Optometrist, Mr B

Optometry Clinic

A Report by the

Deputy Health and Disability Commissioner

(Case 21HDC01007)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

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Executive summary

1. This report concerns the care provided to a woman between September 2019 and November 2020 by an optometrist in relation to a delayed diagnosis of a melanoma.

2. The woman presented to the optometrist several times but he failed to undertake appropriate investigations of the lesion on her eye.

3. Following an eye bleed, the woman presented to a public hospital. Surgery was arranged to remove the lesion, and a biopsy showed it to be a melanoma. Further excision was undertaken and the eye was reconstructed.

4. This report highlights the importance of undertaking the appropriate investigations, and the importance of adequate documentation.

Findings

5. The Deputy Commissioner considered that the optometrist's failure to undertake appropriate investigations of the woman's eye lesion and appropriately document relevant information amounted to a breach of Right 4(1) of the Code.

6. The Deputy Commissioner found that the optometry clinic did not breach the Code.

Recommendations

7. The Deputy Commissioner recommended that the optometrist provide the woman with a written apology. In response to the Deputy Commissioner's provisional recommendations, the optometrist provided evidence of having presented a session about ocular lesions to his colleagues.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Ms A (via the Nationwide Health and Disability Advocacy Service) about the services provided by Mr B and the optometry clinic. The following issues were identified for investigation:

   - *Whether Mr B provided Ms A with an appropriate standard of care between September 2019 and November 2020 (inclusive).*
   - *Whether the optometry clinic provided Ms A with an appropriate standard of care between September 2019 and November 2020 (inclusive).*

9. This report is the opinion of Dr Vanessa Caldwell, and is made in accordance with the power delegated to her by the Commissioner.

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10. The parties directly involved in the investigation were:

Ms A	Consumer
Mr B	Optometrist/provider
Optometry clinic	Optometrists/group provider

11. Further information was received from a district health board and a medical centre.

12. Independent advice was obtained from an optometrist, Dr Geraint Phillips (Appendix A).

Information gathered during investigation

Background

13. This report concerns the management of a growth in Ms A's eye, including the lack of a referral and documentation, and the failure to diagnose a melanoma. In approximately August 2019, Ms A, aged in her sixties at the time of events, developed a growth in her right eye. Between August 2019 and November 2020 she presented to her GP, and also had three consultations with an optometrist, Mr B.[1]

14. Ms A had been a patient at the optometry clinic for 25 years, and had been attending regular appointments to review her contact lenses.

12 September 2019 — GP appointment

15. On 12 September 2019, Ms A presented to her GP with concerns about a growth in her right eye that had been present for five weeks. It was documented that there had been no trauma or injury to her eye, she had no vision issues, and she was not experiencing any pain. The GP diagnosed the growth as a pterygium and prescribed antibiotics.[2] Ms A's GP advised her to attend Accident and Emergency if her symptoms worsened or if new symptoms developed.

16. Ms A stated that after her GP appointment, she recalled telling Mr B that her GP had diagnosed the growth as a pterygium.[3] She stated that Mr B asked her to "come in", as he was the expert.

[1] Mr B had been a director at the optometry clinic for many years.
[2] Chloramphenicol — a medication used in the management and treatment of superficial eye infections such as bacterial conjunctivitis.
[3] A growth in the corner of the eye, which is often triangular in shape. If left untreated, the growth can extend across the pupil and obscure the vision, or it can distort the surface of the eye and cause blurred vision.

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13 September 2019 — appointment with Mr B

17. On 13 September 2019, Ms A attended an appointment with Mr B. Mr B documented: "[R]ight conjunctival bleb temporal.[4] Gp treating with chorisig [antibiotics]. See photos." Mr B took a photo, but did not review Ms A's past records or document his treatment plan.

18. Ms A stated[5] that Mr B told her that the growth was a pinguecula[6] and that it was harmless and she did not need to do anything. Mr B told HDC that his examination showed that the lesion had a smooth appearance with a clear border, and the tissue looked healthy (with no real thickening of the surface), and that Ms A did not report any discomfort. In response to the provisional opinion, Ms A stated that the photographs showed definite thickening of the outside edge of the lesion.

19. In a letter to Ms A written after these events, Mr B stated that he thought the growth in her eye was a conjunctival bleb, blister or retention cyst, as there appeared to be fluid underneath the thin wall of the conjunctiva,[7] and he thought it was caused by an allergy or inflammation resulting from dry-eye issues. He said that in most cases, a conjunctival bleb, blister or retention cyst reduces by itself over time, and therefore he did not consider that a referral appointment was necessary.

