Optometrist, Ms B

A Report by the
Deputy Health and Disability Commissioner

Case 17HDC01046

Contents

Executive summary

1. On 5 December 2015, Mrs A presented to an optometry clinic (the clinic) for a check-up. She told optometrist Ms B that she had floaters,[1] deteriorating vision, and inferior visual obstruction to her right eye.

2. Ms B performed an examination but found no abnormalities. She did not specifically examine the retina. Ms B did not provide Mrs A with relevant and clear follow-up advice for what to do in the event that she experienced further deterioration in her right eye.

3. Mrs A's vision deteriorated, and on 7 January 2016 she was found to have right eye retinal detachment, which required immediate surgery.

Findings

4. By not recognising that a dilated retinal examination of Mrs A's right eye was indicated on 5 December 2015, and by not providing clear follow-up advice to Mrs A in the event that she experienced further deterioration in her right eye, Ms B failed to provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[2]

Recommendations

5. The Optometrists and Dispensing Opticians Board of New Zealand advised HDC that Ms B has retired from practice. It was recommended that the New Zealand Optometrists and Dispensing Opticians Board conduct a review of Ms B's competence should she return to practice, and report the results to HDC.

6. Ms B provided Mrs A with an apology on 16 September 2016.

Complaint and investigation

7. The Commissioner received a complaint about the services provided to Mrs A by an optometrist, Ms B, at an optometry clinic. The following issues were identified for investigation:

- *Whether Ms B provided Mrs A with an appropriate standard of care on 5 December 2015.*
- *Whether the clinic provided Mrs A with an appropriate standard of care on 5 December 2015.*

[1] Spots in vision.
[2] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

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

9. The parties directly involved in the investigation were:

Mrs A	Consumer
Ms B	Optometrist/provider
Optometry clinic	Provider

Also mentioned in this report:

Mr C	Optometrist
Dr D	Ophthalmologist

10. Independent expert advice was obtained from an optometrist, Ms Barbara Shaw, and is included as Appendix A.

Information gathered during investigation

11. On 5 December 2015, Mrs A, aged 58 years at the time, attended an appointment as a new patient with optometrist Ms B[3] at the clinic.

12. Mrs A has a history of myopia,[4] which previously has been corrected surgically.

13. Mrs A explained her visit in a letter to HDC dated 13 June 2017:

> "My visit was to get a pair of prescription glasses (for close vision) but also to consult with an 'expert' regarding the very sudden appearance of a large floater[5] in my right eye and the sudden deterioration of vision in that eye. I had a strange shadowing at the bottom of my eye which I described as almost as if my vision was being obstructed by something or that my cheek was extremely swollen as I could not see downwards."

14. Ms B recorded the reason for the visit as:

> "[First] time to us, developed floaters a few days ago in [right eye], no history of cause, no flashes, no migraines, uses [distance prescription two years old] and hobbies, may want [progressives]."

15. Ms B told HDC that she used an ophthalmoscope[6] to examine Mrs A's eyes. Ms B said that she did not consider it necessary to dilate the eye using dilating eyedrops to help her to

[3] At the time of the event, Ms B was a locum optometrist on a fixed-term contract.
[4] Short-sightedness — light cannot focus on the retina, which causes faraway objects to appear blurry.
[5] Spot in vision.
[6] An instrument for inspecting the retina and other parts of the eye.

view the retina more easily because Mrs A had only "floaters", which are common. Ms B documented that all quadrants were checked in both eyes. She told HDC that she found no abnormalities such as a retinal detachment.[7]

16. Ms B also found an optic nerve appearance consistent with previous myopia but nothing of concern.

17. Ms B told HDC that although she did not document this discussion with Mrs A, as a matter of habit she advises her patients about the "4 F's" (**F**ailing vision, increased **F**loaters, increased **F**lashes and/or a **F**alling veil over their vision), and ensures that they know to present for urgent attention should any of the symptoms occur.

