Fig. 1 Orthopantomogram taken when the patient developed tooth mobility

(Fig. 1). This serves to highlight the important role of the general dental practitioner in the care of patients undergoing treatment of OSA with a MAD, as these patients do not routinely have an orthopantomogram and are often discharged from the maxillofacial clinic six weeks after commencing treatment. Patients with sleep apnoea may benefit from MAD, however, they may be at risk of developing periodontal problems and thus require close monitoring and dental surveillance by their GDP.

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ALARM BELLS

Sir, I write regarding *The full extent* (BDJ 2011; 210: 291) letter describing the case of a follicular ameloblastoma associated with the extraction socket of a LL8. The authors from York do not provide the age of the patient under discussion but the post-extraction OPG seems to indicate a young patient between 18–21 years of age. If this is the case, then what is most disturbing about this report is the fact that the patient's GDP was seemingly unfazed by a patient of this age presenting with a grade III mobile permanent lower third molar tooth. Surely, this clinical scenario alone should have activated 'alarm bells' in the practitioner's mind even without any further

radiographic evidence. Is this a case for additional GDC-led targeted training?

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CQC SEA CHANGE

Sir, we would like to highlight the fact that now the watershed date of 1 April 2011 has passed, a failure to conform to CQC guidelines can lead to a dentist losing his or her licence to practise as well as exposing him or her to the risk of criminal prosecution.¹ This is a sea change in the way the profession is regulated and we are concerned that the implications of this have not been fully digested by all dentists, for example there are important changes to requirements for medical emergency kits in primary dental care.

*Essential standards of quality and safety*² defines the standards required for medical emergency management in primary dental care. Outcomes 9 and 11 appear to be the most relevant to medical emergency management in practice. Outcome 9H states that it is a practitioner's responsibility to ensure that medicines required for resuscitation or medical emergencies are easily accessible in tamper evident packaging.² Outcome 11 is more concerned with equipment and training and states that 'all staff involved in using the equipment have the competency and skills needed and have appropriate training'.² In addition, equipment should be suitable for its stated purpose, be safe to be used, compliant with relevant laws, available in sufficient quantities, installed, used and maintained correctly according to manufacturer's instructions, legislation and with appropriate guidance from expert bodies. This equipment should be properly maintained, tested, serviced and renewed under a recorded programme. It should be stored safely and securely and where the service requires it this should be tamper proof.²

What does tamper evident and tamper proof mean and what impact will this have?

The *Oxford English Dictionary* describes the term 'tamper-evident' as 'designed to make obvious any proper interference with a product'.³ Tamper proof is 'proof against being tampered

with'.³ This in practice means that emergency drug kits need to be redesigned to incorporate these changes and ensure the safety of medicines. Examples of tamper proof packaging are illustrated in Figures 1 and 2. Ideally, these should be uniquely coded so that drugs can be tracked by suppliers. Expiry dates can be maintained and recorded on databases to ensure that kits are kept up to date.

Fig. 1 Emergency drugs in tamper proof packaging

Fig. 2 Tamper proof packaging

In summary, outcomes 9 and 11 have a bearing on emergency kits. These changes need to be incorporated into kits wherever possible to ensure the safety of medicines and assure compliance with CQC guidelines. The authors suggest that standardisation of medical emergency training in addition to standardisation of emergency drugs and equipment is required in primary dental care to optimise patient care should an emergency event occur and that CQC recommendations should be incorporated into medical emergency care in general dental practice.

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