Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against an Independent Dental Practice

NIPSO Reference: 201917415

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The Role of the Ombudsman

The Northern Ireland Public Services Ombudsman (NIPSO) provides a free, independent and impartial service for investigating complaints about public service providers in Northern Ireland.

The role of the Ombudsman is set out in the Public Services Ombudsman Act (Northern Ireland) 2016 (the 2016 Act). The Ombudsman can normally only accept a complaint after the complaints process of the public service provider has been exhausted.

The Ombudsman may investigate complaints about maladministration on the part of listed authorities, and on the merits of a decision taken by health and social care bodies, general health care providers and independent providers of health and social care. The purpose of an investigation is to ascertain if the matters alleged in the complaint properly warrant investigation and are in substance true.

Maladministration is not defined in the legislation, but is generally taken to include decisions made following improper consideration, action or inaction; delay; failure to follow procedures or the law; misleading or inaccurate statements; bias; or inadequate record keeping.

The Ombudsman must also consider whether maladministration has resulted in an injustice. Injustice is also not defined in legislation but can include upset, inconvenience, or frustration. A remedy may be recommended where injustice is found as a consequence of the failings identified in a report.

Reporting in the Public Interest

This report is published pursuant to section 44 of the 2016 Act which allows the Ombudsman to publish an investigation report when it is in the public interest to do so.

The Ombudsman has taken into account the interests of the person aggrieved and other persons prior to publishing this report.

TABLE OF CONTENTS

Page

Case Reference: 201917415

SUMMARY

This complaint is about the care and treatment the Practice provided to the complainant. On 24 December 2020 the complainant attended an emergency dental appointment at the Practice as a filling was dislodged from her tooth. The dentist dressed the tooth with a temporary filling, and the complainant was to return for a permanent filling.
The complainant was noted as being very nervous, and the dentist felt that she would benefit from sedation in order to place a permanent filling on the tooth. Sedation was not offered at the Practice, and so the complainant was to be referred to another Practice which administered sedation.

Following the appointment, the complainant said the Practice had left her with an open tooth and in a great deal of pain over the Christmas period. The complainant said the Practice refused to treat her.

The investigation examined the details of the complaint, the Practice's response, medical records and relevant guidance. I also sought advice from an independent professional advisor. The investigation found the complainant received appropriate care and treatment from the Practice.

The investigation established that there was a service failure in the record keeping by the Practice, and a service failure in the breakdown of communication with the complainant. I recommended the Practice apologise to the complainant for the miscommunication and to reflect on learning to prevent the failure recurring.

THE COMPLAINT

Background

2. On 24 December 2020 the complainant attended an emergency dental appointment at the Practice as a filling was dislodged from her tooth (Upper Right 4). The complainant's tooth required a filling and the Practice stated that in order to complete a permanent filling an 'aerosol generating procedure[1] (AGP)' was required. The Practice said that due to the on-going pandemic, and as it was an emergency appointment, the Practice could not carry out this procedure on 24 December 2020. The dentist dressed the complainant's tooth in ledermix[2] and coltosol[3], and the complainant was to return for a permanent filling.

3. During this emergency appointment, the complainant was very nervous, and the dentist felt that she would benefit from sedation in order to place a permanent filling on the tooth. Sedation was not offered at the Practice, and so the complainant was to be referred to another practice which administered sedation.

4. A chronology of events leading to the complaint is enclosed at Appendix three to this report.

Issue of complaint

5. The issue of complaint accepted for investigation was:

   Whether the care and treatment provided to the complainant was reasonable and in accordance with relevant standards and guidelines.

[1] Medical or health-care procedure that a public health agency has designated as creating an increased risk of transmission of an aerosol born contagious disease such as Covid-19.
[2] Cream used by dentists to fill a cavity to help calm the nerve of a tooth.
[3] Temporary filling material.

INVESTIGATION METHODOLOGY

6. In order to investigate this complaint, the Investigating Officer obtained from the Practice all relevant documentation together with its comments on the issues raised by the complainant. This documentation included information relating to the Practice's handling the complaint.

