HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Optometrists breach Code in care of woman who lost her sight

21HDC02273

Two optometrists have breached the Code of Health and Disability Services Consumers' Rights (the Code) by failing to provide services with reasonable care and skill, and by not complying with legal, ethical and professional standards.

The breaches concern their care of a woman who went on to lose sight in her right eye because of retinal detachment.

The woman presented to the clinic for a routine eye examination and while there, reported black or grey specs in her vision. She was examined, prescribed reading glasses and asked to return in two years' time. She returned 10 months later, reporting dark, blurred vision. Again, she was examined, retinal images were taken and she was prescribed eye drops. She returned five days later, reporting no improvement, and a 'stingy' right eye.

On further examination it was noted that her visual acuity had reduced slightly in the last five days, so a non-urgent referral to an eye specialist was made. The specialist diagnosed a retinal detachment and scheduled corrective surgery. Unfortunately, the woman underwent two unsuccessful surgeries and permanently lost vision in her right eye.

Dr Vanessa Caldwell was critical that a retinal examination was not performed at earlier presentations to the optometrists when there were clear indicators this should have occurred. The failure to assess the information available to them which should have indicated a retinal examination was needed, and the non-urgent referral resulted in a delayed diagnosis of the retinal detachment. She was also critical of their poor documentation and commented that the note taking of one of the optometrists fell far short of the required professional standards.

Since the events, both optometrists have undertaken a range of actions to improve their practice. The clinic has also made changes to its communications practices and updated its technology to strengthen its diagnostic testing capability.

Dr Caldwell made a range of recommendations to both optometrists and the eye clinic including undertaking an audit of files where retinal photography has been performed to examine if clinical observations are up to the required professional standards.

29 July 2024

Editor's notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC's website - see HDC's 'Latest Decisions'.

Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer. More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

Health and disability service users can now access an animated video to help them understand their health and disability service rights under the Code.

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