18. Mrs A told HDC that Ms B advised her that "everyone gets floaters and she would get used to it", and that she left feeling "a bit chastised and foolish".

19. Mrs A continued to have floaters, so on 7 January 2016 she underwent a further right eye examination at the clinic, which was carried out by optometrist Mr C. Mr C identified a retinal detachment, and immediately referred Mrs A to an ophthalmologist. Mrs A underwent an urgent pneumatic retinoplexy.[8]

Further information

Ms B

20. Ms B told HDC that had Mrs A reported the symptoms discussed in her letter dated 13 June 2016, then she would have dilated Mrs A's retina and would likely have referred her to an ophthalmologist urgently. Ms B said that because Mrs A presented with only one of the "four Fs" (the floater), she did not feel it necessary to perform a dilated retinal examination.

21. Ms B also told HDC that her documentation "was not as fulsome and accurate as it might have been". She explained that as a locum she was unfamiliar with the clinic's electronic record system and the severe time restraints she had with 20-minute time restrictions on the appointments. She told HDC that since the event she has improved her record-taking and now documents all her findings and the advice or recommendations she gives.

22. As a result of this complaint, Ms B now recommends to all patients who present with any of the "four Fs" that dilation be performed to enable a better view of the retina.

23. Ms B provided a written apology to Mrs A on 16 September 2016.

The clinic

24. The clinic advised that it has an orientation programme for its locum staff that includes the environment, electronic record system, and all equipment. It also has an open-door policy to enable discussion and peer review at any time.

[7] An emergency when part of the eye (the retina) pulls away from supportive tissue.
[8] Surgical repair of the detached retina.

25. The clinic said that it does not have a policy specifically targeted at dilation of the eye for retinal examination. It said that it adopts the New Zealand Optometrists and Dispensing Opticians Board *Standards of Clinical Competence for Optometrists*, which ensures that appropriate testing is carried out by all optometrists. The clinic stated:

> "It is an expectation in line with registration standards that the optometrist explores and responds to the patient's presenting concerns and formulates an examination plan to obtain the information necessary for diagnosis and management. It is also expected that the optometrist exercises clinical judgement and conducts appropriate tests that are relevant to the investigation. These should be documented along with advice given and management plan."

26. The clinic advised that it does not have a policy specifically relating to appointment times. It said:

> "[C]onsult times will vary for different patients. Our clinic structure allows the optometrist as much time as necessary in which to conduct appropriate tests, review them and make recommendations or referrals as necessary. The time taken with the patient is determined by the relevant optometrist. Our clinic structure also includes 'administrative duty' timeslots which can be used to allow optometrists and patients to complete important follow up tests including dilated fundus examinations, as well as to complete paperwork as required."

Responses to provisional opinion

27. Ms B was provided with an opportunity to comment on the provisional opinion, but had no comment to make.

28. The clinic was provided with an opportunity to comment on the provisional opinion. The clinic advised HDC that it was open during the holiday period of 2015/16, and that Mrs A could have been seen earlier than 7 January 2016. The opinion has been updated to reflect that information. The clinic did not have any further comment to make.

Opinion: Ms B — breach

29. Mrs A presented to the clinic with a history of myopia, and was examined by optometrist Ms B.

30. There are differing accounts of the symptoms Mrs A presented with, but both parties agree that Mrs A had "floaters" in her right eye.

31. Ms B used an ophthalmoscope to examine Mrs A's eyes, and found nothing of concern. Ms B did not dilate Mrs A's pupil to allow a better view of the retina, as she did not consider it necessary to do so.

32. My expert advisor, Mrs Barbara Shaw, advised that a person with a history of myopia is at more risk of a retinal tear or detachment, and on the basis of the presenting symptom of floaters, the accepted standard of care is to undertake a dilated retinal examination. Mrs Shaw advised that not performing or organising a dilated retinal examination at the earliest opportunity was a departure from the accepted standard of care. She said:

> "Considering the 4F's of risk of retinal detachment being **F**lashes, **F**loaters, **F**ailing vision, veil **F**alling over vision, when **any** one of these symptoms are reported, a thorough dilated retinal examination needs to be undertaken to eliminate any peripheral pathology beyond where the retina can be seen through an undilated pupil. [Mrs A] was a previous myope which means she will have a life-long increased risk of retinal detachment."

