Scottish Parliament Region: Central Scotland

Case 200802819: A Dental Practice, Forth Valley NHS Board

Summary of Investigation

Category

Health: Clinical treatment; complaint handling

Overview

The complainant (Mr C) complained about the Dental Practice (the Practice) he was registered with. In February 2009 Mr C complained that they failed to provide agreed treatment and were unprofessional in their behaviour toward him and in the service they provided.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) Mr C was not appropriately treated by the Practice (*upheld*); and

(b) the Practice failed to follow the NHS complaints procedure for Family Health Services (*upheld*).

Redress and recommendations

The Ombudsman recommends that the Practice:

(i) urgently implement policies to ensure that clinical information is appropriately recorded and protected, and policies and procedures are in place to safeguard all clinical information generated;

(ii) take steps to ensure that all staff are aware of these policies and implement them in their working practice;

(iii) take steps to identify all missing clinical information and to try to retrieve this;

(iv) apologise to Mr C for the failures identified in this report;

(v) urgently establishes a complaints procedure in line with the standards set out by the General Dental Council and the NHS complaints procedure; and

(vi) apologise to Mr C for the poor handling of his complaint.

Main Investigation Report

Introduction

1. The complainant (Mr C) complained to the Dental Practice (the Practice) on 10 February 2009 about the care and treatment he had received when he visited the Practice on 9 and 10 February 2009. In his view he had received sub-standard care over a number of months from the Practice, culminating in unfinished dental treatment and a proposal for a referral to Glasgow Dental Hospital. His key concerns were about the state of his teeth and the decision to cease treatment for teeth whitening as a tooth was cracked; a change of treatment decision regarding the placement of a veneer; and being left with temporary fillings. Additionally, Mr C complained about the Practice's view that he was harassing them by making a number of requests about access to clinical information and a decision taken by staff to call the Police when he was at the surgery on 10 February 2009 as he was, in their view, harassing the reception staff. He also asked for the closed circuit television (CCTV) footage of any recorded details of the time he had spent in the Practice on 10 February 2009.

2. The complaints I have investigated are that:

(a) Mr C was not appropriately treated by the Practice; and

(b) the Practice failed to follow the NHS complaints procedure for Family Health Services.

3. As the investigation progressed, I identified issues concerning record-keeping and the lack of development and implementation of a number of policies to support the administration within the Practice, including a lack of an effective complaints procedure. Therefore, I informed the Practice and Mr C that the investigation would consider these issues.

Investigation

4. I obtained information from the Practice and sought advice from an adviser to the Ombudsman (the Adviser). I also wrote to Forth Valley NHS Board (the Board) for some additional information to assist my understanding of the complaints raised.

5. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mr C and the Practice were given an opportunity to comment on a draft of this report. The Practice did not make any comment on the report or the recommendations.

(a) Mr C was not appropriately treated by the Practice

6. Mr C complained he was not provided with adequate care and treatment and had not received the treatment that had been promised to him. Mr C complained to the Practice about the treatment provided by a dentist (Dentist 1) within the employment of the principal dentist and owner of the Practice (Dentist 2). Dentist 1's employment status at the time conveyed the responsibility of complaint handling to Dentist 2 as the Practice owner and principal dentist.

7. The Practice provided information about the treatment that Mr C had received, however, it was not a full record of the treatment that had been undertaken. Dentist 2 told me that Dentist 1 left the Practice very suddenly for health reasons. Dentist 1 removed clinical information about the treatment undertaken and he removed all information regarding the patient care from the Practice other than a brief summary sheet comprising seven short clinical entries regarding visits made by Mr C to the Practice between 28 May 2008 and 09 February 2009.

8. The entries, as quoted below (with a number of typographical errors), comprised:

> '09-Feb-2009 02:27pm, [Dentist 1]
> Patient cam highly stressed. patient already had previous concernes how his treatment will be carried on
> Very difficult to plan any treatment, becose very highly expextetion – Anrealistic expectation about treatment results.
> Wants to combain private treatment with NHS. Been informed –it not poss to do.
> Toking about complanes if it will be done not the way he expects or not the way he wants treatment to be carried on
> With consultation with [Dentist 2] it was decided to refer him to Glasgow dental school.'
>
> '04-Nov -2008 03:25pm, [Dentist 1]
> Pt TCA for bleaching in surgery'
>
> '27-Oct-2008 12:48pm [Dentist 1]
> Bleaching trays given to patient.'

