Dental Service Company
(trading as Dental Service 1)

Dentist, Dr B

Dentist, Dr C

A Report by the

Deputy Health and Disability Commissioner

(Case 18HDC01168)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the services provided to a woman by a dental service in 2018.

2. On 28 April 2018, Dr C extracted the woman's wisdom tooth. The woman developed a painful mouth and visited the dental service to discuss her symptoms on 3 May, 5 May, and 8 May. She also began taking an antibiotic not prescribed by the dental clinic. At the 8 May visit, Dr C prescribed a course of the antibiotic amoxicillin, and discussed with the woman the other antibiotic she was taking.

3. On 11 May, Dr B reviewed the woman at the dental service. Dr B cleaned the socket of her recently extracted tooth and advised her that her infection was improving, and that she should complete her course of antibiotics.

4. Following these events, the woman's infection worsened. She was prescribed further antibiotics and admitted to hospital, where pus was drained from her socket and she was treated in the intensive care unit for two nights.

Findings

5. The Deputy Commissioner considered that Dr C "failed to recognise that the woman's presenting complication was an infection and not a dry socket", "did not provide appropriate treatment for a dry socket", and "missed an opportunity to recommend that she stop taking her own antibiotic and take amoxicillin instead", and found that Dr C breached Right 4(1) of the Code. The Deputy Commissioner also found Dr C in breach of Right 4(2) of the Code for failing to comply with the Dental Council's documentation standards.

6. The Deputy Commissioner found that the dental service had inadequate policies for ascertaining the medications being taken by clients, and that poor record-keeping and missing records indicated broader systems issues at the practice. Accordingly, the Deputy Commissioner found that the dental service company breached Right 4(1) of the Code.

7. The Deputy Commissioner criticised Dr B for not investigating the antibiotics the woman was taking to treat her infection.

Recommendations

8. The Deputy Commissioner recommended that Dr C, Dr B, and the dental clinic apologise to the woman, and that Dr C and Dr B undertake further training.

9. The Deputy Commissioner recommended that the dental service audit its clinical records and develop further policies on the management of patients who are taking medications not prescribed by the clinic.

Complaint and investigation

10. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided to her at Dental Service 1. The following issues were identified for investigation:

- *Whether the Dental Service Company (trading as Dental Service 1) provided Ms A with an appropriate standard of care in 2018.*
- *Whether Dr B provided Ms A with an appropriate standard of care in 2018.*
- *Whether Dr C provided Ms A with an appropriate standard of care in 2018.*

11. This report is the opinion of Deputy Health and Disability Commissioner Kevin Allan, and is made in accordance with the power delegated to him by the Commissioner.

12. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Dr B	Provider/dentist
Dr C	Provider/dentist
Dental Service Company (trading as Dental Service 1)	Provider/dentistry practice
Ms D	Receptionist
Ms E	Dental assistant

13. Information from Ms F (a Director of the Dental Service Company), the district health board (DHB), and Dental Service 2 was also reviewed.

14. Independent expert advice was obtained from a general dentist, Dr Lester Settle (Appendix A).

Information gathered during investigation

Tooth extraction 28 April 2018

15. On 28 April 2018, Ms A, aged in her twenties, first attended Dental Service 1 and saw dentist Dr C.[1] The clinical records state that Ms A was experiencing localised pain in the region of her lower right wisdom tooth, and that she had first felt the pain about two years previously, and had experienced it a few times subsequently.

16. Ms D was working as a receptionist at Dental Service 1, and Ms E was the dental assistant working with Dr C. Ms D said that Ms A came in with a friend, and after Ms A had

[1] Dental Service 1 stated that Dr C is a contractor at the practice.

completed the patient questionnaire, she (Ms D) created Ms A's dental file. Ms E then led Ms A into the surgery room.

17. Dr C stated that Ms A told him that she had been experiencing constant pain for over a week and was finding it difficult to eat or open her mouth. The records state that the pain was localised around tooth 48 (a wisdom tooth). Dr C diagnosed Ms A with pericoronitis[2] and gave her options for treatment — either an antibiotic or extraction of the tooth. The records state that Ms A's preference was extraction to get rid of the pain.

18. Ms A signed an informed consent form, which states:

> "I understand that removing teeth does not always remove the infection, if present, and further treatment may be necessary. I understand the risks involved in having teeth removed. Some of which are: pain, dry socket, spread of infection, or loss of feeling (paraesthesia) that can last for an indefinite period of time. I understand I may need further treatment by another if complications arise during or following treatment."

19. Dr C stated that the extraction was straightforward, and haemostasis[3] was achieved following the extraction.

20. Ms E also said that it was a simple wisdom tooth extraction, and stated:

> "After the extraction, [Dr C] informed [Ms A of the] post extraction care instruction and I gave her a sheet of how to care for your mouth after the surgery. Patient left surgery room."

