

**Optometry Practice
Optometrist, Mr B**

**A Report by the
Deputy Health and Disability Commissioner**

(Case 16HDC00646)



Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. On 28 March 2014, Master A presented to an optometry practice (Clinic 1) and was seen by optometrist Mr B. At the time of these events, Master A was aged six years and lived with his mother. Mr B recorded the reason for Master A's presentation as "routine". No details of Master A's symptoms, family ocular history, general health or medications were documented.
2. Mr B recorded Master A's visual acuity in the left eye as "6/10", and in the right eye as "6/x" — that is, with his right eye, Master A could not identify letters on the Snellen chart at six meters. Mr B made a diagnosis of amblyopia and possible right eye exotropia, and prescribed Master A with glasses. No plan for follow-up or further investigation was noted. Mr B did not refer Master A to the optometry practice's location in a larger centre (Clinic 2) for further testing, or perform appropriate diagnostic tests to rule out pathology.
3. Approximately 14 months later, Master A presented to his GP with headaches, and increased problems with his vision. Subsequently he was assessed at a hospital and diagnosed with a brain tumour.

Findings

4. Mr B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) by failing to take appropriate steps to test the level of acuity of Master A's right eye or consider differential diagnoses before making a definitive diagnosis of amblyopia during the 28 March 2014 consultation; to conduct further investigations or refer Master A to an ophthalmologist to determine the cause of the amblyopia and queried exotropia; to institute an ongoing treatment plan and regularly assess whether Master A's visual acuity was improving; and to document appropriately the patient history and reason(s) for Master A's presentation on the 28 March 2014 consultation.
5. In providing optometry services to Master A, Mr B was acting as an agent for the optometry clinic and within its authority. Accordingly, the optometry clinic was found vicariously liable for Mr B's breach of Right 4(1) of the Code. Adverse comment was also made regarding the failure of the optometry clinic to have policies or procedures relating to staffing levels when unexpected leave was required, and regarding the standard of the consultation form that was used at the time of these events.

Recommendations

6. It is recommended that an apology be provided to Master A and the family by Mr B, for his breach of the Code.
7. Mr B has told HDC that he is no longer practising as an optometrist. It is recommended that the Optometrists and Dispensing Opticians Board provide HDC with an update on Mr B's registration status within three months of this report. Should Mr B return to clinical practice, it is recommended that the Board consider whether a review of his competence is warranted.

8. It is recommended that the optometry practice discuss the findings of this report with its clinical staff; review its consultation form and recall processes; and audit patient records for a one-month period to ensure that patients assessed in Clinic 1 and requiring further testing/assessment have been appropriately referred to Clinic 2 or another healthcare professional. It is also recommended that following this initial audit, the optometry practice conduct a second audit for a two-week period and report back to HDC on the effectiveness of any quality improvement or remedial measure to ensure that patients have been referred appropriately. The optometry practice is also to provide HDC with an update on the changes it has made to its practice, including the implementation of its new policies and procedures.
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Complaint and investigation

9. The Deputy Commissioner initiated an investigation regarding the optometry services provided by Mr B and the optometry practice to Master A. The following issues were identified for investigation:
 - *Whether Mr B provided Master A with an appropriate standard of care in 2014.*
 - *Whether the optometry practice provided Master A with an appropriate standard of care in 2014.*
 10. This report is the provisional opinion of Meenal Duggal, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.
 11. The parties directly involved in the investigation were:

Master A	Consumer
Ms A	Consumer's mother
The optometry practice	Optometry provider
Mr B	Optometrist
 12. Information was also reviewed from:
 - ACC
 - Optometrists and Dispensing Opticians Board
 - Two district health boards
 - Medical centre
 13. Independent expert advice was obtained from optometrist Richard Johnson (**Appendix A**).
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Information gathered during investigation

Background

14. This report relates to the care provided to Master A (six years old at the time of these events) by optometrist Mr B and the optometry practice in March 2014. Master A presented to the optometry practice and underwent an assessment by Mr B, who diagnosed him with amblyopia and prescribed glasses. Approximately 14 months later, Master A presented to his GP with headaches, and increased problems with his vision. Subsequently he was assessed at a hospital, and a diagnosis of craniopharyngioma¹ was made.
15. At the time of these events, Master A lived with his mother, Ms A. Mr B had been working as an optometrist for many years, and had spent most of that time practising optometry in Clinics 1 and 2. Mr B is registered as an optometrist with the Optometry and Dispensing Opticians Board² and is a member of the New Zealand Association of Optometrists and the Corneal and Contact Lens Society.
16. The optometry practice provides optometry services in Clinic 1 and Clinic 2. Mr B provided optometry services from Clinic 1 two days a week. As Clinic 1 has limited equipment, often patients are referred to Clinic 2 for further testing, including optical coherence tomography.³

28 March 2014 optometry consultation

17. On 28 March 2014, Master A presented to Clinic 1 with his mother, and was seen by Mr B. Mr B told HDC that Master A presented to him “as a pleasant young active boy who was quite eloquent for his age and did not seem to demonstrate any physical anomalies or abnormalities with his eyesight”.
18. Mr B recorded in the clinical notes that the reason for Master A’s presentation was “routine”. Mr B told HDC that he used the word “routine” as an abbreviation to remind him of the routine examinations he had performed, rather than to indicate that he felt there was nothing concerning about Master A’s presentation. No details of Master A’s symptoms, family ocular history, general health or medications were documented. However, in a statement to ACC, Mr B said that the reason for the presentation was because Master A “could not see out of his right eye”. Mr B told HDC that it was his usual practice to take a history from his patient and note the reasons for the patient’s presentation, but accepts that he did not include this in the notes taken for Master A’s consultation.

¹ Craniopharyngioma is a benign tumour that develops in the part of the brain near the pituitary gland. This type of tumour occurs most commonly in children.

² At the time of this report, Mr B no longer holds a practising certificate with the Optometrists and Dispensing Opticians Board.

³ Optical coherence tomography uses light waves to take cross-sectional pictures of the retina, and helps to identify changes to the fibres of the optic nerve.

