Case 200601144: Fife NHS Board

Summary of Investigation

Category

Health: Community Dental Services; clinical treatment

Overview

The complainant (Mrs C) raised a number of concerns, alleging that the community dentist (Dentist 1) fitted a denture which had been incorrectly prepared. Also, she was unhappy about the clinical decision which was taken to proceed with treatment.

Specific complaints and conclusions

The complaints which have been investigated are that:

(a) the community dentist (Dentist 1) proceeded with treatment using an incorrectly prepared denture[1] (*upheld*); and

(b) Mrs C subsequently disagreed with the decision taken, to continue with treatment without regard to the stressful circumstances which applied *(partially upheld)*.

Redress and recommendations

The Ombudsman recommends that the Board:

(i) identify and evaluate the measures which are now in place to prevent this occurring again;

(ii) consider the use of a pre-extraction appointment to ensure full understanding of a treatment plan;

(iii) draw up guidelines to consider management and consent when a patient is under particular stress;

(iv) consider the development of a pro-forma to jointly support all clinicians' agreement that the denture made is correctly prepared; and

(v) ensure that a full apology is made to Mrs C for the distress and discomfort caused as a result of the treatment option followed in this particular case.

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[1] As is explained in paragraph 5 of the main report, Mrs C's own dentist (Dentist 2) had ordered the preparation of the denture.

The Board have accepted the recommendations and will act on them accordingly.

Main Investigation Report

Introduction

1. On 17 July 2006 the Ombudsman received a complaint from Mrs C. She complained that there had been mistakes made during her dental treatment. In her complaint she alleged that the denture she had been given, to take on to an appointment with a community dentist (Dentist 1), was not correctly made and had not been checked properly. She said that the incorrectly prepared denture was subsequently used. This meant that more teeth than she expected had to be extracted to allow the denture to fit. Mrs C also complained that she subsequently disagreed with the decision taken, to have the treatment carried out which had resulted in additional teeth being removed.

2. The complaints from Mrs C which I have investigated are that:

(a) Dentist 1 proceeded with treatment using an incorrectly prepared denture; and

(b) Mrs C subsequently disagreed with the decision taken, to continue with treatment without regard to the stressful circumstances which applied.

Investigation

3. The investigation of this complaint involved reading the details of Mrs C's original complaint to the dental practice (the Practice) and a further complaint she made to Fife NHS Board (the Board). I also obtained the details of her clinical treatment. I made an enquiry to the Practice on 19 September 2006 and received their response on 22 September 2006. I also made a formal enquiry to the Board on 1 August 2007 and received their response on 20 September 2007. Advice on the treatment Mrs C received has also been obtained from an independent dental adviser (the Adviser).

4. I have not included in this report every detail investigated but I am satisfied that no matter of significance has been overlooked. Mrs C and the Board were given an opportunity to comment on a draft of this report.

(a) Dentist 1 proceeded with treatment using an incorrectly prepared denture

5. Mrs C had not attended a dentist for a considerable length of time, as a consequence of her anxiety regarding dental treatment, but in the winter of 2005/2006 she received some treatment from her own dentist (Dentist 2). Later, she was referred to Dentist 1 who carried out an extraction and a filling

which were required because of her additional clinical needs. A request for the denture was made to Dentist 2 on 26 January 2006, who ordered a denture to be prepared on 8 April 2006. Mrs C collected the denture and took it to Dentist 1 for her dental treatment on 5 July 2006.

6. On 5 July 2006, when Mrs C presented for her pre-arranged dental appointment with Dentist 1 for her treatment, it was identified that the 'immediate partial denture' (denture) she had brought with her from the Practice for fitting had not been prepared properly. However, Dentist 1 proceeded to undertake treatment that day.

7. Mrs C had complained initially to the Practice about the wrongly prepared denture, that it had been made incorrectly and that this matter was only discussed when Mrs C arrived for her treatment on 5 July 2006. I have been advised by the Adviser that the denture was prepared with additional teeth on it, comprising three additional teeth on the denture which were not requested.