21. Ms D stated:

> "When patient came out of surgery room, she had a piece of A5 paper in her hand, I didn't see what the paper was, but 'How to care for your mouth after oral surgery' information sheet we routinely gave to patient is size A5. Then she came to me at the counter to make payment."

22. Dr C told HDC that the "[p]ost operative instruction and information sheet … was given to [the] patient in [the] clinic room after the procedure".

23. In contrast, Ms A said that she was not given any after-care instructions. Dr C recorded "POIG" in the clinical notes. Ms F, the Director of the Dental Service Company, explained that this meant "Post Operative Instruction Given".

[2] Pericoronitis is inflammation of the tissue surrounding a third molar, otherwise known as a wisdom tooth. The condition most often occurs in molars that are partially impacted, or not fully visible. It is more common in lower molars than in the upper ones.
[3] Stopping of bleeding.

3 May 2018

24. Ms A stated that by 3 May 2018, she was in pain, her face was swollen, and she could not open her mouth, and she returned to Dental Service 1 that day. Ms A produced a series of chat messages between herself and Dr C as evidence to support her account. Ms A's record of the chat messages shows that on 3 May 2018 at 12.53pm Dr C sent a message to Ms A that states, "At 4.45pm, you can go to the clinic," and Ms A responded immediately confirming that she could attend the appointment. Ms A said that she was not given a prescription or treatment at the 3 May 2018 consultation. Ms A's clinical records contain no documentation of her having attended the practice on that date.

5 May 2018

25. Ms A stated that the second time she returned to the clinic was on 5 May 2018. A chat message states: "[Dr C] — Can I make appointment to see you again? Last couple of days painful." Dr C responded that Ms A should come into the clinic at 12.45pm because the extraction site might be infected. Ms A said that Dr C "washed [her] injury" but did not give her a prescription. Ms A's clinical records contain no documentation of her having attended the practice on that date.

8 May 2018

26. The chat messages indicate that on 7 May 2018, Ms A contacted Dr C asking for an appointment the following day because her teeth in front of the site of the wisdom tooth extraction were painful.

27. Dr C stated that Ms A came back to the clinic on 8 May 2018. She presented with limited mouth opening and said that there was a swelling on the extraction area. Dr C said that Ms A told him that in the previous two days she had been taking antibiotics[4] that she had obtained herself from overseas, and she felt that the swelling was getting better. Dr C stated that he examined Ms A and confirmed that she had dry socket. Dr C said that Ms A's limited ability to open her mouth made the irrigation and dressing of the socket difficult. He stated: "I decided not to push her to open her sore mouth, but to prescribe her with Amoxyl[5] 500mg caps to treat the dry socket."

28. Dr C said that he asked Ms A the name of the medication she had been taking, and she told him that it was from overseas but she was unable to tell him the name of the antibiotic. He said that when he finished the notes and went to reception to sign the prescription, Ms A told him that she wanted to keep taking the antibiotics she had at home, and decided not to take the prescription. Ms F told HDC that Dr C advised Ms A to continue taking the antibiotics she was taking, and did not give her a script. Ms A then left the clinic.

29. The clinical notes contain no record of Ms A having refused the prescription, or of Dr C having asked Ms A the name of the antibiotic she was taking.

[4] Ms A's public hospital notes record that the antibiotic she was taking was levofloxacin.
[5] An antibiotic used to treat a wide range of bacterial infections.

30. Ms A disagrees that she did not take the prescription provided on 8 May 2018, and produced a copy of the medication label for 15 amoxicillin capsules, prescriber Dr C, dispensed on 8 May 2018, to support her account. The label instructed her to take one capsule every eight hours until the medicine was finished.

11 May 2018

31. On 11 May 2018, Ms A sent a message to Dr C stating, "Can we make appointment tomorrow for a prescription?" Ms A told HDC that she sent the message because she had run out of medicine and wanted to obtain a further prescription. In response to the provisional opinion, Ms A clarified that she had not run out of her prescription at the time, but was anxious about running out of it the following day. Dr C did not reply to Ms A's message.

32. Ms A told HDC that she was experiencing inflammation and pain, could not open her mouth, and was unable to consume anything other than liquids.

33. Ms D stated that on 11 May 2018 she was the receptionist at Dental Service 1, and Ms E was the dental assistant working with Dr B.[6] Ms D said that Ms A came to the surgery without an appointment. Ms A's face was swollen and she said that she was feeling sore and wanted to see Dr C. Ms D explained that Dr C was not "on roster", and asked whether Ms A wanted to book an appointment with Dr C or whether she would like to be checked by Dr B. Ms A agreed to be seen by Dr B.

34. Ms E said that Ms A had a slightly swollen face, and her ability to open her mouth was very limited. Dr B stated that he remembers being informed by his assistant that Dr C had extracted Ms A's tooth 48, and that Ms A had been reviewed by Dr C a few days previously.