19. Mr B recorded that Master A had a visual acuity⁴ of “6/10”⁵ for the left eye and “6/x” for the right eye — that is, Mr B was unable to ascertain the visual acuity for the right eye at six meters from a Snellen chart.⁶ Mr B made a diagnosis of right eye amblyopia⁷ and possible right eye exotropia,⁸ and prescribed Master A glasses.
20. With respect to the prescription details, Mr B recorded “+1.00/−1.00 * 180” for each eye. “+1.00” refers to a finding of low hyperopia (long-sightedness), “−1.00” refers to a small amount of astigmatism,⁹ and “180” refers to the direction of the astigmatism. Mr B also recorded the dispensing details for the spectacles prescribed, including the frame details and the pupillary distance (the distance between the two eyes so that the centre of the spectacle lenses can be made to match this).
21. Mr B told HDC that he conducted the following tests during his consultation with Master A:
- Checked visual acuity in both eyes.
 - Checked pupillary reflexes both direct and consensual.¹⁰
 - Checked for potential positive relative afferent pupil defect [RAPD].¹¹
 - Performed [a] cover test¹² at near using [an] ophthalmoscope light¹³ as a fixation point.
 - Checked for binocular vision¹⁴ both distance and near. No binocular vision [was] present at either distance or near.¹⁵
 - Checked for simultaneous perception with red [right eye] and green [left eye] at distance.¹⁶ No simultaneous vision was present with very large patches of

⁴ Visual acuity refers to the sharpness of vision, and usually is measured with the use of a Snellen eye chart (a chart with a series of letters and numbers of different sizes).

⁵ 6/10 means that while standing at six meters from a Snellen eye chart, the patient reads as well as a person with “normal” eyesight when standing ten meters away from the same chart.

⁶ A Snellen chart is a chart with letters, numbers or symbols printed in rows of decreasing size. It is used by eye care professionals in distance visual acuity testing.

⁷ Amblyopia is where the vision in one eye is reduced because the eye and the brain are not working together properly. The eye itself looks normal, but it is not being used normally because the brain is favouring the other eye.

⁸ Exotropia refers to the outward turning of the eye.

⁹ An astigmatism is a refractive error that causes blurred vision. It occurs when the cornea is irregularly shaped or because of the curvature of the lens inside the eye.

¹⁰ Following the illumination of a pupil (typically by shining a light into the eye), a “direct” response refers to the constriction of the illuminated pupil, and a “consensual” response refers to the constriction of the pupil that is not illuminated.

¹¹ Relative afferent pupillary defect is a condition in which pupils respond differently to light stimuli shone in one eye at a time. The condition is caused by unilateral or asymmetrical disease of the retina or optic nerve.

¹² A cover test is used to determine whether a person has an ocular deviation/misalignment.

¹³ An ophthalmoscope is a handheld instrument used to examine the interior of the eye.

¹⁴ Binocular vision (or eye coordination) is the ability of both eyes to work together as a team.

¹⁵ A binocular vision test can be performed to assess a patient’s distance and near vision.

¹⁶ Simultaneous perception is the ability to perceive different images placed on each eye. If a patient cannot see or perceive the different images, then the patient does not have simultaneous perception.

stimulus covering a wide area of the macular zone¹⁷ of each eye. [Master A] only saw green stimulus. This would have been consistent with a patient who had amblyopia ...

- Fundus¹⁸ ophthalmoscopy.¹⁹
- Retinoscopy²⁰ (objective refraction²¹).
- Subjective refraction.²²

22. Mr B further stated that no significant RAPD was detected during this consultation, and there was no sign of papilloedema.²³ Mr B told HDC that he accepts that his notes were not a full record, and that he did not perform appropriate diagnostic tests for detecting a tumour, “with the result that a rare craniopharyngioma went undetected”.
23. Mr B stated that as a result of his diagnosis of amblyopia and possible right eye exotropia, he would have expected Master A to have been referred to Clinic 2 for further testing, in accordance with his usual practice. Mr B told HDC that he is unable to say why a referral did not occur.
24. Ms A stated that on the day of the appointment with Mr B, she felt that “things were very rushed”. Mr B told HDC that he spent considerable time explaining the diagnosis of right eye amblyopia and a possible right eye exotropia when talking to Master A’s mother at the visit, and does not consider the consultation to have been rushed.

Subsequent care

25. On 30 April 2015, Master A presented to a medical centre with a fever, sore throat, headaches, and vomiting. The general practitioner’s (GP) clinical impression was “tonsillitis²⁴/dehydration”, and she prescribed amoxicillin²⁵ and paracetamol and recommended fluids. She also made a plan to review Master A “if [he] gets worse”.
26. On 6 May 2015, Master A presented to the medical centre again and was seen by another GP, who recorded:

¹⁷ Macular zone refers to the part of the retina that is responsible for visual acuity and colour vision.

¹⁸ The fundus of the eye is the back portion of the interior of the eyeball.

¹⁹ Ophthalmoscopy is an examination of the back part of the eye, which includes the retina, optic disc, choroid and blood vessels.

²⁰ A retinoscopy is a technique to determine the refractive error of the eye (eg, farsighted, nearsighted, astigmatism) and the need for glasses. The examiner shines a light into the eye and observes the movement of the reflected light from the back of the eye (fundus).

²¹ An objective refraction is a refraction obtained without receiving feedback from a patient. This can be assessed during a retinoscopy.

²² A subjective refraction requires responses from the patient. Typically, a patient sits behind a phoropter (an instrument used to measure refractive error) and looks through it at an eye chart, and provides feedback as to which settings provide the best vision.

²³ Papilloedema is the swelling of the optic disc, visible on ophthalmoscopic examination of the fundus of the eye.

²⁴ Tonsillitis is inflammation of the tonsils (two pads of tissue at the back of the throat). It affects children more often than adults, and most commonly is due to viral infection.

²⁵ Amoxicillin is an antibiotic that is commonly used to treat bacterial infection.

“Over past 3 days presenting to school with headaches and altered behaviour. Not able to walk straight. Increasing visual problems. Rubbing forehead and banging head against wall at times. Usually very talkative, not talking at all. Not able to see things and can’t read book or iPad. Usually writes good stories.”

27. On examination, the GP noted that Master A described seeing “haloes around things in vision” and was “walking very stiffly ... holding hand of health nurse from school” and that his right eye was “inturning slightly”. The GP queried whether Master A had a subdural haematoma.²⁶ The GP telephoned the paediatric registrar at the public hospital and arranged for Master A to be seen that day.
28. Master A presented to the public hospital on the same day (6 May 2015) and received an urgent CT²⁷ scan, and a diagnosis of craniopharyngioma was made. Master A was transferred to a larger public hospital on 7 May 2015, and on 14 May 2015 underwent surgery to remove the brain tumour. Following surgery, it was confirmed that Master A was completely blind in his right eye and had 1/30 acuity²⁸ in his left eye.

Further information from Mr B

29. Mr B was a director and shareholder of the optometry practice, and the sole optometrist at the company at the time of these events. Mr B told HDC that he is paid by way of a director’s fee, and that he does not have an employment contract or other formal agreement with the optometry practice.
30. Mr B retired from clinical practice in 2015 but is still involved in the management of the optometry practice.²⁹ He has asked to be removed from the Optometrist and Dispensing Opticians Board register, and currently is noted on the register as non-practising. Mr B stated that in March 2014 he was experiencing stress and anxiety due to personal matters, and had difficulty in obtaining a locum optometrist cover, which resulted in him working through this period.³⁰
31. Mr B told HDC that he has “contemplated and agonised” over the probable cause of the misdiagnosis of Master A’s eyesight, and is “profoundly regretful”. Mr B stated that he “wishes to apologise profusely both to Master A and his parents for what has happened”.

