Ballynahinch Dental Care
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Unannounced Follow Up Care Inspection of Ballynahinch Dental Care

30 June 2015
14 July 2015

The Regulation and Quality Improvement Authority
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1. Summary of Inspection

An unannounced follow up inspection took place on 30 June 2015 between the hours of 12:50 and 13:20 by Carmel McKeegan. A further announced follow-up visit was undertaken on 14 July 2015 from 10.10 to 10.35 by Emily Campbell.

The purpose of this inspection was to monitor and ensure that a serious issue regarding the provision of emergency medicines identified during the previous inspection undertaken on 26 May 2015, had been addressed.

1.1 Actions/Enforcement Taken Following the Last Care Inspection

Other than those actions detailed in the previous QIP there were no further actions required to be taken following the last care inspection on 26 May 2015.

1.2 Actions/Enforcement Resulting from this Inspection

Enforcement action resulted from the findings of this inspection. An intention to issue a failure to comply notice meeting in relation to the management of medical emergencies was held on 9 July 2015.

A review of the medications retained for use in the event of a medical emergency were reviewed on 14 July 2015 and it was identified that appropriate measures had been put in place. As a result of the corrective action taken a decision was taken that a failure to comply notice would not be issued.

1.3 Inspection Outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	0

This inspection resulted in no requirements or recommendations being made. Findings of the inspection can be found in the main body of the report.

The other requirement and ten recommendations identified in the QIP following the previous inspection on 26 May 2105 still require to be addressed and will be followed up during next inspection.

2. Service Details

Registered Organisation/Registered Person: Dr Clare McGowan	Registered Manager: Dr Clare McGowan
Person in Charge of the Practice at the Time of Inspection: Dr Clare McGowan	**Date Manager Registered:** 4 January 2012
Categories of Care: Independent Hospital (IH) – Dental Treatment	**Number of Registered Dental Chairs:** 3

3. Inspection Focus

The inspection sought to assess progress with a requirement in relation to the management of medical emergencies which had been identified during the announced inspection on 26 May 2105 and during the first day of the follow-up inspection on 30 June 2015.

4. Methods/Process

Specific methods/processes used in this inspection include the following:

- Discussion with two dental nurses;
- Review of emergency medications;
- Tour of the premises; and
- Evaluation and feedback.

Any other information received by RQIA about this practice has also been considered by the inspectors in preparing for this inspection.

5. The Inspection

5.1 Review of Requirement from the Previous Inspection dated 26 May 2015 on 30 June 2015

This was an unannounced inspection to monitor the progress made following the previous announced inspection undertaken on 26 May 2015. The inspection focused on a requirement made to ensure the registered person provides emergency medicines in keeping with the British National Formulary (BNF) in the dental practice.

The requirement is based on The Independent Health Care Regulations (Northern Ireland) 2005.

5.1.1 Previous Requirement made on 26 May 2015

The registered person must ensure that emergency medicines in keeping with the British National Formulary (BNF) are provided in the dental practice.

During the inspection on 30 June 2015 the dental nurse located the emergency medicines from a storage cupboard within a corridor on the first floor of the practice. The corridor leads to the toilet for patient use. It was noted that the cupboard did not have a handle or a lock. The inspector had been informed at the previous inspection that the storage units had recently been installed and as a result they had not yet been made safe for storing medications.

The emergency medicines were reviewed and the following medicines were in place;

- Aspirin Dispersible Tablets 300mg Expiry date 10/2017
- Glucogel Expiry date 11/2016
- Glyceryl Trinitrate Spray Expiry date 02/2018
- Salbutamol Aerosol Inhalation Expiry date 08/2015
- Adrenaline 1mg/10mls 1/10,000 1x10ml prefilled syringe Expiry date 07/2016

The strength of adrenaline is not in keeping with best practice.

In addition to the above itemised medicines, the following medicines were kept in the emergency medicine box;

Atropine Sulphate Injection 3mg in 10ml 1x 10ml prefilled syringe Expiry date 07/2016
Solu- Cortef Hydrocortisone Expiry date 01/2017
Diazepam solution for injection 10mg/2ml 10 amps Expiry date 12/2015
Chlorphenamine 5mg/1ml amps x 5 Expiry date 08/2017

It was also noted that packaged syringes and needles had expired in 2008/2009.

