Northern Ireland
Public Services
Ombudsman

Investigation Report

Investigation of a complaint against a Dental Surgery in County Antrim

NIPSO Reference: 201917236

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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.

Issue of complaint

1. I accepted the following issue of complaint for investigation:

> Whether the complainant received appropriate care and treatment from the Practice between 18 November 2019 and 08 September 2020.

2. The complainant was concerned about Dentist A's decision that she needed root canal treatment rather than a filling, and she questioned whether an X-ray of her tooth was interpreted correctly. The complainant was also concerned that Dentist A did not complete her root canal treatment at the scheduled appointment. The complainant said that Dentist A left her with a temporary filling in place for too long.

3. The Practice provided the complainant's relevant dental records as well as an explanation regarding the treatment provided to the complainant. In relation to complainant's concern that the temporary filling remained in place for too long, the Practice stated that it had offered a follow up appointment to the complainant on 6 February 2020. It further stated that the complainant cancelled this appointment and provided an appointment history. The Practice also stated that it had an answering service in place during this Covid lockdown.

4. I obtained independent professional advice from a dental consultant who has 31 years' experience (BDS MBA MPH FDS RCPS (Glasg) MJDF RCS (Eng). .

5. The independent professional advisor, (IPA) provided advice about the decision to offer the complainant root canal treatment rather than a filling on 18 November 2018. The IPA advised that after *'…identification of decay in the UL7, the patient was offered a filling to repair the tooth and help solve the pain that the patient presented with*.' However, during the procedure to fill the tooth, '*…the nerve was reached, and the dentist then proposed root treatment or extraction'*. .The IPA further advised that *'…The patient chose extraction…*' The IPA went onto advise that the '*…examinations, investigations and assessments were appropriate'* and '*The proposed treatment plan for a*

subsequent visit was therefore an extraction, a scale and polish, and both seem appropriate'.

6. The IPA advised on the complainant's appointment on 28 November 2019. He advised that the records showed the patient wanted her tooth filled and '*did not wish a root treatment or extraction'*. The IPA advised that Dentist A explained that a filling was inappropriate. The IPA further advised '*The dentist then left the tooth as is, at the patient's request. The treatment was therefore to leave the temporary dressing in place, with the patient returning if the tooth causes pain….This plan was appropriate, since it was with the patient's informed consent and wish*.'

7. The IPA advised that at the appointment of 8 January 2020, Dentist A discussed treatment options with the complainant. The complainant said she wanted root canal treatment and she made an appointment for this treatment on 23 January 2020. The IPA advised this was appropriate.

8. In relation to whether the root canal treatment should have been completed during the appointment on 23 January 2020 the IPA advised *'…the notes record "pulp accessed, +++bleeding", "unableto [sic] control bleeding", and then "unable to complete today due to time and bledding [sic]". Excessive bleeding via the root canal is usually a sign of ongoing inflammation and/or infection. Completing the root treatment, under these circumstances, is not recommended.'* The IPA also advised blood would not be visible to the patient during rinsing as it '…*would be taken away by the aspirator (suction tube) or paper points used to tamp the canals during the treatment.* The IPA also advised '*There is no indication that the patient was in pain in the notes. Further, there is no note of added Local Anaesthetic being needed.''*

9. In relation to dental practices during the Covid 19 Pandemic the IPA advised that the '*Practice appears to have complied with HSC Business Services Organisation guidelines (/ (hscni.net)) which stated that only urgent treatment would be available during any restrictions'*. He further advised on 8 September 2020, following the Covid pandemic, Dentist B completed appropriate assessments and recommended appropriate treatment. *'…The patient had*

then agreed the proposed treatment option.' He went on to advise '*The patient had had an appointment for the extraction arranged for the 24th of September 2020…and the patient had subsequently cancelled this appointment'*.

10. In summary the IPA advised that the actions of Dentists A and B *'…caused no detriment to the patient*.' He further advised '*The complainant did…receive appropriate care and treatment and advice during the period of her treatment between November 2019 and September 2020*.'

