed the practice is a good place to work and would be happy for family to receive care at the practice.

Leadership

Governance and leadership

We were told the registered manager also held the roles of practice manager and principal dentist. While they demonstrated commitment to the practice and patient care, the findings of our inspection identified significant weaknesses in governance, oversight and regulatory compliance. This resulted in the service being designated a Service of Concern and an urgent suspension of registration being imposed.

HIW subsequently reviewed the progress made by the service and determined that sufficient improvements had been made to de-escalate the service from Service of Concern status and lift the suspension. However, the inspection findings highlighted the importance of maintaining robust governance arrangements. Consideration should be given to whether additional leadership support or changes to the management structure would strengthen oversight, support ongoing compliance and help ensure improvements are sustained.

We saw evidence that team meetings were documented and held every quarter, with appropriate topics discussed such as surgery maintenance, GDC registration and clinical waste.

Systems were in place to identify, record and manage risks, with risk assessments reviewed regularly and updated when changes occurred. Relevant safety alerts and guidance from external bodies were received via the main reception email and we were told this was shared through staff meetings where relevant.

A register of policies and procedures was maintained through an electronic document. We were told policies were reviewed biannually, and staff were informed of updates. Systems were also in place to monitor whether staff had read and acknowledged revised policies.

Workforce

Skilled and enabled workforce

All staff within the practice worked full time, which ensured there were sufficient numbers of qualified staff available to meet the needs of patients. When additional staffing support was required, the practice would make use of agency staff, or staff from the neighbouring practice upstairs.

We were told the practice supported staff to maintain their GDC registration, and staff were required to provide proof of registration annually.

A Speaking Up policy and whistleblowing procedure were in place, and staff told us they felt able to raise concerns with senior members of the team when required.

The practice had a recruitment and induction policy and processes in place to support the employment of staff. New starters completed an induction programme which we were told was carried out over a month period, followed by a probationary period with ongoing monitoring. Recruitment checks included references, identification verification, Disclosure and Barring Service (DBS) checks, professional registration checks where applicable, and professional indemnity verification.

We reviewed a sample of three staff records and found evidence of GDC registration, professional indemnity insurance, DBS checks, and appraisals. However, we noted one staff member did not have blood results following Hepatitis B vaccinations, and two staff members did not have any employment history or references.

The registered manager must ensure evidence of Hepatitis B immunity status is available for all clinical staff.

The registered manager must ensure evidence of employment history and two written references are available for all staff.

Annual appraisals were completed for staff, and processes were in place to address performance concerns with a disciplinary procedure available if necessary.

Staff had access to online learning through Agilio, and we found generally a good level of compliance with mandatory training requirements. Training records demonstrated that staff had completed training relevant to their roles, including safeguarding, cardiopulmonary resuscitation (CPR), infection prevention and control, and fire safety. However, we noted the clinician had not completed the required number of hours of IR(ME)R training in the five-year cycle. Further information on the issues we identified, and the actions taken by the service, are provided in [Appendix B](#).

Culture

People engagement, feedback and learning

Patients were able to provide feedback through a feedback box located within the waiting area. We were told that patient feedback was collected annually and discussed during practice meetings. The practice may wish to consider sharing examples of how patient feedback has informed improvements, to demonstrate that feedback is valued and acted upon. The practice had a complaints procedure displayed within the waiting area which was easily accessible to patients. The procedure included clear timescales for acknowledging and responding to complaints, details of external support available through the Dental Complaints Service, and information on how complaints could be escalated where local resolution could not be achieved. Contact details for HIW, the Dental Complaints Service and Denplan Clinical Complaints Support were included. We were told the registered manager was responsible for handling complaints and this information was available to patients.

Although a complaints folder was available, we found limited evidence of how complaints were recorded, monitored and reviewed. The folder contained only one historic complaint and there was no clear record of complaints received, informal concerns raised, actions taken or learning identified. We were told that verbal concerns raised with nursing staff would be escalated to the person responsible for complaints; however, there was no documented process outlining how these concerns would be recorded, investigated or used to inform service improvement.

The registered manager must implement effective systems to record, monitor and review complaints and informal concerns, including actions taken and any learning identified.

Information

Information governance and digital technology

The practice used digital systems to manage patient records. Patient records were maintained using a password-protected electronic system, and a mixture of digital and paper was used to manage policies, training and governance documentation.

We were told patient safety incidents were recorded within the accident book. Information relating to incidents was shared with staff through team meetings.