35. Ms E said that Dr B used an irrigation syringe and diluted Savacol[7] to clean Ms A's socket. She said that Dr B asked Ms A about antibiotics, but she does not remember what they discussed. Ms E said that she saw Dr B "writing down notes on patient file after the patient left surgery room".

36. Ms F told HDC that Dr B saw Ms A in between appointments. Ms F said that Dr B checked Ms A's socket, advised her that it was improving and to continue her antibiotics, and to come back if she had further concerns.

37. Ms D said that Ms A left the clinic after seeing Dr B, and did not speak to her. Ms D stated: "[Dr B] was doing his notes on [the] patient file. I asked [Dr B] whether all done, and [Dr B] said yes, he helped clean patient socket."

38. Dr B stated that he must have carried out his usual protocol for patients with persistent pain after dental extractions. He did not prescribe antibiotics, although he said that normally he would have done so, and his reasons for not doing so "could be due to either

[6] Dr B was an employee at Dental Service 1. He has since resigned.
[7] An antibacterial mouth rinse used to prevent and treat gingivitis.

the diagnosis was not significant enough to have antibiotics or the assumption that [Dr C] had done the prescription when she was there recently". Dr B stated that it would be unusual for him to dismiss a patient with a dry socket without providing a prescription. He said that he remembers advising Ms A to go back to Dr C if her pain persisted, as he prefers patients to be treated by the same dentist.

39. Dental Service 1 did not provide any record of Dr B's consultation with Ms A on 11 May 2018. Ms F told HDC that there are no records. Dr B told HDC that it was always his practice to complete his clinical notes and referral letters on the same day the patient came into the clinic. He believes he did so in this case, but the notes "seemed to have gone missing".

Dental Service 2

40. On 12 May 2018, Ms A attended another dental service (Dental Service 2) and saw a dentist. The records state that Ms A had had an extraction two weeks previously and had been on a five-day course of amoxicillin. She had a swollen right lower jaw and was unable to open her mouth wide enough for the dentist to examine her. Ms A was given the antibiotics Augmentin and metronidazole and advised to return in a week's time for reassessment.

Medical centre

41. On 13 May 2018, Ms A attended a medical centre.[8] At that stage she was in severe pain and had a very swollen right mandible and neck. She reported having an upset stomach and fever. She was seen by a doctor, who discussed her presentation with the on-call dentist at the public hospital. The on-call dentist agreed to review Ms A in the Emergency Department. At that stage, Ms A had a temperature of 38.2°C.

42. The discharge summary states that on examination a collection[9] was detected in Ms A's right submandibular space.[10] Ms A was taken to the acute operating theatre on 13 May 2018 for incision and drainage of the collection. She was then admitted to the Intensive Care Unit (ICU) for two nights.

43. On 15 May 2018, Ms A was transferred to a ward for continued monitoring. She was examined by the maxillofacial[11] team on 17 May 2018 and deemed fit for discharge that day.

Further communication with Dental Service 1

44. Ms A provided HDC with a screen shot of an email she sent to Dr C via Dental Service 1 on 28 May 2018. The email said that after the extraction she had suffered infection and pain, which had resulted in an ICU admission and emergency surgery. The email states:

[8] A combined general practice and urgent care clinic.
[9] Pus.
[10] The submandibular space consists of two compartments in the floor of the mouth, the sublingual space and the submylohyoid (also known as submaxillary) space.
[11] Relating to the jaw and face.

> "After care instructions — you did not provide me with any post-extraction care information of the day of surgery. There is no information available on your website, either. Why did you not provide me with instructions to manage the fresh wound?"

45. The email also says that when she returned to the practice because of the pain, she was not provided with information or care, and states: "You did not even reply to my message after 11 May."

46. On 29 May 2018, Dr C sent Ms A the following message: "Too many messages, did not reply on time then forgot apologies. What happened to you? Infection that bad had to go to ICU?"

47. On 29 May 2018, Dental Service 1 sent a response to Ms A's email that states that the practice did not receive any message or call from her after 11 May 2018. The response also states: "Our nurse did give you the after-care instruction sheet, you were holding it when you came out from the surgery room."

Further information — Dr C

48. Dr C told HDC that he has been in a competence programme with the Dental Council since December 2018 and is practising under supervision. He stated:

> "Through this programme, I am more rigorous on patient questionnaire. In particular, the medications patients are taking. And I make full notes of my treatments and my communication with patients."

49. Dr C said that he now thoroughly investigates patients' medication and insists on patients taking his prescriptions when needed. He stated:

> "I realize the danger of self medication from a patient presenting with a combination of facial (or neck swelling), with pain and limited mouth opening, I would [now] recognize as potentially dangerous."

50. Dr C stated that he is sorry for the suffering experienced by Ms A.

Further information — Dental Service 1

51. HDC asked Dental Service 1 for its policies and protocols and/or procedures that were in place at the time of these events. In response, Ms F said that Dental Service 1 operates under the guidelines of the Dental Council's Code of Practice. She said that the dentists seek updates from the Dental Council website for reference on their scope of practice competencies. Ms F did not provide any policies.