33. I accept Mrs Shaw's advice. Mrs A's history of myopia and new floater symptoms indicated the need for a dilated retinal examination. Without this, Ms B could not exclude the possibility of a retinal tear or detachment, and I am critical that she did not consider it necessary to conduct this examination.

Follow-up advice

34. Mrs Shaw was also critical of Ms B's documentation, and I share her concern. It is unclear what follow-up advice Mrs A was given should further symptoms arise.

35. Ms B considers that she would have advised Mrs A about the "4 Fs" and the importance of seeking urgent treatment. However, the documentation does not support this conversation having taken place. Ms B has acknowledged that her documentation was not "as fulsome and accurate as it might have been".

36. Mrs A advised HDC that she left the appointment feeling "chastised and foolish".

37. On the basis of the information available, I consider it more likely than not that Ms B did not give Mrs A the relevant follow-up advice. Further, even if advice were given, it did not clearly portray to Mrs A that she should seek urgent treatment when her floaters continued, which is supported by the fact that she waited until 7 January 2016 to seek advice.

38. Guided by Mrs Shaw's advice, I consider that Ms B should have provided Mrs A with clear follow-up instruction — preferably in the form of written material to be taken away and referred to later — to return promptly if she experienced any further deterioration.

Conclusion

39. By not recognising that a dilated retinal examination of Mrs A's right eye was indicated on 5 December 2015, and by not providing clear follow-up advice to Mrs A in the event that

she experienced further deterioration in her right eye, Ms B failed to provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code.[9]

Opinion: The clinic — no breach

40. As a healthcare provider, the clinic is responsible for providing services in accordance with the Code. In this case, I consider that the error that occurred does not indicate broader systems or organisational issues at the clinic. Therefore, I consider that the clinic did not breach the Code directly.

41. In addition to any direct liability for a breach of the Code, under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority is vicariously liable for any acts or omissions of its employees. A defence is available to the employing authority of an employee under section 72(5) if it can prove that it took such steps as were reasonably practicable to prevent the acts or omissions.

42. At the time of this event, Ms B was an employee of the clinic and was working as a locum optometrist on a fixed-term contract.

43. The clinic does not have a specific written policy that would be relevant to the event in question. It adopts the Standards of Clinical Competence for Optometrists to ensure that its optometrists exercise clinical judgement and conduct the appropriate tests to obtain the information necessary for diagnosis and management.

44. The clinic advised that Ms B received orientation regarding the environment, equipment, and computer system at its store. It also advised that it has an open-door policy so that staff can access help if they need it.

45. It is Mrs Shaw's opinion that the clinic has systems in place to allow for extra testing if required, including a dilated retinal examination. I am guided by Mrs Shaw's advice.

46. I am satisfied that the clinic took reasonably practicable steps to prevent Ms B's errors. Accordingly, I find that the clinic is not vicariously liable for Ms B's breach of the Code.

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

Recommendations

47. The Optometrists and Dispensing Opticians Board of New Zealand has advised HDC that Ms B has retired from practice. I recommend that the New Zealand Optometrists and Dispensing Opticians Board conduct a review of Ms B's competence should she return to practice, and report the results to HDC.

48. I note that Ms B provided Mrs A with an apology on 16 September 2016.

Follow-up actions

49. A copy of this report will be sent to the New Zealand Optometrists and Dispensing Opticians Board, and it will be advised of Ms B's breach of the Code.