Learning, improvement and research

Quality improvement activities

We found the practice lacked systems to monitor and support ongoing quality improvement of the service. We requested to see evidence of audits undertaken; however, we were only provided with a record card audit. This issue was dealt with under our non-compliance notice process. Further information on the issues we identified, and the actions taken by the service, are provided in [Appendix B](#).

We were told the practice monitored information from patient feedback and incidents to support learning and improvement.

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 noted needles and syringes associated with the administration of adrenaline was out of date.	Out-of-date needles and syringes for administering adrenaline may delay emergency treatment, increasing the risk of an ineffective response during a medical emergency and potentially compromising patient safety.	Raised to the registered manager.	The registered manager provided both a junior and adult EpiPen within the medical emergency kit.
We found the safeguarding policy did not include local contact details for reporting safeguarding concerns.	The absence of local safeguarding contact details could delay the reporting of concerns, increasing the risk that vulnerable patients may not receive timely protection and support.	Raised to the registered manager.	Staff added local safeguarding contact details to the policy.

Appendix B – Immediate improvement plan

Service: Huw de Lloyd Dentist Cardiff

Date of inspection: 24 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		The registered manager was unable to provide evidence of a satisfactory Electrical Installation Condition Report (EICR) or evidence of works being completed.	
Improvement needed		Standard / Regulation	
1.	The registered manager must ensure an Electrical Installation Condition Report is undertaken as soon as possible and any remedial works are completed as required.	The Private Dentistry (Wales) Regulation 2017 Regulation 22(2)	
Service Action:		Responsible officer	Timescale
1) The Electrical Installation report has been brought forward from November, we were able to arrange this quickly and subsequent work was able to be carried out last week. The EICR testing and report was provided by Jehu Electrical Ltd on 27th July 2026. The subsequent work was completed by b&l electrical on 30/7/26 and electrical installation certificate provided. See Objective connect upload of up to date Certificate. Completed Task.		Registered Manager	Completed 30/7/26

Findings	The registered manager informed us that a fire risk assessment was undertaken on the 21 July 2026, however, they could not provide any documented evidence of the assessment or associated report.		
Improvement needed		Standard / Regulation	
2.	The registered manager must provide HIW with a current fire risk assessment and evidence that any actions identified have been addressed, or an implementation plan is in place.	The Private Dentistry (Wales) Regulation 2017 Regulation 22(4)(f)	
Service Action:		Responsible officer	Timescale
2) Fire Risk provided by Bison is shared on objective Connect, we have maintained regular servicing of fire alarm systems, Emergency lighting and fire extinguishers, CHUBB fire and security as a building Chubb is very familiar with the system and operations having been their customers for many years. We take fire maintenance and checks very seriously, however I was unaware the last risk assessment was overdue. The high risks of the report highlight the small room undergoing refurbishment, at the time of the risk assessment the damaged ceiling had been removed due to recent renovation to the flat roof above. On receiving the risk assessment we acted immediately to rectify high risk findings. 3/8/26 the ceiling has been sealed to regulation (see photos Objective connect) and the materials impeding path to the fire exit have been cleared that were being stored for the ceiling insulation. There are several medium risk issues that we have acted to manage going forward, we have improved fire instruction signage. Notably we need to make a fire door to the basement fire compliant as a fire door and replace a window under the fire stair. Chubb will be referred for a change in design of system to implement concerns on the risk assessment. Initial Primary task complete. (Medium Risk findings will be managed with Chubb fire and security and installation of window and fire door quote being repaired) Completion by 30/10/26.		Registered Manager	High risk completed. 4/8/26 Medium Risk working towards with qualified individuals- fire door modification or replacement, replacement of window, advice on upgrades to fire system.

Findings	On the day of inspection, we found that:		
	- There was no annual servicing certification for the X-ray machines within the setting - There was no evidence the setting was registered with the Health and Safety Executive (HSE) to carry out work involving ionising radiation - The local rules within surgery one were overdue for review by two years, and there were no local rules available within surgery two - There was no evidence of annual servicing of the compressor - There was no evidence the clinician working in practice had completed the required CPD hours for IR(ME)R within the five year cycle.		
Improvement needed		Standard / Regulation	
3.	The registered manager must provide evidence of the following: - Annual servicing of all X-ray machines within the practice - Registration with HSE to carry out work involving ionising radiation - Up-to-date local rules and evidence they are displayed next to each X-ray set - Annual servicing of the compressor - Evidence that all staff undertaking duties involving ionising radiation have received appropriate training and updates relevant to their role.	The Private Dentistry (Wales) Regulation 2017 Regulation 13	
Service Action:		Responsible officer	Timescale