20. Mr B told HDC that Ms A did not present with symptoms of a conjunctival melanoma (a raised gelatinous opaque growth with superficial blood vessels). In response to the provisional opinion, Ms A told HDC that she had enlarged blood vessels "from the thickened edge of lesion".

21. Mr B stated that as Ms A had visited her GP in respect of the growth, he had assumed that she would continue to see her GP, and that a follow-up appointment had been arranged. He said that he did not tell Ms A this assumption. Mr B told HDC that he did not consider consulting with Ms A's GP about his differential opinion, as he thought that the growth would resolve itself or would be resolved by the antibiotics. Mr B stated that he is now aware that he should have arranged a follow-up appointment with Ms A after 13 September 2019 to assess the growth in her right eye.

24 August 2020 — second appointment with Mr B

22. On 24 August 2020, Ms A attended a further appointment with Mr B for a routine eye test in relation to her contact lenses.

23. Mr B documented in the clinical record: "[GP] referred to hosp[ital] for right temp conj bleb. [Mr B] suggested see private if public to[o] long a wait." He also documented: "[R]ight temp

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[4] A conjunctival bleb, blister, or retention cyst is caused by an allergy or inflammation resulting from dry-eye issues or from abnormal secretions from blocked ducts in the eye.

[5] In a letter to Mr B dated 18 March 2021.

[6] A small, raised, white or yellow-coloured growth that is limited to the conjunctiva; it can occur on the inner or outer side of the eye.

[7] The clear, thin membrane that covers part of the front surface of the eye and the inner surface of the eyelids.

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conj bleb or inflamed area on temp conj [and] early cat and early [age-related] M[acular] D[egeneration] right eye."

24. Mr B also documented that a photograph had been taken at this appointment. In response to the provisional opinion, Ms A told HDC that a photograph was not taken at this visit and that a photograph was not taken until 24 October 2020, which showed that the lesion had already grown a lot bigger.

25. Mr B did not mention the "bleb" in the symptom, diagnosis, or summary section of the record, did not make any recordings under the "Opthalmoscopy" section of the record, and did not document any findings for Ms A's left eye.

Ms A's and Mr B's recollection of events

26. Ms A stated that she recalls that she asked about the growth, as it had grown quite large, and Mr B told her that there was still plenty of clearance for the contact lens. Ms A recalls telling Mr B that using the contact lens irritated her eye, and Mr B said that she "just needed to try different ones", and told her that if the lesion grew bigger it could be drained with a needle.

27. Mr B stated that the purpose of the appointment was an annual review of Ms A's contact lenses, and he regretted that he did not focus on the growth. He stated that his notes record that he inspected the growth, but it appeared to be of a similar size, and as its appearance had not changed, he did not take a photo. He said that the contact lens did not touch the growth, and so he did not note it to be of concern. In response to the provisional opinion, Ms A stated that she told Mr B that the growth had grown and that it was affecting her ability to close her eye.

28. Mr B stated that as the growth had remained a similar size, he still considered it to be a bleb, blister or cyst. He agreed that he advised Ms A that if it grew to the point it would be touching the contact lenses then the fluid could be drained, and stated that this is a common treatment for blebs, blisters or cysts. Mr B did not document this advice.

September 2020 consultation

29. On 16 September 2020, Ms A attended a routine consultation regarding contact lenses, and Mr B took a photo of the growth. Mr B did not document any findings regarding the lesion.

30. Mr B documented: "[R]ight oasys 1 day option 2. initial comfort ok. movement ok left ascend 1 day elite option 1, comfort not as good as moves more."

31. Mr B stated that he was focused solely on fitting Ms A's contact lenses, and inadvertently he failed to consider whether the symptoms of the growth were still consistent with that of a bleb, blister, or retention cyst. In response to the provisional opinion, Ms A told HDC that she raised numerous concerns during this consultation.

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14 October 2020 — second GP consultation

32. On 14 October 2020, Ms A saw her GP and asked for a referral, as the growth was becoming uncomfortable when she opened and closed her eye. The GP documented:

> "Eye lesion R lateral sclera.[8] Present about 10 months, getting bigger and more uncomfortable. Superficial sclera nodule … looks like clump of conjunctiva. Photo take[n]. Refer ophthalmology."

21–24 October 2020 — collection of contact lenses

33. On 21 October 2020 Ms A told the optometry clinic that she was waiting for an appointment at the public hospital regarding her eye. Ms A stated that on 24 October 2020 she picked up her contact lenses and Mr B told her to ask her GP for a private referral as she would be seen earlier. Ms A said that Mr B did not express any urgency or arrange the referral himself.