Further information from the optometry practice

32. At the time of these events, the optometry practice had no policies or procedures in place relating to ocular examinations, training and development, or cover for optician staff. Mr B advised that the optometry practice is in the process of developing such policies and procedures. He also stated that two qualified optometrists have now been

²⁶ A subdural haematoma is a collection of blood between the covering of the brain (dura) and the surface of the brain.

²⁷ CT stands for computerised tomography. CT uses X-rays to make detailed pictures of parts of the body and the structures inside the body.

²⁸ 1/30 acuity means that while standing at one meter from a Snellen Chart, the patient reads as well as a person with “normal” eyesight who is standing 30 meters away from the same chart.

²⁹ Mr B remains a director and shareholder of the practice.

³⁰ Mr B stated that he was able to obtain four days’ cover from a local optometrist in March 2014 but had no success in arranging further cover.

employed “to ensure that there is adequate cover when optometric staff need to take leave”.

Responses to provisional opinion

33. The parties were given an opportunity to comment on the relevant sections of the provisional report. The responses have been incorporated into the report where appropriate. Further responses have been outlined below.

The family

34. The family did not respond to the provisional decision.

Mr B

35. Mr B apologised to Master A and his family and stated that he is profoundly regretful for failing to reach a reasonable standard of care when assessing Master A. Mr B stated that he has no intention of returning to practice as an optometrist.

The optometry practice

36. The directors of the optometry practice stated that all of the policies in Clinic 1 are being upgraded, and that the policies in Clinic 2 have been upgraded and are in the process of being implemented. The directors stated that the optometry practice will comply with the recommendations of this report.

Standards

37. The Optometry and Dispensing Opticians Board’s (Optometry Board’s) publication *Standards of Clinical Competence for Optometrists* (2010) states:

“Task 2. Obtaining a patient history

2.1 Communicates with the patient in an effective way, taking into account the physical, emotional, intellectual and cultural background of the patient ...

2.2 Makes general observations of the patient ...

2.3 Elicits reasons for the patient visit in a structured way ...

2.4 Obtains information required for diagnosis and management from the patient and/or others (including information to safely perform diagnostic procedures) ...

Task 3. Examination of the eye and visual system

3.1 Formulates an examination plan based on the patient history in order to obtain information necessary for diagnosis and management ...

3.2 Implements an examination plan that is progressively modified on the basis of findings ...

3.3 Assesses the structure and health of the components of the ocular adnexae,³¹ for their structure, health and functional ability, using diagnostic pharmaceutical agents where clinically indicated ...

3.4 Assesses central and peripheral sensory visual function and the integrity of the visual pathways (including vision and visual acuity, visual fields, colour vision and pupil function) ...

3.6 Assesses oculomotor³² and binocular function (including eye alignment, eye movement quality and range, binocularity status, vergence system adaptability,³³ accommodation placements and adaptability) ...

3.7 Assesses visual information processing ...

3.8 Considers and assesses ocular and non-ocular signs and symptoms found during the ocular examination relevant to the patient's eye and/or general health, where indicated ...

Task 4. Detection, measurement and diagnosis of variations, anomalies, defects and diseases of the eyes, adnexae and visual system

4.1 Interprets and analyses examination findings and results in order to determine the nature and aetiology of conditions or diseases and to establish a diagnosis or differential diagnoses ...

4.2 Evaluates the expected prognosis of the condition or disease, using all available relevant information ...

Task 5. Patient management Including prescribing (meaning the issuing, usually written, of directions for composition and use) of an ophthalmic appliance, optical appliance or ophthalmic medical device intended for remedial or cosmetic purposes or for the correction of a defect of sight.

5.1.5 Recalls patients for ongoing care and review as indicated ...

5.9 Refers the patient to other professionals in a timely and appropriate manner ...

5.9.1 Recognises the need for referral to other professionals for assessment and/or treatment, discusses this with the patient and recommends a suitable professional.

5.9.2 Makes a timely referral to other professionals, with appropriate supporting documentation.

Task 7. Recording and maintaining of clinical data and records

7.1.1 Promptly records all relevant information pertaining to the patient in a separate record and in a format which is understandable and useable by any optometrist and his/her colleagues (including such information as ... patient history, diagnoses, management strategies, summary of advice given to patient ...”

³¹ Ocular adnexae refers to the adjacent structures of the eye such as eyelids, eyelashes, and extraocular muscles (muscles supporting the eye).

³² Oculomotor refers to the movements of the eyeballs.

³³ Ability of the eyes to move in opposite directions.

Opinion: Mr B — breach

Findings of fact on clinical examination

38. On 28 March 2014, Mr B consulted with Master A. Mr B recorded that the reason for Master A's presentation was "routine". As above, Mr B told HDC that he used the word "routine" as an abbreviation to remind him of the routine examinations he had performed, rather than to indicate that he felt there was nothing concerning about Master A's presentation. Mr B also stated that it was his usual practice to take a history from his patients. However, no details of Master A's symptoms, family ocular history, general health or medications were documented. Mr B told ACC that the reason for Master A's presentation was because he could not see out of his right eye. Mr B told HDC that Master A presented as a pleasant young active boy who was quite eloquent for his age and "did not seem to demonstrate any physical anomalies or abnormalities with his eyesight".
39. With respect to the assessment, Mr B recorded that Master A's visual acuity in the left eye was "6/10" but that he was unable to ascertain the acuity for the right eye at six meters from a Snellen chart ("6/x"). Mr B recorded a diagnosis of amblyopia and possible right eye exotropia. No plan for follow-up or further investigation was noted.
40. Mr B prescribed glasses for Master A. With respect to the prescription details, Mr B recorded "+1.00/-1.00 * 180" for each eye, referring to a finding of low hyperopia and a small amount of astigmatism. Mr B also recorded the dispensing details for the spectacles prescribed, including the frame details and the pupillary distance.
41. Mr B told HDC that he undertook the following actions during the consultation:
 - checked the visual acuity in both eyes
 - a pupillary reflex test (both direct and consensual)
 - a relative afferent pupil defect test (RAPD)
 - a cover test using an ophthalmoscope light as a fixation point
 - binocular vision tests for both distant and short vision
 - a simultaneous perception test
 - a fundus ophthalmoscopy
 - a retinoscopy
 - a subjective refraction test
42. Mr B stated that no significant RAPD was detected, and there was no sign of papilloedema. He further stated that based on the diagnosis of amblyopia he would have expected Master A to have been referred to Clinic 2 for further testing. Mr B is unable to say why this did not occur.
43. Due to the passage of time and the absence of clinical documentation, I am unable to make a factual finding as to whether Mr B conducted a pupillary reflex test, RAPD

test, binocular vision tests for distant and short vision, a simultaneous perception test, a fundus ophthalmoscopy or a cover test.³⁴