3) -Dental directory have confirmed a 3 year contract in place for servicing of all X-ray equipment at the practice. See contract uploaded objective connect 31/07/2026. Engineer for 3 year routine test 9/6/26 See engeineer visit report uploaded to Objective connect.Completed Task. - Ensured reregistration with HSE to work with ionising radiation, certificate uploaded to Objective connect. Completed Task. - Up to date local rules are now presented next to both X-ray machines. Completed Task. - -We have maintained the 2 year old compressor with weekly drainage and checks but it has been a problem finding a dental engineer who would deal with the machine for maintenance. Along with Andrew Thomas dental (first floor), we have purchased a new machine which is Bambi VT250D with a drying function that doesn't need weekly draining due to its drying capability, purchased Friday 31st July, Dental Engineer company expected delivery for installation 5/8/26. Invoice and communication from Dental Engineer uploaded to objective connect. Expected completion 5/08/26. - All certificates of Staff CPR uploaded to Objective connect. Two nurses qualified and registered with GDC recently this year put X-rays through digital scanner had previous internal training and underwent a module on IRMER on their Diploma. Completed Task.	Registered Manager	All tasks completed and evidence sent to Objective connect (Service certificate of x-ray equipment, HSE certificate of reregistration,CPD certificates uploaded.) The new compressor is being delivered for installation 5/8/26.
--	--------------------	---

Findings	On the day of the inspection, we found that:		
	• There was no evidence that an infection prevention and control policy was in place and available for staff • A basic poster for sharps injuries was displayed within the decontamination room, however, it did not provide occupational health information for staff to contact following a sharps injury • There was no evidence of current daily surgery checklists being completed • Autoclave cycle records were not downloaded at frequent intervals; records seen were last downloaded January 2026 • Boxes used to transport instruments between the dental surgery and the decontamination room were not individually labelled as clean or dirty • Bagged instruments stored within a surgery were not signed and dated • There was no contract in place for the regular collection of amalgam, extracted teeth, and gypsum.		
Improvement needed		Standard / Regulation	
4.	The registered manager must provide evidence of the following: • Up-to-date infection prevention and control policy • Sharps injury poster with occupational health information available including phone number and address • Evidence that daily surgery checks are being undertaken and records maintained • Procedure for monitoring and downloading of autoclave cycles • Labelling of boxes to transport instruments to and from the decontamination room • Assurance that instruments are bagged, signed and dated following decontamination • A contract in place for the collection and disposal of amalgam, extracted teeth and gypsum.	The Private Dentistry (Wales) Regulation 2017 Regulation 8(1)(m) and 13	
Service Action:		Responsible officer	Timescale

4) -Infection control policy uploaded, has been kept up to date with Denplan manuals reviewed February each year with updates where required. Uploaded to Objective Connect always available on our Desk top accessible by staff. Uploaded document to Objective Connect. Completed Task. -Sharps poster updated with to include contact information in the event of a sharps injury. Displayed on decontamination room wall, format and template taken from BDA Expert poster uploaded to Objective connect. We have now found an occupational health service, Insight workplace health (Newport Clinc), we have registered on their portal 7/8/26 -We have updated daily check lists to be stored and retained for evidence of daily routine to be maintained by dental nurse working that day (actually found a load of completed documents that weren't accessible at the time of inspection! Staff have been trained and updated on requirements of every task to be recorded including summary of Denplan Expert template uploaded to Objective connect. Completed task. Ongoing assurance of procedure and recorded check lists. -Registered manager is currently responsible for transferring Data logs stored on the autoclave, to a memory stick and stored on the hard drive of the practice server. This file was not updated at inspection last Transfer was May. This was a sporadic exercise, but is now a task undertaken last working day of the month and transferred to the file titled 'Autoclave Data logs' a file that has been present and used on the desk top since having an autoclave with digital data. Completed Task. -Formerly Dirty box was blue and Clean box was Clear with marker pen. We now more clearly identify this with boxes purchased from Agilio shop, a red contaminated box with lid displaying 'contaminated' content and a blue 'clean box'. Photos of new boxes sent to Objective Connect. Completed Task. -We ensure the clean area disinfected instruments are packed and dated with a stamp of processing date and a date a year later for before use, The nurse processing will now initial the pouch at the time of sealing the bag/pouch. We were not aware of this practice but packaging of instruments can be one of two nurses, who will initial the pouches that they pack and store when the practice is running. Completed task.	Registered Manager	Completed
--	--------------------	-----------