'15-Oct-2008 10:53am [Dentist 1]
Patient wants to bleach teeth before treatment starts. Treat dissc, estimate given, impressions for trays taken, goes to Fogg, TCA get trays'

'16-Sept-2008 [Dentist 1]
patient wants to change [the initial dentist, Dentist 3] to [Dentist 2] , TCA for bridge prep'

The last two entries written about two earlier appointments were prepared by Dentist 3 who had seen Mr C and has since left the Practice.

'23-Jun-2008 12:34 pm [Dentist 3]
PFTR'

'28-May-2008 03:44 pm, [Dentist 3]
Xm1B rxd cg discuss Bleaching u/l Quote £150 per arch. Private fill LR1
TCA Imps for bleaching trays'

9. Dentist 2 wrote to Mr C on 24 February 2009 responding to the clinical points raised within his complaint letter. He said Mr C's treatment of teeth whitening could not continue as he had reported sensitivity in his teeth. He also confirmed treatment would not continue without agreeing the cost of treatment. In reference to any possible agreement that treatment would be given without a charge, Dentist 2 let Mr C know this would not be the case. Dentist 2 also let Mr C know in the response letter that an option of an appointment with Dentist 2, himself to discuss treatment in detail, had been available and he expressed regret that Mr C had not taken that up. Within this letter Mr C was advised he was being removed from the Practice list and that the Board was to be notified.

10. The Adviser said:
'It is unclear if [Mr C] had been accepted for NHS treatment as we have no records to indicate if he had signed a GP17. There is no proper clinical record keeping and available x-rays, and no appropriate information re treatment provided to [Mr C].
The dentist [Dentist 1] was the treating dentist and as such responsible for his own acts and omissions.'

11. I wrote to the Board on 21 December 2009 (see paragraph 4) to enquire about the advice provided to the Practice regarding the way to proceed in relation to the sudden departure of Dentist 1 from the Practice. The Board told me there was no understanding between Dentist 2 and Dentist 1 about his unexpected departure from the Practice, which should have been supported by a notice period of up to three months to facilitate arrangements for the ongoing treatment of the patients undergoing treatment. The Board told me that Dentist 1 left to assist another dentist in a Practice outside Scotland. This did not accord with our understanding of the information as provided by Dentist 2 on 14 May 2009 (see paragraph 7). Additionally, the Board said they had no knowledge of Dentist 1 removing clinical information from the Practice.

12. The Practice Manager told me that the Practice was seeking advice to pursue the issue of recovering clinical information from Dentist 1 who left the Practice and took information with him. In relation to further enquiries to the Practice about available policies and procedures, I have been shown a copy of a policy for preventing violence and aggression at work and a policy for the Practice's data protection code of practice that the Practice indicate are in place now. They have also indicated they refer to the General Dental Council's data protection principles.

(a) Conclusion

13. The creation and maintenance of adequate clinical records are fundamental to providing appropriate care and treatment. The security of these records is also important to maintaining patients' trust in dental professionals. No adequate clinical records are available. Measures were not in place to protect the clinical information held about the patient. The Practice Manager provided details of General Dental Council procedures that she was referring to in order to develop administrative systems within the Practice.

14. My enquiries about available procedures in place when Mr C raised his complaint with the Practice brought forward no evidence of relevant policies within the Practice. The Practice Manager told me that the Practice was seeking advice to pursue the issue of recovering clinical information from Dentist 1 who left the Practice and took information with him. Whilst this may benefit the Practice in the longer term and act as a catalyst to ensure their policies are robust and their staff adhere to appropriate safe practices regarding the storage and retention of clinical data, the results of the Practice's efforts will not be available for inclusion within this report.

15. The General Dental Council provide guidance about adequate record-keeping, protecting patient information, and the duties of dentists on their own part and as employers (see Annex 2). I have found no evidence to indicate that the guidance was followed in this case. I uphold the complaint.