Independent Professional Advice Sought

7. After further consideration of the issues, I obtained independent professional advice from an independent professional advisor (IPA) with 31 years experience in the field.

8. The information and advice which informed the findings and conclusions are included within the body of this report. The IPA provided 'advice'; however how this advice was weighed, within the context of this particular complaint, is a matter for my discretion.

Relevant Standards and Guidance

9. In order to investigate complaints, I must establish a clear understanding of the standards, both of general application and those which are specific to the circumstances of the case. I also make reference to relevant regulatory, professional and statutory guidance.

   The general standards are the Ombudsman's Principles[4]:

   - The Principles of Good Administration
   - The Principles of Good Complaints Handling

[4] These principles were established through the collective experience of the public services ombudsmen affiliated to the Ombudsman Association.

10. The specific standards and guidance referred to are those which applied at the time the events occurred. These governed the exercise of the administrative functions and professional judgement of those individuals whose actions are the subject of this complaint.

    The specific standards and guidance relevant to this complaint are:

    - Standards for the Dental Team, The General Dental Council (GDC Guidance);
    - Health and Social Care Board (HSBC) Preparation for the Re-establishment of the General Dental Services – Operational Guidance 4 June 2020 Updated 21 October 2020;
    - Clinical Examination and Record-Keeping Good Practice Guidelines; and
    - Management of Acute Dental Problems Scottish Dental Clinical Effectiveness Program (UK Wide).

11. I did not include all of the information obtained in the course of the investigation in this report but I am satisfied that everything that I consider to be relevant and important was taken into account in reaching my findings.

12. A draft copy of this report was shared with the complainant and the Practice for comment on factual accuracy and the reasonableness of the findings and recommendations.

THE INVESTIGATION

Issue 1: Whether the care and treatment provided to the complainant was reasonable and in accordance with relevant standards and guidelines. In particular, this will consider:

- **The treatment of the complainant's tooth on 24 December 2020.**
- **Referral to another practice.**

Detail of Complaint

13. The issue of complaint is about the Practice's care and treatment of the complainant. The complainant raised the following concerns:
    - The complainant said that the dentist told her that she was nervous and that he could no longer treat her.
    - The complainant said she was left in agony following her attendance at the Practice.
    - The complainant said she was left with an 'open tooth', and unable to get an appointment with another dentist at short notice.
    - The complainant said she was discharged from the Practice without reason.

Evidence Considered

Legislation/Policies/Guidance

14. I considered the following policies/guidance:
    - GDC Guidance;
    - Health and Social Care Board Preparation for the Re-establishment of the General Dental Services – Operational Guidance 4 June 2020 Updated 21 October 2020;
    - Clinical Examination and Record-Keeping Good Practice Guidelines; and
    - Management of Acute Dental Problems Scottish Dental Clinical Effectiveness Program (UK Wide).

Relevant sections of the guidance considered are enclosed at Appendix four to this report.

The Practice's response to investigation enquiries

The treatment of the complainant's tooth on 24 December 2020.

15. The Practice stated the complainant attended an emergency appointment at the Practice complaining of tooth pain, and the dentist identified that the complainant's tooth required a filling. The Practice said, *'completing a permanent filling would have required the tooth to be drilled, which is an aerosol generating procedure.'* The Practice explained that an AGP requires a

significant period of time to elapse following the end of treatment of one patient, before cleaning and decontamination of the dental surgery, and the next patient can be seen. For this reason, the Practice stated that any treatment requiring AGP was not provided during an emergency appointment. The Practice said if an AGP was required, an emergency non-AGP treatment would be provided to a patient, and the patient could return for a planned appointment slot for the AGP treatment to be provided.