52. Ms F stated that she conducted an internal investigation into these events. She said that she interviewed the dentists and support staff individually, but did not make a written report of the investigation.

53. Ms F stated that the practice now routinely checks medications, and clearly states the name of the medication on the patient's file. She said that the dentists are now very aware

of medications that patients have brought from overseas, particularly antibiotics, and stated: "Dentist(s) now make sure dental prescriptions are given to and taken away by patients where required." She said that the practice follows up patients, normally two to three working days after their appointment, to ascertain their recovery status, and notes the follow-up on the patients' files.

Responses to provisional opinion

54. Ms A commented on the "information gathered" section of the provisional opinion, and her responses have been incorporated into this report where appropriate. She restated that she was not given any after-care instructions following her tooth extraction on 28 April 2018, that she discussed the antibiotic she was already taking with Dr C, that she collected the amoxicillin prescription that Dr C made on 8 May 2018, and that she used amoxicillin as prescribed.

55. Dental Service 1, Dr C, and Dr B were each given an opportunity to comment on the relevant sections of the provisional opinion. Their responses have been incorporated into this report where appropriate.

56. Dental Service 1 accepted the proposed recommendations and stated: "We will learn from this event and become a better clinic."

57. Dr C accepted the proposed recommendations.

58. Dr B told HDC that his usual practice was "strictly to go through patient's complaint, history of complaint and medical history before even asking for patient's permission to assess their oral condition", and that he believes he followed this practice at his 11 May 2018 review of Ms A. He stated that given that Ms A had not finished her current course of antibiotics, that he had not seen her before 11 May 2018, and that he performed a socket irrigation on her before dismissing her, he "treated her as much as [he] could within [his] professional practice". He questioned "the necessity of providing another course of antibiotics when 15 tablets [prescribed by Dr C on 8 May] were enough for 5 days".

Relevant standards

59. The Dental Council publication *Patient Records and Privacy of Health Information Practice Standard* (1 February 2018) states:

> "You must create and maintain patient records that are comprehensive, time-bound and up-to-date; and that represent an accurate and complete record of the care you have provided."

60. The publication notes that a record must be kept of any proposed care that is declined by the patient, along with the patient's related comments or concerns.

61. The publication states that a concise description of the care must be recorded, including any medicines administered, prescribed, or dispensed, including the quantity, dose, and instructions, and any preoperative and postoperative instructions given to the patient. Records must also be made of any complaints made or concerns expressed regarding the care provided.

Opinion: Dr C — breach

Extraction

62. On 28 April 2018, Ms A visited Dental Service 1 and was seen by Dr C, who diagnosed pericoronitis and extracted tooth 48. The extraction was uncomplicated.

63. My expert advisor, general dentist Dr Lester Settle, advised that the removal of tooth 48 was an appropriate treatment for Ms A's presenting problem. He was not critical that Dr C did not prescribe antibiotics because it is not usual to give antibiotics for a simple extraction in healthy patients.

64. Ms A stated that she was not supplied with the postoperative instruction and information sheet, or any aftercare instructions. In contrast, Dr C and Ms E stated that Ms A was given instructions on how to care for her mouth. Ms D said that when Ms A came out of the surgery room, she was carrying a piece of A5 paper. Ms F also said that the clinical notes record that postoperative instructions were given to Ms A. I accept that Ms A believes that she was not given after-care instructions, and that she sent a message to Dr C on 28 May 2018 to that effect. However, given the evidence of Ms E and Dr C, I think it is more likely than not that Ms A was given some written documentation. However, I am unable to make a finding as to what information was provided.

3–5 May 2018

65. Ms A stated that by 3 May 2018, her face was swollen and she was in pain and unable to open her mouth fully. She said that she returned to Dental Service 1 on 3 May 2018 but was not given a prescription at that consultation. She said that she returned again on 5 May 2018, and that during that visit Dr C "washed [her] injury" but again did not give her a prescription.

66. There is no record of Ms A having attended the practice on either of those dates. However, the messages she supplied support her account. I consider it more likely than not that she did attend on those days. I am critical that when Ms A attended the practice on 5 May 2018, Dr C did not investigate Ms A's symptoms further, particularly given that the message from Dr C indicated that he considered that the extraction site might be infected.

8 May 2018

67. Ms A returned to Dental Service 1 on 8 May 2018 and saw Dr C. At that time she had limited ability to open her mouth, and she had swelling at the extraction site. She told Dr C

that for the past two days she had been taking antibiotics that she had obtained from overseas. Dr C said that when he examined Ms A he considered that she had dry socket and, rather than requiring her to open her sore mouth, he prescribed her with the antibiotic Amoxyl to treat the dry socket.