44. However, I accept that at a minimum Mr B took some steps to assess Master A's visual acuity, as documented per the clinical notes, and that he conducted a retinoscopy and a subjective refraction test based on the recorded findings of low hyperopia and an astigmatism (ie, +1.00/-1.00 * 180).
45. I note that Mr B told HDC that he remembers Master A as being "pleasant", "active" and "quite eloquent", and that he (Mr B) tested the acuity of both of Master A's eyes. Accordingly, I find that Master A was able to understand and cooperate with the visual acuity examination, and I accept that Mr B tested Master A's acuity for both eyes at a six meter distance from a Snellen chart, as evidenced by his recordings "6/10" and "6/x". I also accept that Mr B intended that Master A be referred to Clinic 2 for further testing, but that a referral did not occur.

Clinical examination

46. As stated, Mr B recorded that Master A's visual acuity in the left eye was "6/10" and in the right eye "6/x" — that is, with his right eye, Master A could not identify letters on the Snellen chart at six meters.
47. My expert optometry advisor, Mr Richard Johnson, noted that if a patient cannot read the largest letter on a Snellen chart from the standard distance of six meters, then the standard of care would be to move the patient towards the chart until the patient is able to read it. If the patient is unable to read the chart from one meter, the standard of care would be to test the patient's ability to count the optometrist's fingers at one meter and, if that failed, then the optometrist would move a hand in front of the patient from a distance of one meter. If the patient is unable to identify the hand movement/direction, Mr Johnson stated that the optometrist would hold a bright light at a distance of 50cm and ask the patient to say when the light is turned on or not.
48. Mr Johnson advised that "6/x" is not a standard level of measured vision, and appropriate annotations for testing acuity would include "counts fingers at 1 meter", "hand movements at 1 meter", "perception of light" or "no perception of light". He stated that documented visual acuity findings are important because they help to correlate vision reduction with the cause of the visual impairment, and also provide a benchmark in which to test whether any treatment offered improves the visual function deficit. Mr Johnson advised that not testing the level of vision in Master A's right eye, despite his understanding and cooperation, would be a severe departure from the expected standard of care.
49. I note that Mr B made no record that demonstrated that he assessed Master A's acuity at any distance other than six meters. That is, there is no evidence to suggest that Mr B moved Master A closer to the Snellen chart to a distance where he could make out the largest letter detailed on the chart, or that Mr B conducted finger/hand testing at one meter, or light testing at 50cm if that was required. All that is known is that

³⁴ However, I note that based on Mr B's recorded diagnosis of exotropia it is possible that he conducted a cover test.

Master A could not read the chart from a six meter distance using his right eye. Accordingly, I find that Mr B failed to take further steps to determine the level of acuity in the right eye, and I am critical that he failed to do so.

50. Mr Johnson further stated that Mr B's diagnosis of amblyopia "was a possibility but inadequately investigated to be able to make a definitive diagnosis". Mr Johnson also advised that exotropia can cause amblyopia, but it is more commonly intermittent and not associated with a dense level of amblyopia. He stated that other differential diagnoses needed to be considered to detect or exclude serious underlying ocular or neurological disease.
51. Mr Johnson advised that the prescription of spectacles was reasonable if Master A was symptomatic (eg, he had problems with reading or eyestrain) but noted that other pathology should have been ruled out as a concurrent cause of the symptoms.
52. I acknowledge Mr Johnson's expert advice and am critical that Mr B did not consider differential diagnoses before making a definitive diagnosis of amblyopia.

Follow-up care and treatment plan

53. Mr B stated that following his diagnosis of amblyopia and possible right eye exotropia, he would have expected Master A to have been referred to Clinic 2 for further testing. Mr B told HDC that he is unable to explain why this did not occur, and stated that he did not perform appropriate diagnostic tests that would assist in detecting a brain tumour.
54. Mr Johnson advised that following a diagnosis of amblyopia, investigation to rule out pathology (disease) is still required. He stated that appropriate steps would be to make a referral to an ophthalmologist or to perform further investigations such as visual field analysis. He said that investigation is also required in order to determine the cause of the amblyopia. Such investigations may include asking the child's parents to bring in photographs of the patient to determine when the turning of the eye began (ie, at birth or subsequently), an assessment of the full range of movement in both eyes to determine the level of deviation, and investigations to determine whether a lesion may be causing the deviation of the eye.
55. Mr Johnson stated that patients with amblyopia under the age of eight should receive ongoing treatment to improve their visual function, in terms of stereopsis (3D vision), so that the affected eye has a higher level of functioning if anything happens to the better eye. Mr Johnson explained that a treatment plan may include the prescribing of spectacles and/or occlusive therapy. He stated that follow-up consultations must be scheduled regularly to ensure that the patient's visual acuity is improving at each visit.
56. Mr Johnson noted that the only treatment offered to Master A following the 28 March 2014 consultation was a prescription for glasses. Mr Johnson stated that the lack of investigation, treatment plan, or follow-up offered to Master A by Mr B following the diagnosis of amblyopia would be viewed by his peers with severe disapproval.
57. I accept Mr Johnson's advice and am critical that Mr B failed to conduct further investigations or refer Master A to an ophthalmologist to determine the cause of the

amblyopia and queried exotropia. Furthermore, I am critical that Mr B failed to institute an ongoing treatment plan and regularly assess whether Master A's visual acuity was improving.

Documentation

58. Mr Johnson advised that "only a minimum of information" from the 28 March 2014 assessment was recorded, and noted that the chief complaint, family history, current ocular medications, current systemic medications, previous ocular history and allergies are all summarised simply as "routine". Mr Johnson considers that Mr B's documentation of the consultation represents a departure from the accepted standard of care. I note that Mr B has clarified that he used the word "routine" as an abbreviation to remind him of the routine examinations he had performed. However, this does not excuse the scarcity of clinical documentation relating to any history taken or examinations performed.
59. This Office has stated previously that record-keeping is the primary tool for continuity of care, and a tool for managing patients.³⁵ I also note that the Optometry Standards require an optometrist to record all relevant information pertaining to a patient, including "patient history, diagnoses, management strategies, summary of advice given to patient".³⁶
60. In my view, Mr B's clinical record-keeping can at best be described as brief, and I am critical that he did not record a more detailed patient history or elaborate on the reason(s) for Master A's presentation on 28 March 2014.