There was no Glucagon for injection and there was no buccal Midazolam/Buccolam. The dental nurse spoken with was not familiar with the names of these medications.

During discussion the dental nurse confirmed that some medicines were kept in the fridge. The inspector provided a description of the Glucagon packaging and following this the Glucagon was located in the fridge. The Glucagon was observed to have an expiry date of 08/2012. It was confirmed that fridge temperatures were not recorded. If Glucagon medication is stored in a fridge, records of daily fridge temperatures should be maintained to evidence that the medication is maintained within the acceptable 2 – 8 degrees centigrade. Glucagon has a shelf life of 18 months when not stored in the fridge and if this approach is adopted a revised expiry date of 18 months from the date of receipt of the medication should be recorded on the medication and emergency drug checking record.

Compliance with this requirement could not be demonstrated.

5.1.2 Enforcement

Following the inspection, this matter was escalated to senior management in RQIA, following which a decision was taken to hold an intention to issue a failure to comply notice meeting.

Dr McGowan attended this meeting at RQIA on 9 July 2015. During this meeting Dr McGowan provided assurances that all emergency medications as identified in the BNF would be provided as a matter of urgency and that storage arrangements would be addressed. In light of these assurances and confirmation from Dr McGowan that the practice was closed from the

date of the meeting until 14 July 2015, a decision was taken not to issue a failure to comply notice at this time. However, Dr McGowan was informed that a further visit would be undertaken to the practice on 14 July 2015 to verify the provision and storage of emergency medications and that if suitable arrangements had not been established, a failure to comply notice would be issued.

5.1.3 Review of Requirement on 14 July 2015

Review of emergency medications confirmed that all emergency medications as identified in the BNF were available and were in date. The Glucagon medication was stored in the fridge. Dr McGowan advised that arrangements would be established to undertake daily fridge temperatures, however, it was identified that the thermometer available was not suitable for this purpose. It was subsequently agreed that a revised 18 month expiry date would be recorded; this was completed during the visit and the Glucagon medication was put into the emergency medications box with the rest of the emergency medicines.

Buccal Midazolam has been provided in the format of Buccolam as recommended by the Health and Social Care Board. The supply is of four prefilled syringes of 10mg which is the standard dosage for age 10 to adult as per BNF. On enquiring how smaller doses would be administered to children under the age of 10 years, Dr McGowan advised she would administer three quarters, half, or one quarter of the amount in the syringe depending on the age of the child. Dr McGowan was informed that the product information label completely covers the barrel of the syringe resulting in the amount of liquid not being visible. The inspector advised Dr McGowan to establish suitable arrangements to ensure that the correct dosage can be administered to patients under the age of 10. As the medication packaging has not yet been opened Dr McGowan will consider replacing the 10mg Buccolam doses with four 2.5mg doses, the administration of all four 2.5mg doses equalling one adult dose. Alternatively if Dr McGowan decides to keep the present provision she will mark the syringes appropriately to ensure the correct dosage can be administered. Dr McGowan demonstrated a clear understanding of how she would address this.

The emergency medicines were still located in the unlocked storage cupboard located in the corridor leading to the patient toilet. Following discussion with Dr McGowan the emergency medicines were relocated to a cupboard within Dr McGowan's surgery in the presence of the inspector.

Compliance with the requirement has been achieved.

5.1.4 Environment

On 30 June 2015 there were estates issues that were of concern to the inspector. These issues included the missing suspended ceiling tiles and exposed electrical cabling on the ground floor, the unfinished refurbishment works around the patient toilet on the first floor and the unlocked storage units where the emergency medication had been stored.

Ballynahinch Dental Practice has not had a RQIA routine estates inspection therefore the issues were brought to the attention of the aligned estates inspector who agreed to review them in due course.

No requirements or recommendations resulted from this inspection.

I agree with the content of the report.			
Registered Manager		**Date Completed**	
Registered Person		**Date Approved**	
RQIA Inspector Assessing Response		**Date Approved**	

Please provide any additional comments or observations you may wish to make below:

Please complete in full and returned to** independent.healthcare@rqia.org.uk /RQIA's office (non-paperlite) **from the authorised email address

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and weaknesses that exist in the practice. The findings set out are only those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not absolve the registered person from their responsibility for maintaining compliance with minimum standards and regulations.