16. The Practice stated that the complainant received a temporary filling using ledermix and coltosol. The Practice said, *'[the complainant] was not therefore, left with an 'open tooth' and steps were taken to address her complaints of pain.'* The Practice said the complainant was a very nervous patient, and was difficult to treat due to her level of anxiety. The dentist however was able to complete the temporary filling as planned. The Practice said given the degree of anxiety the complainant exhibited the dentist *'discussed with her that she may benefit from a referral to a specialist sedation practice, as she could be offered treatment under conscious sedation, which helps alleviate anxiety.'* The Practice said it does not provide conscious sedation treatment, and so the complainant was to be referred to a Practice which offered sedation. The Practice said, *'having discussed this issue with [the complainant] it was [the dentist]'s understanding that she was content to be referred to a specialist sedation practice.'*

Referral to another Practice.

17. The Practice said *'it was not considered that there was any merit in making a referral on Christmas Eve as it was considered that it would not be possible to get an appointment at a sedation practice over the Christmas period. It was, therefore, intended that the referral would be made when the Practice re-opened on 4 January 2021. A handwritten manual note was left that this referral should be followed up when the practice re-opened on 4 January 2021.'* The Practice stated that this hand-written note was not retained, and stated that the Practice would have been content to attempt to complete a filling to the complainant's tooth if she wished them to.

18. The Practice said that the complainant left a voicemail message at the Practice on 24 December 2020 in which she stated she was unhappy that she had been advised to find a new dentist. This message was not picked up until the Practice re-opened on 4 January 2021. The Practice said *'during this call, [the complainant] informed [the Practice manager] that she had found a new dentist. It was, therefore, understood that the new dentist would complete the treatment to the [Upper Right 4]. A referral letter was not, therefore, sent to a sedation practice as had been planned'*.

Relevant Practice records

19. The Practice provided the relevant clinical records and a summary of these records is enclosed in Appendix six to this report.

Relevant Independent Professional Advice

Treatment to the complainant's tooth on 24 December 2020.

20. The IPA advised, *'the procedure of dressing the tooth in ledermix and coltosol was reasonable and followed normal procedure in dealing with temporary tooth repair.'* The IPA set out a typical procedure of applying a temporary filling on a tooth, which is enclosed in Appendix five to this report. The IPA advised, *'the treatment was completed correctly and followed good dental practice'*.

21. The IPA advised that *'following the procedure, it is normal for the patient to feel pain. If the pain increases significantly, then the Practice could either treat or refer the patient'*.

22. The IPA concluded, *'the patient did receive the appropriate treatment on 24 December 2020. The process of dressing the tooth was reasonable and followed normal procedure in dealing with temporary tooth repair, and it is not unusual for the patient to feel pain after this situation'*.

Referral to another Practice.

23. The IPA advised, *'it was appropriate for the dentist to refer the patient to another surgery that offers sedation'*. The IPA made reference to the Conscious Sedation Guidance (Appendix four), that it was appropriate for the Practice to

arrange for the complainant to get sedation, and to refer the complainant to a dentist who could more appropriately carry out the treatment required.

24. The IPA advised, *'the referral was intended to be sent on the 4 January, and this, in my opinion, would be reasonable'*. The IPA advised that most dental practices are likely to be closed during some or all of the festive period, and have limited treatment slots or emergency appointments only. The IPA also advised that this would reduce the opportunity for the referring dentist to draft a referral, or the receiving dentist to receive and process it.

25. The IPA further advised, *'although the referral was appropriate, the referral procedure carried out by the dentist falls below the expected standard'*. The IPA advised that the clinical records lacked detail of the type and basis of the sedation, and the complainant's agreement that information could be shared. The IPA advised that the Practice should make themselves aware of the suggestions laid out in the Conscious Sedation Guidance (Appendix four), and the Clinical Examination and Record Keeping guidance (Appendix four).

26. The IPA advised that the complainant was not impacted by the identified failing and advised, *'the referral was intended to be sent on the 4th of January, and this in my opinion, would be reasonable'*.

Analysis and Findings

Treatment of the complainant's tooth on 24 December 2020.

