

## Delayed melanoma diagnosis 21HDC01007

The Deputy Health and Disability Commissioner has found an optometrist breached the Code of Health and Disability Services Consumer's Rights (the Code).

The breach centres on a delayed melanoma diagnosis for a female consumer. The optometrist failed to undertake the appropriate investigations of the lesion on the woman's eye over the course of several visits. The melanoma was identified during a subsequent hospital admission and biopsy.

Dr Caldwell found the optometrist's failure to undertake appropriate investigations of the woman's eye lesion and appropriately document relevant information breached Right 4(1) of the Code. This gives consumers the right to services provided with reasonable care and skill.

"The optometrist fell short of several standards when he provided care to this consumer. In particular, he failed to identify and manage her lesion appropriately," Dr Caldwell said.

The optometrist's professional obligations are to ensure his clinical record-keeping is in accordance with accepted practice, Dr Caldwell noted. "It is important to maintain a high standard of documentation and, in this case, the lack of detailed documentation meant the size and significance of the melanoma's growth was not tracked accurately," she said.

Dr Caldwell recommended the optometrist provide the woman with a written apology and undertake targeted training on good record keeping and identification and management of anterior segment anomalies.

Since the event the optometrist has arranged further training, including attending continuing professional development in ocular lesions, and created a clinical record-keeping system with an internal peer review audit. Dr Caldwell has recognised these remedial actions as indicating the optometrist has taken the breach seriously.

The clinic, which was not found to have breached the Code has also taken a number of actions in response to the incident, including reviewing the optometrist's record keeping, drafting a new policy agreement and undertaking additional staff training.

## Editor's notes

The full report of this case will be available on HDC's <u>website</u>. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

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

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendations.

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