Conclusion

61. Guided by the expert advice received, I consider that Mr B failed to:
 - Take appropriate steps to test the level of acuity of Master A's right eye or consider differential diagnoses before making a definitive diagnosis of amblyopia during the 28 March 2014 consultation.
 - Conduct further investigations or refer Master A to an ophthalmologist to determine the cause of the amblyopia and queried exotropia, and to rule out pathology.
 - Institute an ongoing treatment plan and regularly assess whether Master A's visual acuity was improving.
 - Appropriately document the patient history and the reason(s) for Master A's presentation on the 28 March 2014 consultation.
62. By failing to undertake these steps, I consider that Mr B did not provide Master A with reasonable care and skill, and so breached Right 4(1) of the Code.

³⁵ Opinion 15HDC00207.

³⁶ See Standard 7.1.1. in *Standards of Clinical Competence for Optometrists* (2010).

Opinion: Optometry practice — breach

63. Section 72(3) of the Health and Disability Commissioner Act 1994 (the Act) states that an employing authority is vicariously liable for any actions or omissions of its agents unless they are done or omitted without that employing authority's express or implied authority.
64. Mr B was a director and shareholder of the optometry practice and, at the time of these events, was the sole optometrist at the company. Mr B confirmed that he was paid by way of a director's fee.
65. Mr B provided optometry services from Clinic 1 two days a week, and, at the time of these events, Mr B provided services to Master A out of Clinic 1. It would have been reasonable for Master A and his mother to assume, on attending the optometry practice' office, that Mr B represented the optometry practice.
66. Accordingly, on the basis of the information provided, I am satisfied that Mr B was acting as an agent of the optometry practice.
67. In providing optometry services to Master A, Mr B was acting within the optometry practice' authority. Accordingly, the optometry practice is vicariously liable for Mr B's breach of Right 4(1) of the Code.

Adverse comment

68. I acknowledge Mr Johnson's advice that the minimum procedures necessary to provide an optometric examination of a patient are clearly defined in the Optometry standards. However, I remain concerned that at the time of these events the optometry practice did not have any policies or procedures relating to staffing levels and accommodation when unexpected leave was required. I note that the optometry practice has informed HDC that currently it is in the process of preparing such policies. I consider that the steps the optometry practice has taken to employ two optometrists will assist in ensuring that appropriate cover is available in the future.
69. Lastly, I note Mr Johnson's suggestion that the optometry practice's consultation form be amended to include additional fields for optometrists to complete when documenting their consultations. Mr Johnson stated that such an amendment would assist in determining what optometric tests were performed during a consultation. He also suggested that the consultation form detail recommended recall times, and a system be established to ensure that recalls occur at the appropriate times. I accept Mr Johnson's advice and recommend that the optometry practice consider Mr Johnson's suggestions and review its consultation form and recall processes.

Recommendations

70. I note that Mr B has told HDC that he is no longer practising as an optometrist. I recommend that the Optometrists and Dispensing Opticians Board provide HDC with

an update on Mr B's registration status within three months of the date of this report. Should Mr B return to clinical practice, I recommend that the Board consider whether a review of his competency is warranted.

71. I recommend that Mr B provide a written apology to Master A and the family for his breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to the family.
72. I recommend that within three months of the date of this report, the optometry practice:
 - a) Discuss the findings of this report with its clinical staff and provide HDC with minutes of that meeting.
 - b) Review its consultation form and recall processes in light of Mr Johnson's suggestions.
 - c) Audit patient records for a one-month period to ensure that patients assessed in Clinic 1 and requiring further testing/assessment have been appropriately referred to Clinic 2 or another healthcare professional (eg, an ophthalmologist). In six months' time, following this initial audit, conduct a second audit for a two-week period, and report back to HDC on the effectiveness of any quality improvement or remedial measure taken to ensure that patients have been referred appropriately.
 - d) Provide HDC with an update on the changes it has made to its practice, including but not limited to, the implementation of its new policies and procedures.

Follow-up actions

73. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Optometrists and Dispensing Opticians Board, the New Zealand Association of Optometrists, the Corneal and Contact Lens Society, ACC, and the district health board, and they will be advised of Mr B's name.
74. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent optometry advice to the Commissioner

The following expert advice was obtained from optometrist Mr Richard Johnson:

Report One

“I have been asked to provide an opinion to the Health and Disability Commissioner on case number CD16HDC00646. I have read and agree to follow the Commissioner’s guidelines for Independent Advisors.

Qualifications and experience:

My qualifications and experience are as follows:

Bachelor of Optometry, University of Auckland, 1993

Certificate in Ocular Pharmacology, University of Auckland, 2007.

2003 until present day:

Principal Optometrist, Ophthalmology Department, Greenlane Hospital, Auckland, NZ (0.7 FTE) with clinics in Emergency Eye care, Glaucoma, Medical Retina and Paediatrics.

Visiting lecturer and examiner in Ocular therapeutics at the Department of Optometry and Vision Science at the University of Auckland. (0.2 FTE)

Instructions from the Commissioner:

I have been asked to comment specifically on the following aspects of this case:

1. The standard of assessment undertaken by [Mr B] of [Master A] on the 28th March 2014.
2. Based on [Master A’s] presentation, was a diagnosis of amblyopia appropriate and should a differential diagnosis have been considered?
3. Was a referral to an ophthalmologist indicated given the inability to record a level of visual acuity in the right eye on 28 March 2014?
4. Any other comments/recommendations on the care provided.

Sources of information reviewed and referenced:

In writing this opinion, I have read a copy of the clinical notes made by [Mr B] on 28 March 2014, a copy of [Mr B’s] letter of response to ACC and a copy of [Mr B’s] letter of response to the HDC. I have sourced the Optometry and Optician’s Board’s ‘Standard of Clinical Competence for Optometrists’ (2010) and the Royal College of Ophthalmologists’ ‘Guidelines for the Management of Strabismus in Children’ (2012) as references in writing this opinion.

Conflict of Interest:

I confirm that I have no conflict of interest in this case.

Background of the case:

The background of this case is as follows:

[Master A] presented to [Clinic 1] on 28 March 2014. He was examined by [Mr B] who was unable to record a visual acuity for the right eye. He made a finding of amblyopia and possible right eye exotropia and prescribed eyeglasses.

Fourteen months after [Master A's] presentation to [the optometry practice], he saw his GP with ongoing headache, lethargy, decreased right side vision, clumsiness and abnormal neurology. He was referred to the Paediatric Service at [the public hospital] where it was found that he had no vision in his right eye and limited vision in his left eye. CT imaging revealed a craniopharyngioma.