8. At her appointment with Dentist 1, Mrs C was told the denture had not been prepared correctly, as additional replacement teeth to those recommended for extraction were present on the denture. A discussion was held and Dentist 1 attempted to contact Dentist 2 without success. Dentist 1 outlined three options for Mrs C during the appointment regarding how to progress with treatment that day. The options were written in the clinical record and in the complaint response made to Mrs C by the Board on 10 November 2006. These options were:

- delay treatment for a new denture to be made;
- proceed to remove teeth and have a new denture made, addressing Mrs C's dental treatment needs but leaving her with gaps in her mouth until the new denture could be prepared;
- proceed with treatment, taking out the additional teeth to enable the denture to fit.

9. The Board, in their response my enquiries on 20 September 2007, indicated that these three options had been presented to Mrs C (see paragraph 8) and she was given time to consider them. The Board explained that the option of extracting additional teeth was considered because 'these teeth either had large restorations or were decayed'. The Board went on to say 'Only minor adjustment would be carried out as significant adjustments would be the responsibility of the dentist who made the denture'.

10. I have considered the advice of the Adviser and have to be guided by him in these matters. He said that the denture was incorrectly prepared and Dentist 1 removed three additional teeth to enable the incorrectly prepared denture to fit into Mrs C's mouth. The denture had been prepared for Mrs C to be able to have replacement teeth in her mouth on a denture as soon as the extractions were carried out.

11. The Adviser identified a key issue during his consideration; that Dentist 2 changed his instructions to the laboratory which prepared the denture for Mrs C's treatment. The Adviser also said that the changes to the plan of treatment, adding additional teeth to the denture and a subsequent addition of a further tooth, were not picked up before the denture was handed to Mrs C and given to Dentist 1 for use following Mrs C's extractions.

12. The Adviser pointed out that the request to the dental technician indicated additional teeth for the denture and that this was not the same as the records showed from the dental appointment on 24 February 2006. The Adviser noted that the laboratory sheet dated 8 April 2006 indicated 'partial upper acrylic (plastic) denture immediate'. On this sheet the teeth marked for the denture preparation are: the upper right canine UR3; upper left incisor UL1; upper left lateral incisor UL2; upper left canine UL3; upper left first molar UL6; upper left second molar UL7. Additional to this, Dentist 2 also added upper first molar UR6 and upper right first premolar UR4, to be added to the denture. This gave an instruction for eight teeth to be placed on the denture.

13. When the denture was returned to Dentist 2, there was a further tooth on the denture: upper left third molar UL8. The Adviser said that it is the responsibility of a dentist who requests a denture to check it is constructed properly and this does not appear to have happened in this case.

14. In his view, the Adviser did not consider that Mrs C was given the appropriate opportunity to consider her options and to give an informed consent on 5 July 2006, when she was presented with the options for treatment and in light of the incorrectly prepared denture (see paragraphs 10, 12 and 13). The Adviser considered that it would have been better to delay treatment under these circumstances. He indicated that the decision being sought at that point would have been extremely difficult for Mrs C, as she was being asked to make

a decision without having a reasonable amount of time to consider the information.

15. A fourth option was suggested after the event by the Practice and which Dentist 1 has indicated he did think about on the day of treatment, that being the additional teeth on the denture could have been removed to allow a fitting. The Adviser also considered that the option to make good a denture from the available denture was a reasonable suggestion which should have been fully considered. In any event, Dentist 1 proceeded to treat Mrs C without a dental plan which was agreed, through either written or verbal instruction from Dentist 2. This report acknowledges that the denture should have been checked by Dentist 2, notwithstanding, the decision to proceed was made by Dentist 1.

16. The Adviser said that, although it is clear that additional teeth incorrectly placed on the denture were consistent with teeth which, in Mrs C's mouth, did not have a long term future, they were, nonetheless, removed without verbal or written instruction from Dentist 2.