27. I note the complainant said that she was in a lot of pain following her appointment and the Practice had left her with an 'open tooth'. I note the Practice records document that the complainant attended an emergency appointment on 24 December 2020, and was complaining of pain. I also note the Practice dental records document that the complainant was given a temporary filling, and *'[the complainant] to return for fill'*.

28. I note the Practice stated that the complainant was fitted with a temporary filling, as a permanent filling was an AGP that required using dental drills. I note the HSCB guidance (Appendix four) states that AGP is a recognised risk in the

spread of Covid19, and therefore requires enhanced levels of Personal Protective Equipment, as well as a significant fallow period to be set aside in order to allow any virus particles to settle and to then clean down the surgery. I note the Practice explained that AGP treatments are not provided to patients during emergency appointments, and emergency non-AGP treatments are provided, and the patient is to return for an appointment planned AGP treatment.

29. I note the Management of Acute Dental Problems Guidance (Appendix four) states *'if reversible pulpitis, consider providing a temporary dressing'*. I note the IPA advised that as this was an emergency appointment the best option would be to place the temporary filling material into the cavity, and for the complainant to return at a later stage in order to receive a permanent filling into the tooth. Therefore, I am satisfied that it was appropriate for the Practice to provide a temporary treatment for the complainant in this instance.

30. I note the Practice's dental records state that the complainant's tooth was dressed in ledermix and coltosol. I note the Practice explained that ledermix includes active ingredients, which have an antibiotic and sedative effect. I note the IPA's advice that by dressing the complainant's tooth in ledermix and coltosol, the Practice followed a recognised and appropriate treatment to the complainant's tooth in this instance. I note the IPA's advice that *'following the procedure, it is normal for the patient to feel pain. If the pain increases significantly, then the Practice could either treat or refer the patient'*.

31. After consideration of all the evidence available to me, I do not uphold this element of the complaint. I accept the IPA's advice that the complainant did receive the appropriate treatment on 24 December 2020, and that the process of dressing the tooth was reasonable and followed normal procedure in dealing with temporary tooth repair. I also accept the IPA's advice that it is not unusual for the complainant to feel pain after this type of treatment.

Referral to another Practice.

32. I note the complainant said that she was discharged from the Practice without reason. I note the Practice's dental records document that the complainant was

very nervous and needed a dentist who provided sedation. I also note the Practice dental records state, *'[the complainant] understands and agrees that she is almost impossible to treat'*.

33. I note the Conscious Sedation in Dentistry Dental Clinical Guidance (Appendix four) states *'the provision of adequate anxiety control is an integral part of the practice of dentistry'*. I note GDC guidance (Appendix four) states, *'You should refer patients on if the treatment required is outside your scope of practice or competence'*. I also note the Clinical Examination and Record Keeping Good Practice Guidelines (Appendix four) states *'A dentist should refer any patient if, in the dentist's own opinion, the treatment is outside of their training or competence and another clinician would more appropriately carry out the treatment required'*.

34. I note the IPA's advice that it was appropriate for the dentist to refer the complainant to another surgery that offers sedation. I also note the IPA advised, *'the referral was intended to be sent on the 4 January, and this, in my opinion, would be reasonable'*. I note the IPA explained that this was because most dental practices are likely to be closed during some or all of the festive period, and have limited treatment slots or emergency appointments only. I also note the IPA advised that this would reduce the opportunity for the referring dentist to draft a referral, or the receiving dentist to receive and process the referral. Therefore, I am satisfied that it was appropriate for the Practice to refer the complainant to a Practice which offered sedation, in order for her to receive a permanent filling on her tooth. I am also satisfied that it was appropriate for the Practice to delay the referral to 4 January 2021, upon the reopening of the Practice following the Christmas break.

35. I acknowledge the IPA's advice that the referral procedure carried out by the Practice fell below the expected standard. However, I do understand that in this instance the complainant's referral was a 'draft referral' that was completed on Christmas Eve following emergency appointment. I note the Practice stated that it was intended to complete the complainant's referral process upon it's reopening on 4 January 2021.