11. However, the IPA also advised that '*There is no evidence of a signed treatment plan within the notes. This does not fulfil the requirement in the GDC's Standards for the Dental Team…The patient does not appear to have been disadvantaged by this omission, however, since it appears that she has been kept informed of the treatment options during this time period'.*

Complainant's Response to Draft Decision Report

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

13. The complainant said she had not needed root canal treatment and had repeatedly asked Dentist A for an amalgam filling instead. She also said that her tooth was only sensitive when eating ice cream and that the toothpaste prescribed initially by Dentist A had worked well. The complainant also said the note in her dental records of 18 November 2019 referring to her taking Ibuprofen was incorrect, as she cannot take Ibuprofen for medical reasons. In relation the appointment on 23 January 20202 she said she had been in 'severe pain' during the procedure. The complainant made a general point about communication from the Practice. She said that Dentist A could have explained her treatment better and could have communicated more during appointments. She also said that the Practice should have made more of an effort to contact her and provided a better duty of care. The complainant said she had had to get antibiotics and had to go somewhere else to have the tooth removed. She said that she could not register with another dentist with the root

canal started. She said could only go to another dentist to have the tooth extracted.

Analysis and Findings

14. In relation to the care and treatment provided to the complainant I acknowledge the complainant's comments that she said had requested amalgam filling due to the sensitivity of her tooth and her comments in relation to the pain she experience on 23 January 2020. I note the IPA's advice that on 18 November the complainant agreed to an extraction and on 28 November requested a filling. I further note that on 8 January 2020 the complainant agreed to root canal treatment and an appointment was made to have this treatment carried out. Whilst I acknowledge the pain the complainant experienced during her appointment of 23 January 2020, I have been unable to corroborate this and I note the IPA's advice '*There is no indication that the patient was in pain…*' and '…*there is no note of added Local Anaesthetic being needed*.' Given the available evidence, I accept the advice of the IPA that '*The complainant did…receive appropriate care and treatment and advice during the period of her treatment between November 2019 and September 2020*.' Therefore, I do not uphold this issue of complaint.

15. Although I have not upheld the complaint I acknowledge the complainants account of the pain she experienced due to her treatment. I have considered the complainant's comments that she cannot take Ibuprofen and although I cannot corroborate the conversation between the complainant and Dentist A on 18 November 2020, if the complainant considers she can show this is inaccurate she may wish to seek advice from the ICO as to how this might be corrected.

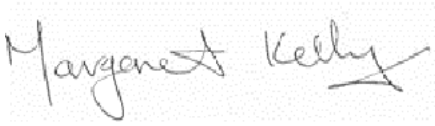
16. In relation to the complainant's comments about the communication provided by the Practice regarding her treatment, the IPA commented that '…*it appears that she has been kept informed of the treatment options during this time period...*'. However, the Practice did not provide signed treatment plans in line with GDC guidance. I find the IPA's advice that the lack of treatment plans would have not disadvantaged the complainant reassuring. However, I would

ask the Practice to reflect on his comments in relation to the provision of treatment plans.

17. In relation to the length of time the temporary filling was in place, I accept the IPA's advice as to why the treatment on 23 January 2020 was not completed. The complainant also commented that she did not cancel the appointment of 6 February 2020. The appointment log provided by the Practice documents that the patient cancelled the appointment. Following the cancelled appointment there is no recorded contact between the Practice and the complainant until the complainant telephoned the Practice Manager on 26 August 2020. The complainant indicated that she rang the Practice during the Covid 19 pandemic but did not leave a message. The IPA has advised that during Covid 19 the Practice complied with relevant guidelines. When the patient was reviewed on the 8 September the IPA advised that Dentist B offered the complainant appropriate advice on future treatment however, she cancelled the appointment for this treatment.

18. Given the available evidence, and due to the changes in how dental services were provided during the Covid pandemic, I am satisfied that the length of time the temporary filling was in place was not because of a failing by the practice. Therefore, I do not uphold this issue of complaint.

19. The Practice accepted the report findings and I note it has started providing patients with treatment plans. I welcome this learning.



MARGARET KELLY **30 March 2022**
Ombudsman

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 Two

PRINCIPLES OF GOOD COMPLAINT HANDLING

Good complaint handling by public bodies means:

Getting it right

- Acting in accordance with the law and relevant guidance, 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 learnt from complaints.
- Including complaint management as an integral part of service design.
- Ensuring that staff are equipped and empowered to act decisively to resolve complaints.
- Focusing on 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.

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

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.

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 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.

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.

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 the learning from complaints.
- Regularly reviewing the lessons to be learnt from complaints.
- Where appropriate, telling the complainant about the lessons learnt and changes made to services, guidance or policy.