-We have discussed with our Medical waste collection in detail with Initial who have been helpful in implementing changes to our contract agreement to include Amalgam pots, Amalgam sludge drum and gypsum buckets. See new agreement uploaded to Objective Connect. Completed Task.		
---	--	--

Findings	On inspection, we found that: - Medicines were being inappropriately disposed of in a sharps box instead of an appropriate pharmaceutical waste container - There was no system in place to regularly check the temperature of the clinical fridge to ensure the ongoing efficacy of the medication stored within - There was no razor within the medical emergency kit - The weekly checklist of the medical emergency kit was undated, and no historical checks were available - Expired dental materials were found within the stock cupboard, medical fridge and within a surgery. We also found the needles and syringes to be used with Adrenaline were out of date, with only a junior EpiPen available. However, we acknowledge that the registered manager purchased an adult EpiPen on the day of the inspection		
	Improvement needed		Standard / Regulation
5.	The registered manager must provide evidence of the following: - Pharmacy box is implemented for the disposal of medicines - Policy and procedure for the regular temperature check of the clinical fridge - Addition of a razor to the medical emergency kit - Policy or procedure for the checking of dental materials to ensure they are within date - Policy or procedure for the weekly checks of medical emergency drugs and equipment - Evidence that all expired medicines and dental materials have been removed from use and that effective stock checking arrangements are in place.		The Private Dentistry (Wales) Regulation 2017 Regulation 31 and 13
Service Action:		Responsible officer	Timescale

5) We have made arrangements with Initial medical waste for a blue lidded medical waste box, for the appropriate disposal of our emergency drug waste and collection. -We have a fridge thermometer to monitor the environment where the temperature sensitive Glucagon ‘hypostop’ is stored this is on the weekly checklist of emergency drugs and daily check list. We believe the temperature should be between 2 and 8 degrees but are seeking clarity on this. I have purchased a new small fridge to ensure these temperatures are maintained. Photo of fridge thermometer sent to Objective Connect. Updated Emergency drug check list uploaded to Objective connect. This check is now included with weekly with the emergency drug check. (Registered manager checks this every Friday). Completed Task. (New fridge being delivered 4/8/26). -The Defibrillator storage case does have a small disposable razor. This was difficult to identify at the time of inspection, would not be immediately identifiable, it came supplied with the defibrillator, we have also added a more conventional razor to avoid confusion. See photo of small razor supplied with Defibrillator on Objective Connect. Completed Task. -Stock check arrangements Eve Long will be made responsible for the inventory of stock supplies, weekly checks of supplies and order of storage. We noted some sterile products with long life were highlighted at the inspection as out of date, Scalpel blades and long life sterile single use items needles and syringes in the Emergency drug kit large sticky labels highlighted use by dates. New policy document available on Objective Connect. A pannavia cement was also removed from the surgery refrigerator that was immediately removed. Completed Task.	Registered Manager	Arrival of new drugs box and Amalgam sludge drum delivered with scheduled waste pick up 12th August 26
---	---------------------------	---

Findings	We were told the practice completed patient record audits; however, no other clinical and non-clinical audits were undertaken.		
	Improvement needed	Standard / Regulation	
6.	The registered manager must provide assurance that systems have been put in place to assess and monitor the quality of the service by implementing a formal programme of quality improvement activity. This should include a documented audit programme, timescales for completion, and arrangements for reviewing and acting upon the findings.	The Private Dentistry (Wales) Regulation 2017 Regulation 16(1)(a)	
	Service Action:	Responsible officer	Timescale
	6) BDA Expert has allowed access to important Audit tools that were previously unavailable that will allow easier implementation of Audits. We have started the process of becoming a BDA Good Practice. Registered manager will undertake targeted Audits through August on record keeping, oral cancer risk factor records (completed 7/7/26), healthcare waste audit, all areas highlighted by the inspection that we need to focus and improve on. We will put together a program that will ensure Audit findings are discussed and results implementing changes or appropriate updates. The HEIW Decontamination audit will be the focus of the next practice meeting. Regular 6 month repeat Audits cycles will ensure the principle of governance is introduced and will be a far more common exercise in the running of the practice. Self auditing of my own x-rays registered manager, will be replaced with 6 month radiograph retrospective quality audits will be undertaken mutually with Andrew Thomas in the practice above Huw de Lloyd Dentist, this will allow for Peer review and a necessary Quality assessment activity for the radiation Protection file for both dentists. The decontamination audit will be reviewed in 6 months.	Registered Manager Dental Nurse Dental Nurse	Audits on records for oral cancer risk factors completed 10/08/26, Patient record keeping, Radiograph retro Quality completed 30th August 2026