34. Mr B stated that when Ms A collected the contact lenses she said that she would have a specialist appointment within four months, and that this is a standard wait time for a specialist appointment. Mr B said that it was around this time that he considered the matter to be more urgent, which is why he suggested that Ms A ask her GP to refer her privately. He acknowledged that he did not express this urgency to Ms A.

35. Mr B stated that in hindsight he should have organised a private referral. He explained that as Ms A was in the system with her GP, and as she had been to her GP regarding the growth, he considered it better for the referral to remain with the GP. Mr B said that GPs tend to have more influence within the hospital system, and he thought that Ms A would be more likely to get an appointment sooner by returning to the GP for the referral. He told HDC that he now realises that he was wrong to make these assumptions, and he apologised.

1 November 2020 — emergency department

36. On 1 November 2020, Ms A presented to the emergency department (ED) at the public hospital because her eye was bleeding and she was unable to open it without pain, and she had vision changes. During her admission, ED staff noted that the growth was not a ptyergium as it did not encroach onto the cornea. A plan was made for Ms A to attend an eye clinic on 2 November 2020.

5–23 November 2020

Eye clinic

37. Ms A presented to the eye clinic on 5 November 2020. On examination it was noted that she had a "right conj peduculated lesion[9] [that] appeared mobile". A plan was made for the lesion to be removed surgically before Christmas, and she was referred back to her GP.

[8] The white outer layer of the eyeball.

[9] A conjunctival lesion growing from a stalk of tissue.

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GP consultation

38. Ms A had a consultation with her GP on 13 November 2020. It was noted that the lesion was growing rapidly and she had pending surgery on 7 December 2020, and that a photograph and an urgent referral had been sent to the DHB.

39. Ms A underwent surgery to remove the conjunctival lesion on 23 November 2020. A biopsy showed that the lesion was a melanoma.[10]

Subsequent events

40. On 7 January 2021, Ms A underwent further surgery to remove the melanoma and to reconstruct her eye. The procedure went well.

Documentation

41. Mr B told HDC that he is aware that consultation notes in respect of Ms A were, at times, lacking in detail and were not consistent with expected professional standards (and were not at his own usual personal standards). Mr B stated that his notes should be reviewed in the context of the long-term patient–practitioner relationship he and Ms A had, which meant that over time the appointments became less formal. Mr B said that Ms A often dropped by unexpectedly, and he made an effort to see her between appointments and completed his notes at the end of the day, which at times meant he did not record the full details. In response to the provisional opinion, Ms A told HDC that it was incorrect that she often "dropped by unexpectedly". She stated that she always telephoned before attending, and she attended when the receptionist instructed her to do so.

Further information

Mr B

42. Mr B told HDC that he has reflected on this incident at length and acknowledges that he made mistakes in Ms A's care. He apologised sincerely for failing to recognise that the growth in Ms A's eye was a melanoma, and for not personally referring her to a specialist earlier. Mr B stated that he has reflected on the care provided and accepts that during the appointments he focused too heavily on the new contact lenses and not on the growth (believing that Ms A was seeing her GP for the required assessment and treatment of the growth). Mr B apologised for this misunderstanding. He acknowledged that he should have considered other causes of Ms A's discomfort, and should have organised referrals when he considered these to be required. In response to the provisional opinion, Ms A stated that she told Mr B that she had not seen her GP.

43. Mr B stated that he has learnt that he needs to be clear in his communication, in particular to ensure that patients understand what assumptions and/or conclusions he has made, and he needs to be clear in his written communications.

Optometry clinic

44. The optometry clinic told HDC that the directors expect a higher standard of client care for their patients and, on behalf of the whole team, they apologised unreservedly for the

[10] A cancer of the eye.

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treatment Ms A received. While they recognise that this will not alter Ms A's situation, they hope that the practice's continued efforts to implement change to ensure that this never happens again will provide "some solace" for her. In response to the provisional opinion, Ms A told HDC that this does not alter the fact that she was told that she needed to have her eye reviewed every six months.

Responses to provisional opinion

Ms A

45. Ms A was given the opportunity to comment on the "information gathered" section of the provisional opinion. Where appropriate, her comments have been incorporated above.

Mr B

46. In response to the provisional opinion, Mr B reiterated that he acknowledges that he made mistakes in Ms A's care and is deeply regretful of this, and is committed to ensuring that these mistakes do not happen again.

Optometry clinic

47. In response to the provisional opinion, the optometry clinic stated that it has taken the investigation very seriously and acknowledges the findings. The optometry clinic reassured HDC that the other directors will support Mr B and continue to peer review Mr B's diagnosis and treatment plans.