68. Dr Settle advised me that dry socket (alveolitis) is a common occurrence after removal of a lower wisdom tooth. He said that usually it starts two to four days post extraction, and the symptoms can last for up to two weeks. He stated that the usual treatment for alveolitis is gentle irrigation of the socket to wash out the dead clot and any foreign matter, followed by a medicament dressing to relieve the symptoms. Dr Settle advised that Ms A may or may not have suffered from alveolitis, but her presentation was more symptomatic of an infection, in which case, the expected treatment was to prescribe the correct antibiotic and possibly curettage and irrigation of the socket. He said that amoxicillin is the first choice of antibiotic in this situation. I accept Dr Settle's advice. Although a prescription of antibiotics was in the event the correct treatment for the infection, it was not the correct treatment for dry socket. Dr C both failed to diagnose an infection appropriately on 8 May 2018, and also failed to provide the appropriate treatment for his inaccurate diagnosis of a dry socket.

69. Furthermore, there is no evidence that Dr C investigated further what antibiotic Ms A was taking prior to this consultation. I agree with Dr Settle's advice that a patient who is taking self-prescribed medication is a significant "red flag", and that Dr C should have investigated further to ascertain what antibiotic Ms A was taking. Dr Settle stated: "This is significant as the noted symptoms presenting at this appointment are not consistent with alveolitis ten days post extraction."

70. It appears from Ms A's public hospital clinical records that the antibiotic she was using was levofloxacin. Dr Settle noted that in New Zealand, this antibiotic is available only in intravenous form for the treatment of serious skin infections. He stated that levofloxacin is effective only against gram positive bacteria, and is not effective against gram negative or anaerobic bacteria. Dr Settle stated that use of levofloxacin in the case of a dental infection can lead to a super infection. Had Dr C made appropriate enquiries into the antibiotic Ms A was taking, he could have identified the risks associated with levofloxacin and emphasised the need for her to cease taking her own antibiotics and take amoxicillin instead.

11 May 2018

71. On 11 May 2018, Ms A sent a message to Dr C stating, "Can we make appointment tomorrow for a prescription?" Ms A told HDC that she sent the message because she had run out of medicine and wanted to obtain a further prescription. Dr C did not reply to Ms A's message, so Ms A attended Dental Service 1 without an appointment and saw Dr B.

72. Dr C was aware that Ms A was experiencing pain and complications. In my view, he had a responsibility to ensure that he, or someone else at the practice if he was unavailable, responded to Ms A's messages and followed up her concerns.

Conclusion

73. Dr C failed to investigate Ms A's symptoms further on 3 and 5 May, when he first suspected an infection. On 8 May 2018, he failed to recognise that Ms A's presenting complication was an infection and not a dry socket. He did not provide appropriate treatment for a dry socket. Furthermore, Dr C failed to find out what antibiotic Ms A was taking, which meant that he missed an opportunity to recommend that she stop taking her own antibiotic and take amoxicillin instead. When Ms A sought assistance on 11 May 2018, he did not respond to her. I find that Dr C failed to provide services to Ms A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[12]

Record-keeping

74. The Dental Council publication *Patient Records and Privacy of Health Information Practice Standard* (1 February 2018) states:

> "You must create and maintain patient records that are comprehensive, time-bound and up-to-date; and that represent an accurate and complete record of the care you have provided."

75. Dr Settle advised that Dr C's notes on 28 April 2018 are excellent. However, Dr C made no notes regarding the communications he received from Ms A on 3 May 2018 and 5 May 2018. In addition, there is no record that Ms A attended the practice on these days, or of any treatment provided.

76. Ms F said that on 8 May 2018, Dr C advised Ms A to continue with her own antibiotic, and she declined to take the script he provided. The Dental Council publication *Patient Records and Privacy of Health Information Practice Standard* states that a record must be kept of any proposed care that is declined by the patient, along with the patient's related comments or concerns. If Dr C believed that Ms A had refused the script, he should have recorded that.

77. Ms A provided this Office with a copy of the medication label, so it is apparent that she did take the prescription and have it filled. However, Dr C made no record of his discussions with Ms A in this regard, and remained of the view that Ms A had refused the prescription.

78. In my view, Dr C failed to maintain adequate records, and so did not comply with the professional standards mandated by the Dental Council. Accordingly, I find that Dr C breached Right 4(2) of the Code.[13]

[12] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[13] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

Opinion: Dr B — adverse comment

79. On 11 May 2018, Ms A presented to Dental Service 1 without an appointment and asked to see Dr C. As Dr C was not on duty that day, Ms A was offered an appointment with Dr B. Dr B considered that Ms A had dry socket.

80. Dr Settle advised that Ms A may or may not have suffered from dry socket, but her presentation was more symptomatic of an infection, in which case, the expected treatment was prescribing the correct antibiotic and possibly curettage and irrigation of the socket. He said that amoxicillin is the first choice of antibiotic in this situation.

81. Ms E said that Dr B used an irrigation syringe and diluted Savacol to clean Ms A's socket, and that he discussed antibiotics with Ms A.