36. I note the Practice records on 24 December 2020 state: *'Discussed calling a sedation practice that would better suit [patient's] needs if feels she cannot undergo any dental treatment'*. I also note the Practice records also states, *'She understands (sic) and agrees she is almost impossible to treat'*.

37. I note on 4 January 2021 the Practice records state: *'Called [patient] re telephone message on Christmas Eve – very unhappy that was advised to find a new dentist – Explained to the patient that we were sorry she felt like that – appeared ok on the day nervous [patient] difficult to treat as grabbed dentists hand – Needs specialist dental care – sedation'*. The Practice advised this Office that during this telephone call, the complainant advised the Practice manager that she had found a new dentist, *'it was therefore, understood that the new dentist would complete the treatment to the [Upper Right 4]. A referral letter was not, therefore, sent to a sedation practice as had been planned.'* In response to this Office's enquires the Practice was unable to provide a record of this conversation. As there are no records of this conversation, I consider this is a service failure. I would ask the Practice to reflect on the learnings set out in the conclusion of this report.

38. I note the Conscious Sedation in Dentistry Dental Clinical guidance (Appendix four) states *'to provide the patient with information about why they are being referred, likely options for care and what to expect'*. I note Clinical Examination and Record-keeping Good Practice Guidelines (Appendix four) states *'Referral, including options and reasons, should be discussed with the patient. The outcome should be recorded, and if referral is agreed it should be confirmed with the patient that this includes consent to provide relevant information for the referral.'* I also note that this guidance states, *'however it is not necessary to record that the patient gave consent as this is part of the process of referral'*.

39. I cannot determine whether the complainant gave consent for her details to be forwarded to a sedation practice, as it is not a requirement to record this in the complainant's notes under the Clinical Examination and Record-Keeping Guidance. I note that the complainant's medical records document that a referral to a sedation practice was discussed with the complainant; however, I

do not believe she fully understood the referral process and the plan for her future treatment. The complainant believed she was discharged from the Practice without reason, and had to find a new dentist to complete the treatment.

40. I have considered all of the evidence available to me, and I do not believe the complainant received the appropriate communication from the Practice about the referral process, and plans for her future treatment. For the reasons outlined in this report, I partially uphold this element of the complaint.

CONCLUSION

41. I received a complaint about the care and treatment provided to the complainant by the Practice on 24 December 2020. I partly uphold the complaint for the reasons outlined in this report.

42. The investigation established that the Practice provided the complainant with the appropriate care and treatment to her tooth on 24 December 2020. The investigation established that it was appropriate for the Practice to refer the complainant to a practice, which offers sedation, and to delay this referral to 4 January 2021, following the Christmas break.

43. The investigation established that the record keeping of the telephone conversation on 4 January 2021 fell below the expected standard. I would ask the Practice to reflect on the record keeping guidelines set out by the GDC Guidance (Appendix four).

44. The investigation established that the Practice's communication with the complainant regarding the referral process, and plans for her future treatment fell below the expected standard. This led to a miscommunication with the complainant, and her understanding of the dentist's intentions by referring her to a sedation practice. I would ask in future that the Practice talks through its treatment plan with patients, and to ensure a patient fully understands the referral process to prevent future breakdowns in communication.

45. I hope the findings in this report provides reassurance to the complainant that the Practice did act appropriately in relation to the care and treatment to her tooth and by the intention to refer her to a sedation practice, in order to relieve some of her anxiety. I would also like to inform the complainant that the Practice advised this Office the complainant is still registered as a patient with the Practice until September 2022.

Recommendations

46. I recommend that the Practice provides the complainant with a written apology in accordance with NIPSO 'Guidance on issuing an apology' (June 2016), for the service failure in the miscommunication within **one** month of the date of this report.