50. 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 advice to the Commissioner

The following expert advice was obtained from an optometrist, Mrs Barbara Shaw, on 12 November 2017:

> "In response to the Commissioner's request for an opinion on case **C17HDC01046** I have read and agree to follow the Commissioner's Guidelines for Independent Advisers. I have no conflict, professionally or privately, in this case.
>
> I have a Diploma of Optometry (1981) and a Certificate in Ocular Pharmacology (therapeutics, TAPIOT) 2006 from the University of Auckland. I have been in private independent practice since February 1982, and I am employed by a large, multi-practitioner practice that I previously co-owned. The practice is involved in general optometry and complex contact lens fitting including referrals from colleagues and ophthalmologists. I am also a current examiner for the CAA in New Zealand.
>
> In the case presented, the Commissioner requests information and advice on whether the care provided to [Mrs A] by [Ms B] was reasonable in the circumstances, and why. In particular matters on the following issues: The appropriateness of the examinations performed by [Ms B] during the appointment of 5 December 2015. Whether a diagnosis of retinal detachment could have been made by [Ms B] on [Mrs A's] clinical presentation. Any other matters in this case that you consider warrant comment. For each question, I have been asked to advise on: 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 do I consider it to be? How would it be viewed by my peers? Recommendations for improvement that may help to prevent a similar occurrence in the future.
>
> *General information*
> To assist the Commissioner I would like to provide some general information that will be helpful in understanding the opinion that I provide. The vitreous (the gel within the eye) is attached to the retina and in some people starts to degenerate with age, shrinking and causing a detachment from the underlying retinal layers. When the vitreous detaches from the retina, it is called a Posterior Vitreous Detachment (PVD). If this detachment occurs around the optic nerve, a large floater (shadow) is created that is very visible to the patient in the central area of vision. This is called a Weiss Ring. The PVD can be uncomplicated or complicated. An uncomplicated PVD is when the vitreous detaches cleanly without any points of residual adhesion to the retina. A complicated PVD is where the vitreous does not detach cleanly and remains attached at one or more points. This can cause tugging on the underlying retinal layers. This often, but not exclusively, will cause symptoms of floaters and/or flashes of light. The vitreous may still subsequently detach cleanly, without further complication and then it becomes regarded as uncomplicated from that time. However, if the tugging on the retina is significantly strong it can cause a retinal tear or hole. Once a hole or tear occurs there is a very high risk of retinal detachment. Sometimes the floater or

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

floaters are the only symptoms of a retinal tear or detachment. Another definitive symptom of a retinal detachment is a visual field loss. A short-sighted (myopic) person usually has eyes that are larger than average, which makes the retina less robust than a long-sighted person (hypermetropic) who has smaller eyes. An analogy to this is to consider the retina like a balloon that is hyper-inflated and stretched compared to an under-inflated balloon. Refractive surgery corrects the optical error of the eye but does not alter the retina. Therefore when examining a patient who was myopic and has had refractive surgery from an eye health point of view, the eye must still be viewed as myopic. A myopic person is more at risk of a retinal tear and/or retinal detachment. A patient presenting with new floaters needs to have a thorough dilated fundus (retinal) examination. An un-dilated pupil is too small to allow a thorough investigation of the peripheral retina.

On the NZ Association of Optometrists website (www.nzao.co.nz/comprehensive-eye-examination) there is a webpage on what to expect in a comprehensive eye examination. The webpage states that a dilated fundus examination will often be required to complete a thorough retinal examination. When Optometrists undertake a dilated fundus examination it is standard practice to record the drug used to dilate, the concentration, the time instilled, in addition to the batch number and expiry date of the drug.

When a patient presents with a new floater <u>and</u> a visual field loss, the initial differential diagnosis should be presumed to be a retinal detachment until proven otherwise. All patients deemed to have a PVD should also be warned of the signs and symptoms of a retinal detachment. These are called the **4F's. F**ailing vision, increased **F**loaters, increased **F**lashes and/or a **F**alling veil over their vision. The patient should also be warned that should any of these symptoms occur, they need to seek urgent immediate attention, on the same day and to attend hospital ED if out of business hours or an Optometrist/Ophthalmologist if within business hours. The issuing of this warning should be noted on the patient clinical file.