48. The optometry clinic stated that it will continue to ensure that record-keeping within the practice is of a high standard; policies and procedures are reviewed and updated regularly (as required); staff are reminded of their professional obligations; and training is provided to all staff.

Opinion: Mr B — breach

49. Optometrists who hold an annual practising certificate are required to abide by the Optometrists and Dispensing Opticians Board (ODOB) Standards of Clinical Competence for Optometrists. As such, Mr B was subject to these standards during 2020 when Ms A's growth was first noticed.

50. Mr B fell short of several standards when he provided care to Ms A. In particular, he failed to identify and manage Ms A's lesion appropriately.

51. I sought independent clinical advice from an optometrist, Mr Geraint Phillips, to assist my assessment of this matter, and I refer to this advice in my discussions below.

Misdiagnosis

52. The clinical notes from the 13 September 2019 consultation describe the lesion as a "bleb" and note that it was being treated by the GP with an antibiotic (chloramphenicol). Mr Phillips

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advised that the term “bleb” is generally included in the description of a type of glaucoma treatment called “filtration bleb”, which is not the case here.

53. Mr Phillips stated that the photograph taken by Mr B during the September 2019 appointment shows a raised, vascularised[11] lesion on the temporal conjunctiva of the right eye, and the lesion appears to be solid and not filled with fluid. Mr Phillips advised that a lesion of this appearance would require and benefit from chloramphenicol, and the appearance of the lesion should have raised further questions and investigations. Mr Phillips stated that the more solid appearance and the presence of the dilated blood vessels should have triggered a review of Ms A’s past records to see whether the lesion was new or longstanding. As Ms A had been seen regularly in the past, this review would have likely established whether the lesion had grown in size or changed in morphology over time. Mr Phillips said that the photo taken in October 2020 shows that the lesion had changed in shape and grown in size, and this should have triggered a high degree of suspicion.

54. Mr Phillips identified a number of standards relevant to Ms A’s case. Section 3.3 of the ODOB Standards of Clinical Competence for Optometrists states that an optometrist must “assess the structure and health of the components of the eye and ocular adnexae,[12] for their structure, health and functional ability, understanding the need for and using diagnostic pharmaceutical agents where clinically indicated”. Section 3.3.2(a) states that an optometrist must “assess and evaluate the structure and health of the anterior segment including, but not limited to … conjunctiva …”. Section 4.1 states that an optometrist must “interpret and analyse examination findings and results in order to determine the nature and aetiology of conditions or diseases and to establish a diagnosis or differential diagnosis”.

55. Mr Phillips said that Mr B should have completed more thorough investigations following the examination of the growth during the 13 September 2019 consultation, and when Mr B reviewed the second photo in October 2020, this should have triggered him to conduct further investigations. Mr Phillips advised that the care provided by Mr B regarding seeking a diagnosis of the growth falls below the ODOB standards, in particular sections 3.3, 3.3.2(a) and 4.1. As Mr B did not complete a thorough investigation of the growth, and did not review the photos taken to examine the growth’s movement and shape change adequately, he failed to reach an appropriate differential diagnosis.

56. I accept Mr Phillips’ advice that the standard of care provided by Mr B during this period is a moderate departure from what would have been expected.

Documentation

57. Ms A had been Mr B’s customer for a number of years, and had seen him frequently in the time leading up to her diagnosis. In the consultations between September 2019, when Ms A first presented to Mr B with the growth, and October 2020, when Ms A received the diagnosis, Mr B made very brief clinical notes.

[11] Showing blood vessels.

[12] The parts of the orbital region that are outside the eyeball.

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58. Mr B acknowledged that the consultation notes in respect of Ms A lacked detail at times, and were not consistent with expected standards (and not to his own usual personal standards). He stated that this was because he had a less formal relationship with Ms A. He said that Ms A often dropped by unexpectedly, and he made an effort to see her between appointments and completed his notes at the end of the day, which at times meant that he did not record the full details.

59. Mr Phillips advised that generally, the level of Mr B's documentation during this period is best described as minimal, and it does not allow an adequate picture of what was determined from the history questions and clinical findings and, most importantly, of the management.

60. Mr Phillips advised that the documentation of the lesion in the form of photographs over two visits was appropriate and of high quality. However, it appears that there are no consultation notes to accompany the photographs taken at the 24 October 2020 visit. Mr Phillips said that the accepted practice for this type of presentation would be to document clearly an outline of the history of the lesion, a diagnosis or tentative diagnosis, and the proposed management. Mr Phillips advised that Mr B's lack of documentation was at the upper end of a moderate departure from the accepted practice.