82. Dr B told Ms A that her socket was improving, and to continue her antibiotics and to come back if she had any further concerns. Dr Settle advised me that this was a lost opportunity to work out what antibiotic Ms A was taking at that time — either the antibiotic prescribed by Dr C or her self-prescribed antibiotic (or both). As discussed below, there is no entry in the patient notes regarding this visit.

83. Dr B stated that his usual protocol for patients with persisting pain after dental extractions would have been to prescribe antibiotics. He said that it would be unusual for him to dismiss a patient with dry socket without any prescription. I have also considered Dr B's statement in response to the provisional opinion that he believes that on 11 May he followed his usual practice of going "through patient's complaint, history of complaint and medical history before even asking for patient's permission to assess their oral condition". However, in my view, Dr B should have taken greater care when he saw Ms A, and clarified whether she was taking antibiotics and, if so, what antibiotics she was taking. However, Dr B did advise Ms A to go back to Dr C if her pain persisted. I also note that Dr B saw Ms A without an appointment between his scheduled appointments.

84. With regard to there being no clinical records of this consultation, I note that Dr B stated that it was always his practice to complete his clinical notes on the same day the patient came in, and he believes he did so in this case, but the notes have gone missing. This account is supported by Ms E, who said that she saw Dr B writing notes on the patient file after Ms A left the surgery room. Ms D also stated that Dr B was completing notes. Given these accounts, I find it more likely than not that Dr B did make some clinical records, and that subsequently they have gone missing.

Opinion: Dental Service Company — breach

85. As a healthcare provider, the Dental Service Company is responsible for providing services in accordance with the Code. The Dental Service Company employed Dr B at the time of these events, and Dr C is a contractor at the practice. I am critical that several examples of poor care and inadequate record-keeping reflect a lax attitude at Dental Service 1.

86. The Dental Service Company was asked for Dental Service 1's policies, protocols, and/or procedures that were in place at the time of these events. In response, Ms F said that Dental Service 1 operates under the guidelines of the Dental Council Code of Practice. She said that the dentists seek updates from the Dental Council website for reference on their scope of practice competencies. No policies were provided.

87. I am not satisfied that Dental Service 1 had adequate policies to deal with the situation when a patient is known to be taking medication that has not been prescribed by the practice to treat dental conditions. Neither dentist ascertained what antibiotic Ms A was taking.

88. Furthermore, I consider that the poor record-keeping and missing records also indicate broader systems issues at the practice. Therefore, I consider that the Dental Service Company did not provide services to Ms A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Recommendations

89. I recommend that Dr C, Dr B, and the Dental Service Company each separately apologise to Ms A for the criticisms in this report. The apologies are to be sent to HDC, for forwarding, within three weeks of the date of this report.

90. I recommend that within four months of the date of this report, Dental Service 1 obtain an audit of its clinical records to demonstrate that adequate records are maintained, and report the outcome to HDC.

91. I recommend that within four months of the date of this report, Dr C and Dr B each undertake further training with regard to medication management and post-extraction infections, and report to HDC on the content of the training and evidence of attendance.

92. I recommend that within four months of the date of this report, Dr C undertake training with regard to maintaining adequate clinical records, and report to HDC on the content of the training and evidence of attendance.

93. I recommend that within four months of the date of this report, Dental Service 1 develop policies to ensure that all dentists who work in the practice are aware of the risks to

patients who take medications that are prescribed or provided by others for dental conditions.

Follow-up actions

94. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Dental Council, and it will be advised of the names of Dr B and Dr C.

95. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the New Zealand Dental Association and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from a general dentist, Lester Settle:

"**Complaint:** Care received by [Ms A] from [Dr C] dentist at '[Dental Service 1]'

Reference: C18HDC01168

To Complaints Assessor Health and Disability Commissioner

Dear Sir/Madame

Introduction
I am a general dentist practising in both the private and public settings. I graduated from the University of Otago in 1988.

I own my own practice in suburban Christchurch which I bought in 1995 and have grown from a single surgery, to a four-surgery practice. The practice is a general family practice but my main interest is in minor oral surgery.

For the past 9 years I have spent 50% of my working week as Clinical Director of the Hospital Dental Service, Canterbury District Health Board. This mix of private and public dentistry allows me a good over-view of dental health and practice …

I have been asked to provide a report on the care received by [Ms A] (the complainant) and [Dr C] of '[Dental Service 1]'.

On the 28th of April 2018 [Ms A] had tooth 48 (lower right 3rd molar) removed as she had pain in this area, diagnosed as pericoronitis. On the 13th of May [Ms A] was admitted to [a public hospital] suffering an acute infection attributed to the infected extraction site. This infection was severe enough for [Ms A] to spend 2 days in intensive care after having surgery to achieve drainage of the submandibular infection. Infections in this area can be life threatening as they may obstruct the airway and are treated with a high level of respect and suspicion.