Findings	During the inspection, we reviewed a sample of five patient records and found:		
	• There was no evidence of any up-to-date medical histories completed by patients and documented within patient records • Language preferences were not recorded for any of the patients • Patients with a Basic Periodontal Examination (BPE) score of 3 or above, did not have 6-point pocket charting recorded • There was no record of patients with a BPE score of 2 and below being given hygiene instruction or treatment • None of the five patient records contained evidence of an extra-oral examination • Where applicable, patients did not have treatment plan options recorded • Risk assessments were not documented • Two patients did not have the X-ray quality grade recorded • There was no record of verbal or written consent from patients for treatment provided.		
Improvement needed		Standard / Regulation	
7.	The registered manager must ensure all patient notes are accurate, contemporaneous, and include all information that has been highlighted as missing by HIW. The registered manager must implement a policy or procedure to ensure follow up and discharge letters for all referred patients, including suspected oral cancer referrals, are monitored, reviewed and acted upon appropriately.	The Private Dentistry (Wales) Regulation 2017 Regulation 20(1)(a)	
Service Action:		Responsible officer	Timescale

7) -All new patients have always had to sign a medical history document to register with us that is present in patients notes, we always include medical updates to records and a verbal discussion of any medical update is routinely asked at Examinations and at tooth extractions with changes being clearly recorded. We have not been routinely asking for signed medical history updates but staff are now under a strict regime to communicate with patients prior to their appointments, we have implemented a policy to ensure signatures as a key part of evidencing medical histories and treatment plans. A new medical history is required to be signed and updated on our records annually. -We have not recorded language preferences of patients in the past and relied on family members of friends to translate where necessary. We will record patient language preferences in our records. We have incorporated a link with 'language line' for situations requiring interpretation. -We have updated Periodontal Recording will be based on British Society of Periodontal guidelines for examination, diagnosis and treatment/management. Guidelines available in both surgeries for reference. -We routinely give oral hygiene advice and would be very unusual to not receive treatment involving supra gingival cleaning, we will be more thorough recording this information in patients dental records going forward. -Up until now our extra oral examination has included records of TMJ and submandibular lymph nodes. Where positive findings of facial abnormalities they have been recorded, we will now comment and record on negative findings of the head and neck, this has been introduced into our clinical software. has not been Our clinical records and dental assessment template is based on the College of General Dentistry recording a wider range of information than previously Nurses have been trained to record a wider range of examinations than previously. Audits prior to the Inspection highlighted deficiency's on examination and observations being recorded by registered manager.. Periodontal Recording will be based on British Society of Periodontal guidelines and diagnosis. We have introduced a policy directly as a result of I inspection findings in this area and hope to demonstrate these improvements with ongoing audits of the subject. Nurses have undertaken CPD courses on patient records this week and information on Periodontal testing and diagnosing updated. It is the upmost priority to ensure signed records of treatment plans and medical histories are contained regularly in patients notes to demonstrate and record, consent and updated medical history checks. Ongoing activity to improve this area with ongoing audits.	Registered Manager	Prepared for records as soon as patients return to the practice. Implemented 30/6/26
--	---------------------------	---

Findings	During the inspection, we found the following issues: • The worktop in surgery two had a powder substance on the surface • Drawers within the surgeries were not visibly clean • Dust present on drawer ledges • Skirting boards and doors had stains present • Fabric chairs were used within surgeries risking cross contamination • Fabric chairs within the waiting room appeared visibly stained • The staff changing area was cluttered, with patient dental models and cleaning items stored in the room, and no external lock in place • Sinks within clinical rooms were visibly stained • There was no evidence of cleaning schedules being maintained.		
Improvement needed		Standard / Regulation	
8.	The registered manager must provide evidence of the following: • All areas of the practice have been cleaned thoroughly • Fabric chairs have been removed from the dental surgeries • All fabric chairs within the practice are cleaned with a regular schedule in place • The staff changing area must be decluttered • Patient dental models and cleaning items kept in changing area to be stored in a locked area • Evidence that cleaning schedules are being completed and monitored.	The Private Dentistry (Wales) Regulation 2017 Regulation 13(6)(b)	
Service Action:		Responsible officer	Timescale