61. Section 7.1 of the ODOB states that an optometrist must ensure that clinical data is documented in English, in a legible, secure, accessible, permanent and unambiguous manner. Subsection 7.1.1 states that an optometrist must record all relevant information pertaining to the patient in an individual patient record promptly.

62. I accept the advice provided by Mr Phillips. In my view, Mr B failed to record all relevant information. I acknowledge Mr B's submission that his documentation should be viewed in the context of the longstanding patient–practitioner relationship he had with Ms A. However, I consider that the nature of his relationship with Ms A does not excuse Mr B from his professional obligations to ensure that his clinical record-keeping is in accordance with accepted practice. It is important to maintain a high standard of documentation and, in this case, the lack of detailed documentation meant that the size and significance of Ms A's growth was not tracked accurately. In addition, Mr B's level of clinical note-taking falls below the standards set by the ODOB.

Conclusion

63. I consider that Mr B did not provide services to Ms A with reasonable care and skill during the consultations between September 2019 and October 2020 because he failed to:

a) Undertake appropriate investigations of Ms A's eye lesion, which had changed shape and grown in size between consultations; and

b) Document relevant information appropriately, including the history, clinical findings and management of Ms A's eye lesion.

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64. Accordingly, I find Mr B in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[13]

Opinion: Optometry clinic — no breach

65. The optometry clinic employs Mr B as an optometrist. Mr B is also a director of the company.

66. Mr Phillips reviewed the optometry clinic's policies and procedures in place at the time of events in respect of referral management, and considered that these were adequate. He advised that by adopting the Optometrists and Dispensing Opticians Board's Standards of Clinical Competence, the optometry clinic acted appropriately. He said that the onus is on the registered optometrist to ensure that they conform to these standards.

67. In light of Mr Phillips' advice, I am not critical of the services the optometry clinic provided to Ms A, and consider that it did not breach the Code.

Changes made since events

Mr B

68. Since these events, Mr B has undertaken, or is undertaking, the following:

a) He arranged individual training sessions with a specialist in anterior eye conditions and eyelids and, once completed, he presented the training to his colleagues.
b) He attended a continuing professional development course in relation to ocular lesions. Based on this learning, he prepared a presentation in respect of ocular lesions, which was presented to his colleagues at the optometry clinic.
c) He read textbooks and online publications in relation to ocular lesions, and reviewed case studies to improve his knowledge.
d) He reviewed numerous cases of ocular lesions with melanomas and discussed them with fellow optometrist colleagues.
e) He created a clinical record-keeping system with an internal peer review audit whereby his clinical notes from (at least) five random cases a week will be peer reviewed by a colleague to ensure compliance with professional standards. A peer audit undertaken to date reported an improvement in Mr B's record-keeping since May 2021. In response to the provisional opinion, Mr B told HDC that he was involved in another peer review exercise with a focus on record-keeping in September/October 2021.

[13] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

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f) He completes detailed notes at the end of every examination and ensures that every patient interaction is detailed, including normal and satisfactory findings rather than reporting only the abnormal findings.

g) He communicates with other practitioners and/or specialists involved in a patient's care to adopt a collaborative approach to patient care and to avoid miscommunication and/or referral delays.

h) He adopts a holistic approach in his day-to-day examinations, including actively listening to a patient's concerns, not assuming the purpose of the visit, and more regularly arranging follow-up appointments for potential ongoing issues. For example, if an annual check-up is arranged, he ensures that he asks about any other health concerns the patient may have at that time rather than solely undertaking the standard annual assessments.

i) He asks more in-depth questions to capture the patient's full medical history.

j) He adopts a systematic approach to his consultation and uses a checklist to ensure that nothing important is missed.

k) He is writing a letter of reflection to the optometry clinic regarding the incident, identifying areas that require improvement, what he has learned, and what steps he will take to prevent anything like this occurring again.

l) He is not working independently, and another optometrist will always be available for peer discussions and to offer second opinions. This will continue until Mr B and the directors of the optometry clinic are comfortable that Mr B's diagnosis abilities, case management, and clinical record-keeping are at the required standards.

Optometry clinic

69. The optometry clinic told HDC that since these events, it has undertaken, or is undertaking, the following:

Record-keeping

a) It conducted a review of Ms A's clinical notes completed by Mr B, which revealed shortcomings in Mr B's use of the digital patient record database.

b) It discussed with Mr B that his poor record-keeping may have contributed to a failure to identify the nature of Ms A's lesion earlier.

c) It assisted Mr B to improve his clinical record-keeping, and emphasised the importance of record-keeping standards and pointed him to the following professional guidance documents:

- The Optometrists and Dispensing Opticians Board's Standards of Clinical Competence for Optometrists*;* and
- The Civil Aviation Authority's accredited optometrist scoring sheet as an indicator of best practice.