Information received
I have been provided with the following information to base my review on:

- Email to '[Dental Service 1]' from [Ms A], dated 28th May.
- HDC complaint submission form, dated … Email reply to [Ms A], from '[Dental Service 1]'. Copy of consent for 'removal of Teeth', from '[Dental Service 1]'.
- 'How to care for your mouth after oral surgery', an information pamphlet provided to [Ms A] after surgery to remove her tooth.
- Reply to HDC in response to questions from HDC, provided by [Ms F], from [Dental Service 1]
- Copy of computer notes from [Dental Service 1]
- Reply to HDC from [Ms A], 'Feedback on Provider Response'.

- Copy of chat message between [Ms A] and [Dr C] in [their language].
- Transcript of chat message above provided by [HDC employee].
- Copy of computer notes from [Dental Service 2].
- Letter from [Dental Service 2] to HDC. Patient medical history/notes from GP at [the medical centre], notes pertain to the 13th May 2018.
- Copy of all the DHB notes from [Ms A's] hospital stay.
- Copy of OPG (radiograph), presumably taken prior to removal of tooth 48.

Background

As previously stated [Ms A] had complications following the removal of tooth 48 or more commonly referred to as a 'wisdom' tooth.

Timeline of events, some events and dates are contested and if so I will note this.

- 28th April 2018 [Ms A] visited [Dental Service 1] and was seen by [Dr C]. [Dr C] diagnosed pericoronitis (a soft tissue infection around a partially erupted tooth) and to treat this problem he removed tooth 48.
- [Ms A] presented again to [Dental Service 1] where [Dr C] (from computer notes provided) diagnosed a 'dry socket' or alveolitis and prescribed a five day course of Amoxycillin. This was dated the 8th of May in the notes however [Ms A] in her notes says 7th of May. In the written response to questions asked by HDC it is stated [Ms A] **did not take her prescription**. This is not in the computer notes provided.
- 11th May [Ms A] presented again to the practice, without an appointment. [Ms A] was seen by [Dr B] between booked patients. Apparently he checked the extraction site and advised [Ms A] it was healing and to come back if no better. There are no computer notes to go with this visit.
- 12th May [Ms A] visited another dental practice [Dental Service 2] and was seen by [a dentist]. At this appointment [Ms A] was prescribed a course of antibiotics, Augmentin and Metronidazole. The notes provided do not cover dose and or frequency of the medication prescribed.
- 13th May [Ms A] visits [the medical centre] and is seen by [a] (medical Dr) and is urgently referred to [the public hospital].
- 13th May [Ms A] is admitted to hospital.
- 15th May [Ms A] is operated on to achieve drainage of infection.
- 14h May [Ms A] is admitted to ICU (Intensive Care Unit).
- 17th May [Ms A] is discharged from hospital.

Standard of Care

The initial appointment for the removal of tooth 48, is the appropriate treatment for the presenting problem. The treatment notes are excellent and the operation was completed without apparent difficulty.

It is not usual to give antibiotics for a simple extraction in healthy patients. The use of pre and or post treatment antibiotics is not supported in the literature, unless the

patient is immunocompromised in some way (prosthetic heart valve is a common reason).

Dry socket or alveolitis is a common occurrence after removal of a lower wisdom tooth, with occurrence as high as 40%. Alveolitis is a disruption of the blood clot, leading to the loss of the clot and subsequent pain. Alveolitis usually starts 2–4 days post extraction and the symptoms can last for up to 2 weeks. The usual treatment for alveolitis is gentle irrigation of the socket to wash out the dead clot and any foreign matter, followed by a medicament dressing to relieve the symptoms.

The appointment on the 8th May (clinical notes) is 10 days post extraction. The notes indicate severe trismus (restriction in opening the mouth) and that [Ms A] has been self-prescribing an antibiotic from [overseas].

There was no mention of irrigation of the socket or placement of a medicament, usual treatment for alveolitis. However there was a prescription given for Amoxycillin 500mg capsules, one capsule three times per day for 5 days. No mention was made in the notes of which antibiotic or medicine [Ms A] had been self-prescribing. Any self-prescribed medication is a significant red flag and should have been investigated further. This is significant as the noted symptoms presenting at this appointment are not consistent with alveolitis 10 days post extraction.

In the reply to questions raised by the office of the Health and Disability Commissioner the practice states [Dr C] advised her to continue on with her own antibiotic and she didn't take the script. This is not in the notes.

[Ms A] did visit the practice on the 11th of May but there were no notes made of this visit. Though there was no scheduled appointment on this day for [Ms A] she was seen (however briefly) but no record of this was made in her notes. Apparently [Ms A] was advised to continue on with her antibiotics but it is not clear which antibiotic. The fact there was no clinical notes for this visit is a significant departure from expected and mandated practice.