Comment with regard to the standard of assessment undertaken by [Mr B] of [Master A] on the 28th March 2014.

With regard to the standard of care undertaken by [Mr B] of [Master A] on the 28th March 2014, based on the clinical notes made by [Mr B] on that day, and in regard to the standard of clinical competence for optometrists as made by the Optometry and Dispensing Optician's Board¹ (2010), [Mr B's] documented examination falls below the standard expected on a number of aspects. These are documented below:

Standard 2.4 Obtains information required for diagnosis and management from the patient and/or others.

The patient history was summarised as 'routine', with no recording of the reduced right vision that was the presenting complaint. No further investigation of symptoms, duration, family ocular history, general health or medications taken was documented.

Standard 3.3 Assess the structure and health of the components of the ocular adnexae for their structure, health and functional ability.

This was either not performed or not recorded in the clinical notes.

Standard 3.4 Assess the central and peripheral sensory visual function and integrity of the visual pathways (including vision and visual acuity, visual fields, colour vision and pupil function).

Only the visual acuity of the left eye was assessed, the right eye is recorded as "6/x". Visual fields, colour vision and pupil function were either not performed or not recorded in the clinical notes.

Standard 3.6 Assess oculomotor and binocular function (including eye alignment, eye movement quality and range, binocularity status, vergence system adaptability, accommodation placements and adaptability).

Although the notes record the possibility of an exotropia, none of the other above investigations were recorded as having been performed.

Standard 4.1 Interprets and analyses examination findings and results in order to determine the nature and aetiology of conditions or diseases and to establish a diagnosis or differential diagnosis.

A diagnosis of exotropic amblyopia has been made in this case based on limited clinical findings with no differential diagnoses investigated or noted.

Standard 5.1 Develop a management plan for each patient that is implemented in agreement with the patient/carer.

The management options for the diagnosed condition were not noted to have been discussed.

Standard 5.1.5 Recalls patient for ongoing care and review as indicated.

No recall or follow up has been documented.

Standard 5.9 To refer the patient to other professionals in a timely and appropriate manner.

The patient was not referred for a paediatric assessment by [Mr B] despite the ambiguous diagnosis and limited clinical examination.

1. Optometry and Optician's Board 'Standard of Clinical Competence for Optometrists' (2010).
https://www.odob.health.nz/cms_show_download.php?id=108

The standard of care to be expected/accepted in practice has therefore, in my opinion, not been met on many facets of the examination and I would consider this a severe departure from the level of care expected.

I have discussed the case in a confidential manner with 2 of my peers [...] . We feel that the level of clinical examination undertaken in this case would meet with severe disapproval from our peers.

Based on [Master A's] presentation, was a diagnosis of amblyopia appropriate and should a differential diagnosis have been considered?

A diagnosis of amblyopia ('lazy eye') is made when no organic pathology can be seen in an eye, yet the eye has reduced visual function. It can be due to 3 main causes:

Firstly, refractive. If there is a significant difference in the level of long-sightedness (or rarely, short-sightedness) between the two eyes, the associated defocus can cause amblyopia if not addressed (usually with eyeglasses). In this case, [Master A] was found to have no difference in the refractive status of the two eyes, ruling this out as a cause of amblyopia.

Secondly, occlusive amblyopia may develop in the presence of a congenital cataract or ocular media opacity such as a corneal scar. Although no ocular health examination was documented to have taken place on the 28 March 2014, [Master A] was not diagnosed by the Paediatric specialist as having a congenital cataract.

The third cause of amblyopia is strabismic, whereby one of the eyes deviates inward (esotropia) or outward (exotropia). Most strabismus cases are of esotropia. Approximately half of these cases are due to uncorrected long-sightedness and half are due to eye muscle mispositioning. All cases should undergo a cycloplegic assessment of the eye and refractive status to determine which is the cause. This involves putting a drop of a cycloplegic agent such as cyclopentolate onto the eye which temporarily paralyses the focussing lens in the eye and allows the full level of long-sightedness to be ascertained.

Exotropia may cause amblyopia but it is more commonly intermittent and not associated with a dense level of amblyopia.

Based on the presentation in this case, in my opinion, the diagnosis of amblyopia was a possibility but inadequately investigated to be able to make a definitive diagnosis. Other differential diagnoses have to be considered and, as stated in the management aims in the treatment of amblyopia in children, the first aim is 'to detect/exclude serious underlying ocular or neurological disease'.²

2. (<https://www.rcophth.ac.uk/wp-content/uploads/2014/12/2012-SCI-250-Guidelines-for-Management-of-Strabismus-in-Childhood-2012.pdf>)

Do I consider that a referral to an ophthalmologist was indicated given the inability to record a level of visual acuity in the right eye on 28 March 2014?

The inability to record a visual on children may be limited by understanding or poor cooperation. This cannot be the cause in this case though as a left eye visual acuity was obtained and found to be 6/10.

If a patient cannot read the largest test letter on the chart from a standard test distance of 6 metres, then the standard of care is to move the patient toward the chart until it is able to be read. If the chart is unable to be read from a distance of 1 metre, then the examiner should test the ability to 'count fingers at a distance of one metre'. If the patient is unable to count fingers at 1 metre, then the examiner should move their hand either horizontally or vertically to ascertain if the vision level is 'hand movements at 1 metre'. If unable to describe the movement direction more correctly than guessing, the examiner should hold a bright light at a distance of 50 cm and ask the patient if they can say when the light is on or not.

All levels of visual acuity from 6/6 to 6/60 (by chart at 6 metres) to 1/60 (at one metre) are therefore able to be recorded and beyond this, either count fingers, hand movements, perception of light or no perception of light, to allow the quantification of the level of visual function of an eye.

Not testing the level of vision, despite understanding and cooperation from the patient, is therefore, in my opinion, a severe departure from the standard of care expected and is, in my opinion, likely to be met with severe disapproval from my peers.

The lack of obtaining a visual acuity on the right eye, despite cooperation and understanding by the patient, should have led to further investigations as to the cause of the severely reduced vision. These tests would include a full binocular vision assessment, ocular health assessment, peripheral visual field assessment which would have then led to the detection of the compressive lesion along the visual pathway. This would have then led to the urgent referral to a paediatric ophthalmologist.

Final comments/recommendations on this case

If a child is diagnosed with amblyopia, after a full ocular assessment to ensure the correct diagnosis, a management plan is undertaken to improve the visual function. This may include the prescribing of spectacles and or occlusive therapy (patching).

Follow up must be scheduled regularly to ensure that the visual acuity is improving at each visit.

Unfortunately, [Mr B] has, in my opinion, undertaken an inadequate examination of [Master A] in a number of areas including:

- the clinical history (symptoms, general health, family history, etc)
- the ocular health check,
- the assessment of the visual system including visual acuity quantification, colour vision, binocular vision and peripheral vision.