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Policies and procedures

d) It drafted a new policy agreement, which came into effect on 1 September 2021, addressing both what the optometry clinic will do to ensure that nothing like this happens again, and also what Mr B will do.

e) It reformulated policies and procedures to prevent similar issues arising in future, including in relation to:

- Specialist referrals/referral management policies;
- Incident reporting policies and procedures; and
- An updated incident and accident reporting form for all practitioners, which must be assessed and signed by a director.

f) It adopted the Auckland Eye Manual guidelines on the management of eye growths, and ensured that all of its practitioners understand that this forms part of the optometry clinic's formal policy.

Training

g) It ensured that all staff are aware of their obligations as healthcare professionals, and reminded everyone of their professional obligations when it comes to client care.

h) It ensured that all practitioners re-familiarised themselves with the WorkSafe New Zealand guidelines regarding notifiable events, and the Optometrists and Dispensing Opticians Board's Standards of Clinical Competence for Optometrists.

70. In addition, the optometry clinic implemented a peer review system for Mr B's suggested treatment and management plan for an ocular lesion, which will remain in place for the next six months, or until the directors are confident that he is competent in this area.

Recommendations

71. I consider that Mr B has taken this matter seriously and undertaken several remedial actions to mitigate any recurrence of these events. Further to these, I recommend that Mr B:

a) Provide a written apology to Ms A for the breach of the Code identified in this report. The apology letter is to be sent to HDC within three weeks of the date of this report.

b) Undertake targeted training in the area of the identification and management of anterior segment anomalies, and on good record-keeping. Evidence of this is to be provided to HDC within six months of the date of this report. In response to the provisional opinion, Mr B organised monthly one-on-one sessions with an ophthalmologist. The sessions are scheduled to start in February 2023, and will discuss identification and management of anterior segment anomalies, specific cases, and their treatment. The sessions will also discuss good record-keeping practices. Mr B

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anticipates that he will have four sessions, which will likely be one hour each. Evidence of having completed the sessions will be provided to HDC.

Follow-up actions

72. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the Optometrists and Dispensing Opticians Board, and it will be advised of Mr B's name.

73. A copy of this report with details identifying the parties removed, except the advisor on this case, will be sent to the New Zealand Association of Optometrists and the Cornea and Contact Lens Society of New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from an optometrist, Dr Geraint Phillips:

"RE: ref: 21HDC01007

I have been asked to provide my opinion on this case concerning the care provided by [Mr B] and [the optometry clinic] to [Ms A] between September 2019 and October 2020 (inclusive).

I can confirm I have no personal or professional conflict of interest in this case.

I have been supplied with:

- Letter of complaint dated 7 May 2021
- [Mr B's] response dated 14 September 2021
- [The optometry clinic's] response dated 14 September 2021
- Clinical records from [the optometry clinic] covering the period of September 2019 to October 2020
- Clinical records from [the DHB] and [the medical centre] covering the period September 2019 to September 2021

From this information, I have been asked to provide an opinion on the following:

1. The adequacy of [Mr B's] documentation;
2. The reasonableness of the care provided by [Mr B] between September 2019 and October 2020;
3. The adequacy of [the optometry clinic's] policies and procedures in respect of referral management that were in place at the time of these events. Please comment on what policies you would expect to be in place;
4. Any other matters in this case that you consider warrant comment.

For each question, I have been asked to advise:

What is the standard of care/accepted practice?

If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be?

How would it be viewed by your peers?

Recommendations for improvement that may help to prevent a similar occurrence in future.

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1. The adequacy of [Mr B's] documentation during the period September 2019 to October 2020.

I have reviewed the documentation from the visits that took place during this period. Within these visits, the entries specific to this complaint are as follows:

13/09/2019. This was labelled as a Contact Lens Consultation.

In Notes, it states 'right conjunctival bleb temporal. gp treating with chorsig see photosw'

These are no other clinical entries for this visit. The power of the contact lenses at this visit are stated as -10.50 in both eyes.

There are anterior eye photographs of the right eye temporal lesion dated 13/9/2020.

24/08/2020. Consultation type not labelled.

In the 'Symptom' section there is no mention of questions about the previously recorded 'bleb'.

The entry in the 'Biomcr' (*Biomicroscope*) section is 'right temp conj bleb or inflamed area on temp conj'.