In response to the Commissioner's request, I make the following comments:

The appropriateness of the examinations performed by [Ms B] during the appointment of 5 December 2015

[Mrs A] presented to [Ms B] with symptoms of a new large floater in her right eye in conjunction with a sudden deterioration of vision and an obstruction/shadowing in the lower part of her vision. [Mrs A] likened the obstruction in her lower right eye vision to be similar to having a swollen cheek. [Mrs A] reported that she had previously undergone refractive surgery. [Ms B] undertook an examination and did not find anything of concern, but noted vitreous floaters and an optic nerve appearance consistent with previous myopia.

Reviewing the clinical notes from the examination on 5 December 2015, I refer to page 3 of 3 under the section 'external examination and ophthalmoscopy'. There are

options on the clinical record to record how the retina was examined. [Ms B] has not filled this section in and the following is recorded as a default: Direct — no; Indirect — no; Volk — no; Dilated — no; slit lamp — no. Usually the optometrist will change on the record, one or more of these methods to 'yes' to indicate how the retina was examined. Therefore it is unknown what methodology [Ms B] used to examine [Mrs A's] retina. [Ms B] must have used one or more of these methods as the clinical records show findings that cannot be found without one or more of these procedures.

Referring to the general information provided above, the presenting symptoms of a retinal detachment must be the primary differential diagnosis until proven otherwise. Therefore it is essential that a dilated fundus (retinal) examination is undertaken, as an un-dilated pupil is too small to allow a thorough investigation of the peripheral fundus. **Not to undertake a dilated fundus examination in these circumstances is a departure from the accepted level of care and would be regarded as a serious departure of standards.**

Further information from [Mrs A] was requested from the Commissioner, at my request, in regard to the consultation on 5 December 2015. [Mrs A] was asked by the Commissioner if dilation drops had been administered to her by [Ms B] on 5 December 2015. [Mrs A] could not recall if dilating drops had been administered by [Ms B] at this consultation. So the question is whether a dilated fundus examination was in fact undertaken or not by [Ms B] on [Mrs A] on 5 December 2015. No such examination was documented. If a dilated fundus examination was undertaken, there should have been a record of the drug used, concentration, time of instillation, batch number or expiry. **Failure to record this would be regarded as a mild departure from accepted standards.**

A dilated examination requires more examination time than typically is allocated in a standard or routine examination. However, in exceptional circumstances such as the case of [Mrs A], [Ms B] should at the very least have rescheduled a time for a dilated fundus examination at the earliest possible time that same day. Ideally this should have occurred at the time of initial presentation irrespective of how late [Ms B] would run for subsequent examinations. [The clinic] has provided a 'Review of store processes' that states that their clinic structure allows time for such cases as an urgent dilation. [Mrs A] reported, on 5 December 2015, a loss of vision in the lower part of her right eye as if her cheek was swollen (her cheek was not swollen). The clinical records provided by [the clinic] show a record of [Mrs A's] visual field test completed on 5 December 2015. This visual field test only assesses the central twenty degrees of field of view and certainly would not show a peripheral retinal detachment. As a result, this visual field test result cannot confirm the existence of a retinal detachment.

Referring to the general information provided above regarding the warning about the 4Fs; there is no documentation from [Ms B] to say that she warned [Mrs A] of the symptoms and risks of retinal detachment. If [Ms B] had warned [Mrs A] of these

symptoms and risks, then [Mrs A] may well have acted sooner to seek further advice. **Failure to advise [Mrs A] of the importance of these symptoms and risks is a significant departure of accepted level of care.**

Whether a diagnosis of retinal detachment could have been made by [Ms B] based on [Mrs A's] clinical presentation.

As noted above, given the presenting symptoms, a retinal detachment should be the primary differential diagnosis. As [Mrs A] was myopic prior to her refractive surgery some years prior, the risk of detachment is even greater. Given the lack of clinical notes regarding the methodology of retinal examination and the fact there is no information about whether dilating drugs were used, I have assumed that a dilated fundus examination was not undertaken. [Ms B] was unable to see any anomaly through a 'presumed' un-dilated pupil. A dilated examination should have been performed. [Ms B] would then have been able to undertake a thorough examination of the peripheral retina.