(a) Conclusion

17. The Board have indicated in their letter to me dated 20 September 2007, that they are reviewing the work undertaken in the Community Dental Service. Nevertheless, the advice I have received (see paragraphs 10 to 16), is that Dentist 1 should have delayed treatment given the errors in the preparation stages of the denture and that, in going ahead with treatment, additional teeth were removed without verbal or written instruction from Dentist 2. In these circumstances, I uphold this complaint.

18. It is also clear that there were errors in the preparation stages of the denture and the Practice have told me they have since reviewed their procedure and made alterations in their practice to ensure this cannot arise again. The Practice also said that they have introduced measures which include additional checking of a laboratory slip before it is sent away. Additionally, they have agreed that markings are clear on the denture model as well as the request slip, to ensure that instructions are clear for technicians to follow. They have also agreed that the dentist who requests the denture preparation checks it in the patient's mouth, as far as they can. These improvements are welcomed and are consistent with improving the opportunities to check the prepared work before it is handed to a patient for further fitting.

(a) Recommendations

19. The Ombudsman recommends that the Board:

(i) identify and evaluate the measures which are now in place to prevent this occurring again;

(ii) consider the use of a pre-extraction appointment to ensure full understanding of a treatment plan;

(iii) draw up guidelines to consider management and consent when a patient is under particular stress; and

(iv) consider the development of a pro-forma to jointly support all clinicians agreement that the denture made is correctly prepared.

(b) Mrs C subsequently disagreed with the decision taken, to continue with treatment without regard to the stressful circumstances which applied

20. Mrs C felt the decision she was asked to make about how to proceed with her dental treatment on 5 July 2006 was very difficult, under the particular circumstances at the time (see paragraph 8).

21. This was endorsed during a telephoned interview, held with Mrs C's husband on her behalf on 26 November 2007. He said that Dentist 1 had not given Mrs C the time needed to make the decision and the matter whether to proceed or otherwise was considered under a great deal of pressure and the clinic which was running at the time was the 'sedation list' clinic.

22. This information appears to be supported by the Board in their letter to me dated 20 September 2007. They stated that Dentist 1 'was undertaking his sedation list at that time and continued attempts to re-contact the Practice were not possible'.

23. The view of the Adviser is that the options should not have been put to Mrs C in this way. It should have been a matter which was discussed in a meeting prior to treatment and then a fully informed and considered decision could have been made.

24. The investigation into this complaint yielded a fourth option was available to Dentist 1 (see paragraph 15) but that was not fully considered with Mrs C at the time. In the circumstances, Mrs C was not given an appropriate amount of

time or support to have made her decision. I am, however, mindful that a consent form was signed by Mrs C, which I have seen.

(b) Conclusion

25. Mrs C was asked to make a decision under very difficult circumstances. It appears there was a fourth option but this was not discussed with Mrs C at the time (see paragraph 15 and 24). In these particular circumstances, and in view of the evidence available to me I, therefore, partially uphold this aspect of the complaint as the fact remains Mrs C had signed a consent form, albeit under stressful circumstances.

(b) Recommendation

26. The Ombudsman recommends that the Board ensure that a full apology is made to Mrs C for the distress and discomfort caused as a result of the treatment option followed in this particular case.

27. The Board have accepted the recommendations and will act on them accordingly. The Ombudsman asks that the Board notify her when the recommendations have been implemented.

Annex 1

Explanation of abbreviations used

Mrs C	The complainant
The Board	Fife NHS Board
The Adviser	Independent dental adviser to the Ombudsman
The Practice	Mrs C's dental practice
Dentist 1	The NHS Board community dentist
Dentist 2	Mrs C's dentist
The denture	Immediate partial denture

Annex 2

Glossary of terms

Sedation list clinic	Specific clinic time set aside to conduct treatment under sedation