(a) Recommendations

16. The Ombudsman recommends that the Practice:

(i) urgently implement policies to ensure that clinical information is appropriately recorded and protected, and policies and procedures are in place to safeguard all clinical information generated;

(ii) take steps to ensure that all staff are aware of these policies and implement them in their working practice;

(iii) take steps to identify all missing clinical information and to try to retrieve this; and

(iv) apologise to Mr C for the failures identified in this report.

(b) The Practice failed to follow the NHS complaints procedure for Family Health Services

17. Further to the complaint received by the Ombudsman's office on 10 February 2009, information was requested from the Practice for the details of the complaint. They sent an email dated 25 February 2009 with copies of some relevant correspondence. Consent was then sought from Mr C to gather all the information required from the Practice and on 19 March 2009 the Practice was asked to provide this information by 2 April 2009. This was followed up on 7 April 2009 and I was advised Dentist 2 was on holiday and that the matter would be dealt with on their return.

18. A number of contacts were made with the Practice which resulted in some information being provided on 14 May 2009. This information confirmed the Practice had not responded to the complaint in line with the NHS complaints procedure. The procedure states that the Practice should have an internal system in place to receive, investigate and respond to complaints in writing within ten days of receiving the complaint. Where there may be some delay in responding within that time scale, the Practice should advise the complainant of the delay and likely resolution time.

19. Additionally, the Practice should provide a complainant with a full response to their complaint and let them know about the role of the Ombudsman,

providing details about how to refer their complaint on if they remain dissatisfied with the response they receive at the local resolution stage of the NHS complaints procedure. The complaint response of 24 February 2009 was very brief, gave no information about how the complaints had been considered, and gave no information about the role of the Ombudsman. I asked them to provide a response to Mr C in line with the procedure for Family Health Services. In an email dated 14 May 2009, Dentist 2 advised me:

> 'I understand that [Dentist 1] had made detailed written notes regarding the complaint but I have been unable to make contact with him since he left the practice a few weeks ago.'

20. On 19 May 2009, the complaint file was closed by me pending a full investigation by the Practice and further response to Mr C in line with the NHS complaints procedure. The Practice wrote to Mr C again on 3 August 2009 and he referred the complaint back to the SPSO on 11 August 2009 prompting further enquiries, and the file was re-opened on 28 August 2009. Despite my enquiries, the Practice have not provided evidence to show they met their obligations in dealing with Mr C's complaint.

21. The Practice were asked to provide information about the policies and procedures they had in place to ensure they can effectively respond to complaints raised by patients. I wrote to the Practice again on 20 November 2009 to seek information regarding the policies and procedures in place within the Practice, seeking a response by 4 December 2009. Further to telephone contacts with the Practice to seek the information requested, some information was provided by 17 December 2009.

22. The Practice provided no further information about the events that led to the complaint being made or the Practice's resolution of the complaint. The Practice Manager considered there was no further information to pass on and she explained she was in the process of developing a number of policies and procedures for the Practice. No evidence of any complaints policies or procedures has been provided. The Practice Manager explained she had only been in post since August 2009 and was developing the procedures for the service.

(b) Conclusion

23. The Practice did not handle the complaint in line with the NHS complaints procedure. They have not been able to provide any evidence that they had or have a complaints procedure. I uphold this complaint.

(b) Recommendations

24. The Ombudsman recommends the Practice:

(i) urgently establishe a complaints procedure in line with the standards set out by the General Dental Council and the NHS complaints procedure; and

(ii) apologise to Mr C for the poor handling of his complaint.

Annex 1

Explanation of abbreviations used

Mr C	The complainant
The Practice	The Dental Surgery
The Adviser	Adviser to the Ombudsman
The Board	Forth Valley NHS Board
Dentist 1	Treating dentist – employee
Dentist 2	Principal dentist – practice owner and employing dentist
Dentist 3	Initial dentist providing treatment

Annex 2

List of legislation and policies considered

NHS complaints procedure for Family Health Services

Medical and Dental Defence Union of Scotland – Essential Guide to Medical and Dental Records

General Dental Council Guidance on Principles of Management Responsibility

General Dental Council Standards for Dental Professionals