Departure from standard of care or accepted practice.
The most striking departure from accepted practice is the lack of notes for the visit on the 11th of May. The failure to make notes from a visit are a significant departure from the 'Standard of Care' mandated by the New Zealand Dental Council. 'You must create and maintain patient records that are comprehensive, time-bound and up-to-date; and that represent an accurate and complete record of the care you have provided' is a direct quotation from the Dental Council Standards Framework. This standard must be complied with as it is a minimum standard, and not a guideline or suggestion.

Patients who present to a practice without an appointment can make life difficult for the whole team as often there is not 'time' to easily see the patient. The dentist can feel pressured by both the patient and his own staff to see such a patient and may agree to see the patient for a 'quick look', knowing this could make him run late for

the next patient/patients. A desire to help though may place this dentist in a potentially jeopardous position where treatment is rushed and standards are not followed. Exacerbating this problem was the lost opportunity to work out what antibiotic [Ms A] was taking at the time, the antibiotic prescribed by [Dr C] or her self-prescribed antibiotic.

The reason determining which antibiotic was actually being taken is a significant factor in this case. The reported antibiotic being used was Levofloxacin. This is an antibiotic only available in IV form in New Zealand, for the use of serious skin infections. Levofloxacin is only effective against gram positive bacteria and is not effective against gram negative or anaerobic bacteria. Use of this antibiotic in the case of a dental infection can lead to a super infection as dental infections tend to be polymicrobial comprising facultative anaerobes, such as viridans group **streptococci** and the *Streptococcus anginosus* group, with predominantly strict anaerobes, such as anaerobic cocci, Prevotella and Fusobacterium species.

The second departure from expected standard of care is in the lack of notes regarding the facts around the prescription for amoxycillin and if this was accepted or refused. The written response from the practice insists the script was not taken and it was assumed/agreed [Ms A] would continue with her own prescription.

View of Peers

Both departures from standard of care contributed to a serious potentially life threatening occurrence, but I suspect an opinion from peers would suggest they are at the lower end of the scale. Neither omission is in any way deliberate or for self-benefit.

I believe from the evidence received [Dr C], for the right or wrong reasons, actually did the correct thing and prescribed the first line antibiotic. [Ms A] may or may not have suffered from alveolitis but her late presentation is more symptomatic of infection and hence needs a different awareness. The expected treatment in the case of infection is the correct antibiotic (amoxycillin is first choice) and possibly curettage and irrigation of the socket.

With this in mind the view of his peers would possibly consider he did not fully recognise the problem presented to him or the potential seriousness, though he attempted to do the 'right' thing.

I believe the co-incidental finding of 'departure from the accepted standard of care' by [Dr B] would be viewed by his peers in a similar light.

I also believe, dental peers would also believe [Ms A] contributed (significantly) to the outcome (unintentionally) by self-prescribing. The medication she was taking for the problems experienced may have substantially contributed to the final outcome. The concern is in both dentists failing to understand the significance of this action and not investigating it further.

Recommendations
I would hope that when reading the report from the Health and Disability Commissioner's office both dentists will see areas where their care could be improved.

[Dr C] will be more aware of the seriousness of post extraction infections, particularly wisdom teeth and the close attention this complication requires. Secondly the need to determine what medication patients are taking, particularly self-prescribed medications and how detrimental to optimal outcomes this may be.

[Dr B] will realise the position no notes place you in and no matter how brief the appointment is once a patient is in your surgery it requires your full care, both diagnostic and procedural.

Further Comment
It is my opinion that in this case opportunities for a better outcome were missed for a variety of reasons or circumstances. None when taken by themselves would seem too 'bad' but together add to the poor outcome. Secondly as already mentioned self-prescription is fraught with risks.

Addendum
The comments of not seeing a patient of his own relate to [Dr B] who saw the patient when [Ms A] turned up to the practice without an appointment and was seen by [Dr B] as [Dr C] was not present. There is no entry in the patient notes re this visit. Though it is in the reply to the Commissioner from the practice. This was a finding from reviewing the case, though not the original dentist in the complaint.
I would categorise this as a moderate departure from accepted standards, because of the patient outcome.

With regards to [Dr C] I would quantify the overall departure from expected care as moderate as well. The reasons for this are the failure to recognise the presenting complication, failure to fully clarify the antibiotic issue and make sure the correct advice was given.

Further addendum
I would not expect a practice to have specific practice policies or manuals in these instances, but how they keep staff informed should be to some extent auditable.

Staff would need to be aware of expectations regarding maintaining records, based on NZDC regulations. How this is achieved will be up to each practice. We have staff meetings where these things are discussed and noted and it is in job manual/guide for reception/assistant staff.

The dentist would be responsible for inquiring about self-prescribed medications, this issue comes up quite frequently in drug prescribing and interaction update days. Drug questions are the responsibility of the dentist.

Patients arriving without appointment is common and how it is dealt with varies. We have a series of screening questions for reception to ask and then come and speak to the relevant dentist. It would seem a good idea to have something written but I am not sure if it is required."