There is no mention of the 'bleb' in the 'Diagnosis' section.

The following is entered in the 'Management' section: '24/10/20 gp referred to hosp for right temp conj bleb. [I] suggested see private if public to long a wait'.

There is no mention of the 'bleb' in the 'Summary' section and an annual recall was advised.

21/10/20. This is in the form of a 'Pop-up Note (#14883)'. There are a series of entries.

The first includes: '— going publically for pterygium'. There is no indication who made this entry.

The second includes: 'Rang ***** back — has been referred to specialist by GP for Lump?

Pterygium? Eyes watering all the time and right eye very uncomfortable'. 'Talk to [Mr B] and see what he wants to do — [initials]'.

The third entry includes: 'Is Seeing the specialist about her eyes'. ' — [initials]'.

24/10/2020

There is a right anterior eye photograph but no corresponding visit or clinical notes.

HDC

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Generally, the level of documentation during this period is best described as minimal. For example, in the 24/08/2020 visit, there are no recordings under 'Ophthal' (*ophthalmoscopy — the examination of the posterior part of the eye*) even though in Diagnosis it states, 'early cat (*cataract*) and early AMD (*age-related macular degeneration*) right eye'. There is no mention of the findings for the left eye. The documentation for the 13/09/2019 visit only has the one entry and there is no indication of the ongoing management that was determined at this visit.

The documentation of the lesion in the form of photographs over two visits was appropriate and of high quality. However, there does not appear to be any visit notes to accompany the photographs at the 24/10/20 visit.

Specific to this complaint, the level of documentation during this period does not allow an adequate picture of what was determined from the history questions, clinical findings and most importantly, the management. The documentation gives the impression that a lesion ('bleb') was noted at the 13/09/2019 visit and that the GP was treating it with the topical antibiotic 'chlorisig' (*chloramphenicol*). A photograph was taken but there is no indication of what management plan was given at this visit.

The documentation for the 24/08/2020 visit indicates that the lesion ('bleb') was present and the management states that the GP referred the patient to the hospital, and that a private consultation was suggested if the wait for the public health system was too long. Presumably, this suggestion was for a private Ophthalmology consultation although it does not state this. There is no documentation as to whether the lesion ('bleb') had changed in size since the last visit, either from asking the patient or by reviewing past photographs. There is no documentation to show that advice was given regarding the urgency to which a private consultation should be sought nor whether a private referral was facilitated.

There is no documentation to accompany the photographs taken on 24/10/20.

It is my opinion that the accepted practice for documentation for this type of presentation would be to clearly outline the history of the lesion (eg how long had it been there, any changes in size, colour), a diagnosis or tentative diagnosis and the management. I would consider the departure from the accepted practice in this case was at the upper end of moderate and that it would be viewed by peers as below standard. My recommendation would be that accepted standards of documentation should be reviewed and adhered to.

2. The reasonableness of the care provided by [Mr B] between September 2019 and October 2020;

The main issues regarding reasonableness of the care during this period centre on the identification and management of the lesion on the temporal side of the right eye. The clinical notes on 13/09/2019 describe the lesion as a 'bleb' and that it was being treated by the GP with the antibiotic, chloramphenicol. The term 'bleb' is generally included in the description of a type of glaucoma treatment called a filtration bleb, which is not the

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case here. The photograph from this visit shows a raised, vascularised (blood vessels) lesion on the temporal conjunctiva of the right eye. The lesion appears solid and does not seem fluid-filled. That a lesion of this appearance would require and benefit from chloramphenicol should have raised further questions and investigations. The more solid appearance and the presence of the dilated blood vessels should have triggered a review of the past records to see if it was new or longstanding, especially as the patient had been seen regularly in the past. This review would have likely established whether the lesion had grown in size or changed in morphology over time. From the photograph taken on 24/10/2020 it appears that the lesion had changed shape and grown in size and this should have triggered a high degree of suspicion.

It is my opinion that the reasonableness of the care provided during this period is a moderate departure from what would be expected. It would be viewed by peers as below standard. My recommendation for improvement would be targeted training in the area of the identification and management of anterior segment anomalies.

3. The adequacy of [the optometry clinic's] policies and procedures in respect of referral management that were in place at the time of these events. Please comment on what policies you would expect to be in place;

I have been provided with:

— [The optometry clinic's] Operational Manual (undated) and a statement that includes 'The business has adopted the ODOB (*Optometrist and Dispensing Opticians Board*) Standards of Clinical Competence for Optometrists as a minimum expected standard for optometry record keeping and competence this document outlines the expectations of an optometrist which includes and is not limited to, clinical responsibilities, testing, clinical records, patient management and co-management, referrals and reviews.' 'The ODOB Standards of Clinical Competence for Optometrist can be found on the OneNote resource or on Shared documents.'