MARGARET KELLY
Ombudsman **January 2022**

Appendix 1

PRINCIPLES OF GOOD ADMINISTRATION

Good administration by public service providers means:

1. Getting it right

- Acting in accordance with the law and with regard for the rights of those concerned.
- Acting in accordance with the public body's policy and guidance (published or internal).
- Taking proper account of established good practice.
- Providing effective services, using appropriately trained and competent staff.
- Taking reasonable decisions, based on all relevant considerations.

2. Being customer focused

- Ensuring people can access services easily.
- Informing customers what they can expect and what the public body expects of them.
- Keeping to its commitments, including any published service standards.
- Dealing with people helpfully, promptly and sensitively, bearing in mind their individual circumstances
- Responding to customers' needs flexibly, including, where appropriate, co-ordinating a response with other service providers.

3. Being open and accountable

- Being open and clear about policies and procedures and ensuring that information, and any advice provided, is clear, accurate and complete.
- Stating its criteria for decision making and giving reasons for decisions
- Handling information properly and appropriately.
- Keeping proper and appropriate records.
- Taking responsibility for its actions.

4. Acting fairly and proportionately

- Treating people impartially, with respect and courtesy.
- Treating people without unlawful discrimination or prejudice, and ensuring no conflict of interests.
- Dealing with people and issues objectively and consistently.
- Ensuring that decisions and actions are proportionate, appropriate and fair.

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.
- Putting mistakes right quickly and effectively.
- Providing clear and timely information on how and when to appeal or complain.
- Operating an effective complaints procedure, which includes offering a fair and appropriate remedy when a complaint is upheld.

6. Seeking continuous improvement

- Reviewing policies and procedures regularly to ensure they are effective.
- Asking for feedback and using it to improve services and performance.
- Ensuring that the public body learns lessons from complaints and uses these to improve services and performance.

Appendix 2

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

1. **Getting it right**

    - Acting in accordance with the law and with regard for the rights of those concerned.

    - Ensuring that those at the top of the public body provide leadership to support good complaint management and develop an organisational culture that values complaints.

    - Having clear governance arrangements, which set out roles and responsibilities, and ensure lessons are learned from complaints.

    - Including complaint management as an integral part of service design.

    - Ensuring staff are equipped and empowered to act decisively to resolve complaints.

    - Focusing the outcomes for the complainant and the public body.

    - Signposting to the next stage of the complaints procedure in the right way and at the right time.

2. **Being customer focused**

    - Having clear and simple procedures.

    - Ensuring that complainants can easily access the service dealing with complaints, and informing them about advice and advocacy services where appropriate.

    - Dealing with complainants promptly and sensitively, bearing in mind their individual circumstances.

    - Listening to complainants to understand the complaint and the outcome they are seeking.

    - Responding flexibly, including where appropriate co-ordinating responses with any other bodies involved in the same complaint, where appropriate.

3. **Being open and accountable**

    - Publishing clear, accurate and complete information about how to complain, and how and when to take complaints further.

- Publishing service standards for handling complaints.

- Providing honest evidence-based explanations and giving reasons for decisions.

- Keeping full and accurate records.

4. Acting fairly and proportionately

- Treating the complainant impartially, and without unlawful discrimination or prejudice.

- Ensuring that complaints are investigated thoroughly and fairly to establish the facts of the case.

- Ensuring that decisions and actions are proportionate, appropriate and fair.

- Ensuring that complaints are reviewed by someone not involved in the events leading to the complaint.

- Acting fairly towards staff complained about as well as towards complainants

5. Putting things right

- Acknowledging mistakes and apologising where appropriate.

- Providing prompt, appropriate and proportionate remedies.

- Considering all the relevant factors of the case when offering remedies.

- Taking account of any injustice or hardship that results from pursuing the complaint as well as from the original dispute.

6. Seeking continuous improvement

- Using all feedback and the lessons learnt from complaints to improve service design and delivery.

- Having systems in place to record, analyse and report on learning from complaints.

- Regularly reviewing the lessons to be learnt from complaints.

- Where appropriate, telling the complainant about the lessons learnt and the changes made to services, guidance or policy.