This has led to a presumptive diagnosis which was incorrect.

Follow up was also not booked to ensure improvement in [Master A's] symptoms.

The above have, in my opinion, led to a late referral at a stage when the visual acuity was severely affected in both eyes and neurological and systemic symptoms were present.

Based on the diagnosis of a craniopharyngioma, if a complete examination had been undertaken on 28 March 2014, the following findings could have been expected, any of which may have led to an earlier referral:

- Dense reduction in right visual acuity. Strabismic amblyopia only affects the central vision and usually is only mild in an exotropia.
- Reduced monocular colour vision due to the compression on the right optic nerve.
- Investigation of the exotropia, which in this case was secondary to the poor visual function of the right eye rather than a true muscle mispositioning.
- Ophthalmoscopy may have shown a swollen or pale right optic nerve head due to the compression on the optic nerve.”

Report Two

“I have been asked to provide a further opinion to the Health and Disability Commissioner on case number CD16HDC00646, specifically in view of updated correspondence on this case. I have read and agree to follow the Commissioner’s guidelines for Independent Advisors.

Qualifications and experience:

My qualifications and experience are as follows:

Bachelor of Optometry, University of Auckland, 1993

Certificate in Ocular Pharmacology, University of Auckland, 2007.

2003 until present day:

Principal Optometrist, Ophthalmology Department, Greenlane Hospital, Auckland, NZ (0.7 FTE) with clinics in Emergency Eye care, Glaucoma, Medical Retina and Paediatrics.

Visiting lecturer and examiner in Ocular therapeutics at the Department of Optometry and Vision Science at the University of Auckland. (0.2 FTE)

Instructions from the Commissioner:

I have been asked to comment specifically on the following aspects of this case:

1. The assessment conducted by [Mr B] of [Master A] on the 28th March 2014.
2. Whether any follow up care from [Mr B] was clinically indicated following the 28 March 2014 assessment.
3. The standard of [Mr B's] clinical documentation.
4. Any other comments/recommendations on the care provided.

I have also been asked to comment on the adequacy and appropriateness of the services provided by the optometry practice on:

1. The clinical systems in operation at the time (2014)
2. The level of support to clinical staff.
3. The absence of policies and procedures in relation to optometry care.
4. The changes that the company has made to practice.

Sources of information reviewed and referenced:

In writing this opinion, I have read a copy of the clinical notes made by [Mr B] on 28 March 2014, a copy of [Mr B's] letter of response to ACC and a copy of [Mr B's] letter of response to the HDC. I have also read the updated correspondence from [Mr B's] Barrister dated 31 March 2017 and a transcript of a phone call from the HDC to [Ms A] ([Master A's] mother) dated the 9th of May 2016. I have sourced the Optometry and Optician's Board's 'Standard of Clinical Competence for Optometrists' (2010) and the Royal College of Ophthalmologists' 'Guidelines for the Management of Strabismus in Children' (2012) as references in writing this opinion.

Conflict of Interest:

I confirm that I have no conflict of interest in this case.

Background of the case:

The background of this case is as follows:

[Master A] presented to [Clinic 1] on 28 March 2014. He was examined by [Mr B] who was unable to record a visual acuity for the right eye. He made a finding of amblyopia and possible right eye exotropia and prescribed eyeglasses.

Fourteen months after [Master A's] presentation to [the optometry practice] Optometrists, he saw his GP with ongoing headache, lethargy, decreased right side vision, clumsiness and abnormal neurology. He was referred to the Paediatric Service at [the district health board] where it was found that he had no vision in his right eye and limited vision in his left eye. CT imaging revealed a craniopharyngioma.

Comment with regard to the standard of assessment undertaken by [Mr B] of [Master A] on the 28th March 2014.

The following comments are additional to those made in July 2016 regarding this case, with a more specific focus on the aforementioned aspects and considering the updated correspondence on the case.

With regard to the standard of care undertaken by [Mr B] of [Master A] on the 28th March 2014, based on the clinical notes made by [Mr B] on that day, and in regard to the standard of clinical competence for optometrists as made by the Optometry and Dispensing Optician's Board¹ (2010), [Mr B's] documented examination falls below the standard expected on a number of aspects. These are summarised below. More detailed explanations were given in my advice dated July 2016:

Standard 2.4 Obtains information required for diagnosis and management from the patient and/or others.

Standard 3.3 Assess the structure and health of the components of the ocular adnexae for their structure, health and functional ability.

Standard 3.4 Assess the central and peripheral sensory visual function and integrity of the visual pathways (including vision and visual acuity, visual fields, colour vision and pupil function).

Standard 3.6 Assess oculomotor and binocular function (including eye alignment, eye movement quality and range, binocularity status, vergence system adaptability, accommodation placements and adaptability).

Standard 4.1 Interprets and analyses examination findings and results in order to determine the nature and aetiology of conditions or diseases and to establish a diagnosis or differential diagnosis.

Standard 5.1 Develop a management plan for each patient that is implemented in agreement with the patient/carer.

Standard 5.1.5 Recalls patient for ongoing care and review as indicated.

Standard 5.9 To refer the patient to other professionals in a timely and appropriate manner.

[Mr B's barrister] mentions that [Mr B] recalls [Master A] as being a 'pleasant young active boy who is quite eloquent for his age'. Despite this, he has recorded [Master A's] vision in his left eye as 6/10 and his right eye as '6/X'. Visual function must be recorded in all patients, even if they can't read the largest optotype on a Snellen chart at a distance of six metres, in which case the patient can move closer until they can see it (in which case the vision may be recorded as 1/60, for example) or recorded as 'count fingers at 1 metre', 'hand movements at 1 metre', 'perception of light' or 'no perception of light'. This is important as it can correlate the vision reduction with cause and also that any treatment offered (such as glasses in this case) are shown to be improving the visual function deficit. [Master A] was clearly able to understand and

cooperate with the testing process for his left eye and [Mr B] should therefore have been able to determine the level of vision for the right eye.

In his statement to ACC dated 24 July 2015, [Mr B] states that (although not recorded as being performed), he tested pupillary responses to test for a relative afferent pupillary defect (RAPD). Although he says that no RAPD was present, this test is observer dependent. There is no way of knowing whether this test was either actually performed or correctly interpreted.

He also says that he tested for stereopsis (3D vision) (again, not documented as being performed) and found this to be absent. This finding could be consistent with the exotropia (turned-out eye) noted, whether the exotropia was a congenital condition as [Mr B] felt that it was, or secondary to the severely reduced vision in the right eye, making this test fairly specific and non-diagnostic.