— A position description dated 3/8/2018 ('Job Title Optometrist/Administrator') that includes in the position purpose 'To provide up to date, evidence based clinical care in all facets of contemporary general optometry.'

Optometrists holding an active Annual Practising Certificate are required to abide by the ODOB Standards of Clinical Competence for Optometrists. The relevant parts of these Standards that apply to this case include:

— 1.1 — Keeps optometric knowledge, clinical expertise, skills and equipment maintained and up-to-date.

  1.1.1 Accesses relevant evidence-based material, including, but not limited to, journal articles, internet material, and textbooks, to inform clinical practice.

— 1.3 Acts in accordance with the standards of ethical behaviour of the profession.

  1.3.1 Holds patient health care interests and comfort paramount.

  1.3.2 Provides optometric services as necessary for the management of the patient.

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— 1.4 Communicates advice and information to patients and others.

  1.4.2 Maintains appropriate liaison with other professionals, including recognising and communicating significant clinical presentations to other practitioners involved in the patient's care.

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

  3.3.2 (a) Assesses and evaluates the structure and health of the anterior segment including, but not limited to, the cornea, conjunctiva, anterior chamber and aqueous humour, anterior chamber angle, anterior chamber depth, episclera, sclera, iris, pupil and ciliary body (including surgical alterations).

— 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.

— 5.1 Develops a management plan for each patient that is implemented in agreement with the patient/representative.

  5.1.2 Addresses the importance of the presenting problems and findings in the management plan and discusses options to address the patient's needs.

— 5.10 Refers patients in a timely, ethical and appropriate manner.

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

By referring to these Standards, [the optometry clinic] acted appropriately when dealing with the expectations of their Optometrists. However, even without this explicit referral to the Standards, the onus is on the registered practitioner to ensure they conform to these standards. [The optometry clinic's] Position Description includes reference to 'evidence based clinical care' for which again, the Registered Practitioner is responsible to maintain. [The optometry clinic] states that they provided a collegial environment for case discussion and were supportive by facilitating and paying for ongoing Continuing Professional Development (CPD).

It would be reasonable to expect that [the optometry clinic] would have no barriers in place relating to referral management at the time of these events, ie the ability to communicate findings in writing or orally to others, appropriate Electronic Record Systems etc.

In summary, it is my opinion that [the optometry clinic's] policies and procedures in respect of referral management that were in place at the time of these events were adequate.

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Comments on what policies you would expect to be in place in respect of referral management.

As already stated, the onus is on the Registered Practitioner to ensure they meet their Competency Standards. If the Practitioner is employed, the Employer should have policies in place that facilitate referral management, which could include for example, administrative support for correspondence, storage and retrieval of documents, IT record-keeping systems, electronic alerts and recalls. It is my opinion that it would not be reasonable for an Employer or a Practice to specify a referral management for every type and presentation of all clinical conditions. When applying Competency Standards to clinical practice, there is always an element of clinical judgement that has to be applied to each finding and each case. With diagnostic and treatment/referral criteria changing over time, the best sources of up-to-date, evidence-based information are via CPD and the current literature. Textbooks can be an appropriate source of information so long as they are contemporary.

4. Any other matters in this case that you consider warrant comment.

I have no further comments on any other matters in this case.

I would be happy to clarify any of the above comments if you would like me to do so.

Yours sincerely.

Geraint Phillips”

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Appendix B: Optometrists and Dispensing Opticians Board Standards

The Optometrists and Dispensing Opticians Board has set the following standards of clinical competence to be observed by the profession of optometry:

"…

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

…

3.3.2(a) Assesses and evaluates the structure and health of the anterior segment including, but not limited to, the cornea, conjunctiva, anterior chamber and aqueous humour, anterior chamber angle, anterior chamber depth, episclera, sclera, iris, pupil and ciliary body (including surgical alterations).

…

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.

…

7.1 Ensures that clinical data is documented in English, in a legible, secure, accessible, permanent and unambiguous manner.

7.1.1 Records all relevant information pertaining to the patient in an individual patient record promptly and in a format which is understandable and useable by another optometrist which includes, but is not limited to, information such as name and address of patient, names of examining practitioners, patient history, diagnoses, management strategies, summaries of advice given to patient, imaging information from all consultations, dates and information relating to all patient contacts, timing of review, copies of referral letters and reports, consent and therapeutic prescription."

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