8) -We were disappointed on the feedback of cleanliness at the Inspection but have taken it on board as a crucial area for cross contamination and general presentation of the practice going forwards. A more regimented and specific list of items has been introduced to cleaning routinely. Time has been set aside in the week for staff to thoroughly clean areas. - fabric chairs kept in surgeries for family and guardians have been disposed of and replaced with wipe down plastic chairs to avoid possible contamination issues with the former. -Fabric chairs in the waiting room have been removed replaced with more cleansable faux leather chairs with higher positioning and supportive arm rests for elderly patients and easier cleaning. -We have reorganised the changing room and removed patient models and clutter. Cleaning products have been moved to the basement and stored in purpose built lockable storage cabinet. -Cleaning schedules are being ensured and regimented, with training for staff and filling in of check sheets. Ongoing Progress	Registered Manager Dental Nurse Dental Nurse	3/8/26
--	---	---------------

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): Huw de Lloyd

Job role: Principle dentist/Manager

Date: 07/08/26

Appendix C – Improvement plan

Service: Huw de Lloyd Dentist Cardiff

Date of inspection: 24 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.	The patient information leaflet was not available.	The registered manager must ensure the patient information leaflet is made available to patients.	The Private Dentistry (Wales) Regulations 2017 Regulation 6(3)	We did have a patient leaflet available, however we have made a new one more concise with a template from BDA and a file to send as an email to patients.	Registered Manager	Completed Renewed 30/7/26
2.	Job titles, General Dental Council (GDC) registration numbers, and other GDC registered staff information was missing.	The registered manager must ensure information for all the clinical team including names, GDC registration numbers and job titles is displayed in an area easily seen by patients.	GDC Standards for the Dental Team Standard 6.6.10	Both Nurses XXX and XXX now have their certificate of registration displayed in the waiting room after feedback at the inspection.	Registered Manager	Complete 27/7/26

3.	The practice business continuity plan directed you to the Health and Safety Executive (HSE) document, which was not practice specific.	The registered manager must implement a business continuity plan and ensure it is practice specific with relevant contact details.	The Private Dentistry (Wales) Regulations 2017 Regulation 8(1)(o)	We had one documents in place, but we are working through a BDA document that gives a more concise plan of different elements.	Registered Manager	30/9/26
4.	We noted that the key to operate the X-ray unit for surgery one was left within the machine at all times.	The registered manager must ensure keys for X-ray units are removed from the machine when not in use and are kept in a secure location.	The Private Dentistry (Wales) Regulations 2017 Regulation 13(3)(a)	The X-ray operating unit key to the front surgery is kept inside the surgery in the dentist draw when not in use.	Registered Manager	Completed 14/9/26
5.	One staff member did not have blood results following Hepatitis B vaccinations.	The registered manager must ensure evidence of Hepatitis B immunity status is available for all clinical staff.	The Private Dentistry (Wales) Regulations 2017 Regulation 18	XXX had booster injections after a weak immunity detected, follow up blood test were cancelled and rescheduled.	Registered Manager	Completed 21/09/26

6.	Two staff members did not have any employment history or references.	The registered manager must ensure evidence of employment history and two written references are available for all staff.	The Private Dentistry (Wales) Regulations 2017 Regulation 18(3)	We have references available for each current staff member. Recruit policy and document storage is updated for future employment to ensure more robust evidence of staff investigation, in line with requirements. As I personally knew people who managed XXX and XXX I had verbal references before their employment began.	Registered Manager	Completed 8/26
----	--	---	--	---	--------------------	----------------

7.	Although a complaints folder was available, we found limited evidence of how complaints were recorded, monitored and reviewed. There was also no documented process outlining how verbal concerns or complaints would be recorded, investigated or used to inform service improvement.	The registered manager must implement effective systems to record, monitor and review complaints and informal concerns, including actions taken and any learning identified.	The Private Dentistry (Wales) Regulations 2017 Regulation 21(5)	Complaints are acknowledged and responded to in line with our complaints policy, with details being recorded in a log book stored in complaints folder. All Interaction and acknowledgment during the process are recorded and stored. When a complaint is resolved, it will be reflected upon at staff meetings, where any source of complaint can be discussed with actions taken and recorded to avoid a repeat complaint if possible.	Registered Manager	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): Huw de Lloyd

Job role: Registered Manager

Date: 18/9/26