The standard of care to be expected/accepted in practice has therefore, in my opinion, not been met on many facets of the examination and I would consider this a severe departure from the level of care expected.

I have discussed the case in a confidential and anonymous manner with 4 of my peers [...]. We feel that the level of clinical examination undertaken in this case would meet with severe disapproval from our peers.

Whether any follow up care from [Mr B] was clinically indicated following the 28 March 2014 assessment?

[Mr B] has made a diagnosis of amblyopia ('lazy eye' or reduced vision in the absence of pathology) in this case. Amblyopia is regarded as being treatable up until the age of 8, with more evidence recently that even older ages may benefit from treatment.

Glasses were prescribed but no further investigation or treatment was offered. Although [Clinic 1] is run as a part-time, rural practice, investigation to rule out pathology is still required, either to an ophthalmologist or with further investigation techniques in another practice, such as visual field analysis.

Investigation is also required as to the cause of the amblyopia if this diagnosis is made. Further testing may include asking the parents to bring in previous photographs of the patient to determine when the turning of the eye began, either from birth or later on. Assessing the full range of movements of the eyes can also determine whether the level of deviation of the eyes is more in one eye than the other (constant or alternating) or whether a neurological lesion may be causing the deviation of the eye noted.

Treatment should be offered for patients with amblyopia under the age of eight to try and improve the useful vision level, both in terms of stereopsis (3 D vision) and so that the affected eye has a higher level of functioning if anything happened to the better eye. We would regard a vision improvement to 6/6 as ideal but a vision improvement to 6/12 as reasonable as it will still allow a car licence to be kept later if the patient were to become monocular later in life.

In this case, neither investigation nor treatments were offered, other than the prescribing of glasses (with no follow up booked to record any improvement in symptoms or lack thereof).

Again, I have discussed this aspect of the case in a confidential manner with 4 of my peers (see above). We feel that the lack of investigation, treatment or follow up offered in this case would meet with severe disapproval from our peers.

Comment on the standard of clinical documentation from the assessment conducted on 28 March 2014?

Unfortunately only a minimum of information from the assessment is recorded.

The chief complaint, family history, general health, current ocular medications, current systemic medications, previous ocular history and allergies are all summarised simply as 'routine'.

Anterior and posterior segment health assessment, as well as that of ocular adnexa health, are not recorded as being performed. Ocular motility, visual field assessment, colour vision are not recorded as being performed other than the note of an exotropia (turned out eye) as the only assessment of binocular function.

The only documentation made of any examination findings are the prescription which is recorded as +1.00/-1.00 x 180 in each eye. This is a finding of low hyperopia (long-sightedness), being +1.00, (normal for the age) and a small amount of astigmatism (-1.00) and the direction of the astigmatism (180 degrees). The findings for each eye are symmetrical but the vision is recorded as 6/10 (which can be thought of as 90% of normal vision) in the left eye and 6/X in the right eye (which is not a standard level of measured vision, see earlier comments).

The prescription of spectacles for the above level of long-sightedness and astigmatism is reasonable if the patient is symptomatic (e.g., problems reading, eyestrain, etc) but other pathology must, of course, be ruled out as a concurrent cause of symptoms during the course of the complete eye examination.

The remaining details on the record are the dispensing details for the spectacles prescribed and dispensed such as the frame details and the PD (pupillary distance, this being the distance between the two eyes so that the centre of the spectacles lenses can be made to match this).

No documentation is made of the vision obtained with the prescribed spectacles at the time of their collection by [Master A].

The poor documentation recorded from this assessment of the patient, is therefore, in my opinion, a severe departure from the standard of care expected and is, in my opinion, likely to be met with severe disapproval from my peers.

2. Comments on the adequacy and appropriateness of the services provided by the optometry practice.

- a. **The clinical systems in place at the time of the events (2014).** Although the practice seems to have been using a paper-based system at the time, I note that

there is no area for recommended recall times on the consulting form. It may be that there was a separate system in place for this. If not, the consultation form should have this added and a system in place to act on the recall time requested by the optometrist.

The paper consultation form is also limited in the number of printed fields for completion by the optometrist. Many practices now have fields on their consultation form for the optometrist to fill in, either on paper or computerised. This can help to reduce any ambiguity about test findings or whether a test was actually performed, which is a key point in this case due to the limited documentation made by [Mr B] of the examination of [Master A].

- b. **The level of support available to the clinical staff.** Not applicable as ancillary staff were not involved (for example, pre-testing of patients). Many optometric practices now utilise ancillary staff to pre-test patients by performing non-invasive procedures such as retinal photography and eye pressure measurements. Routine audit of these pre-testing findings should be performed to ensure accuracy of results that will be assumed during the optometric clinical examination of the patient. In this case, [Mr B] performed the examination himself. I also note that he did not have an Employment Contract with the optometry practice.
- c. **The absence of policies and procedures in relation to optometry care.** The minimum procedures necessary to provide an optometric examination of a patient are clearly defined by the Optometry and Dispensing Opticians Board (ODOB) Registration requirements. I refer the reader to my previous advice dated July 2016 for more detail on areas where [Mr B] has not met the required aspects of performing a full examination in this case. I note that [Mr B] has ceased working as an optometrist and that he now employs two (more recently qualified) optometrists with wider scopes of clinical practice. Hopefully they will be in a position to collaborate in cases such as this in the form of a formal, regular, internal Peer Review process in addition to the ongoing Continuing Professional Development (CPD) that is required by all registered optometrists.

Many optometric practices also implement a courtesy follow up phone service whereby a phone call is made to the patient a week or two after the collection of spectacles to ensure that the presenting symptoms are improved and check that the patient is satisfied with the outcome. If they raise any issues with the desk staff making the phone call, a short follow up can be made with the optometrist. Although more time consuming, this procedure could help to ensure that cases such as this where the patient has had no improvement in symptoms (or in fact worsened) may prompt a rethink about the original diagnosis.

- d. **The changes that the company has made to practice.** [Mr B] is in the process of implementing changes and policies within the practice. I cannot comment further as these are not yet available or have not been implemented.

The issue of recall has already been discussed. The examination of the patient, as mentioned above, falls under the ODOB definitions.

Unfortunately, [Mr B] has, in my opinion, undertaken an inadequate examination and failed to document his assessment of [Master A] in a number of areas including:

- the clinical history (symptoms, general health, family history, etc)
- the ocular health check,
- the assessment of the visual system including visual acuity quantification, colour vision, binocular vision and peripheral vision.

This has led to a presumptive diagnosis which was incorrect.

Follow up was also not booked to ensure improvement in [Master A's] symptoms.

The above have, in my opinion, led to a late referral at a stage when the visual acuity was severely affected in both eyes and neurological and systemic symptoms were present.