[Mrs A] consulted [Mr C] on 7 January 2016 (not 6 January as documented by [Mrs A]) and she advised him that her vision was getting worse. [Mr C] saw the detachment with an un-dilated pupil that [Ms B] had not seen on 5 December 2015. It is probable that the detachment got larger between 5 December 2015 and 7 January 2016 and could by then be seen through an un-dilated pupil. **This re-iterates the need to dilate all patients presenting with a history of new floaters/flashes of light. It is my opinion that [Ms B] should have been able to diagnose a retinal detachment on 5 December 2015 had she performed a dilated fundus examination.**

Any other matters in this case that you consider warrant comment

[Ms B] was working as a locum at [the clinic] when she saw [Mrs A]. It is important locum Optometrists are advised and are aware of [the clinic's] procedures where they are working. This includes the knowledge that there is time to perform urgent procedures, such as dilations and there is support from staff to facilitate this. It appears that [the clinic] does have an allocation of time for performing urgent procedures as per the 'Review of Store Process' provided to the Commissioner. It is important that this is clearly communicated and fully understood by the locum.

In summary: Given the symptoms of [Mrs A], it is NZAO standard practice to complete a dilated fundus examination. There is no evidence that a dilated fundus examination was undertaken. If a dilated fundus examination had been competed it should then have been possible to view a superior retinal detachment in the right eye, thus allowing for the appropriate action to be taken. [Ms B] should have, at the very least, warned [Mrs A] of the symptoms and risks of a retinal detachment and have told her of the upmost urgency in seeking further advice should any of these symptoms occur.

Yours sincerely

Barbara Shaw
Optometrist DipOpt Cert Oc Pharm (TAPIOT)"

Further advice was received on 9 September 2018:

> "In response to the Commissioner's request for an opinion on case: C17HDC01046 I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. I have no conflict professionally or privately in this case.
>
> I have a Diploma of Optometry (1981) and a Certificate in Ocular Pharmacology (therapeutics, TAPIOT) 2005 from the University of Auckland. I have been in practice for 36 years. I co-owned one of the largest optometry practices in the South Island employing 22 staff including four Optometrists, spread over three sites, until December 2014. At that time the practices were sold and I remain an employee/consultant optometrist, within the same practice, 3 days per week. The practice specialises in general optometry and contact lenses including complex referrals from colleagues and ophthalmologists.
>
> In the case presented, the Commissioner requests my review of the documents provided and responses from both [Ms B] and [the clinic]. In particular, the Commissioner has asked whether the responses to notification alters my advice with regards to the severity of the breaches.
>
> In reply to the letter of response written on behalf of [Ms B] by [her lawyer] dated 2 July 2018:
>
> Point 3.1 of this letter states 'The electronic record card completed by [Ms B] at the time of [Mrs A's] consultation recorded the reason for [Mrs A's] visit as follows: Developed floaters a few days ago in RE, no history of cause, no flashes, no migraines'.
>
> The letter of complaint from [Mrs A] to the HDC dated 13 June 2016 states:
>
> 'My visit was to get a pair of prescription glasses (for close vision) but also to consult with an "expert" regarding the very sudden appearance of a large floater in my right eye and the sudden deterioration of vision in that eye. I had a strange shadowing at the bottom of my eye which I described as almost as if my vision was being obstructed by something or that my cheek was extremely swollen as I could not see downwards.'
>
> Both parties agree there were floaters. On the basis of the presenting symptoms of new floaters which [Ms B] records, large or otherwise, it would be the accepted standard of care to undertake a dilated retinal (fundus) examination.
>
> Retinal photographs are inadequate to exclude a retinal tear or detachment as the photos do not show enough of the peripheral retina. This is documented in the letter from [Dr D], Ophthalmologist, to [Mrs A] dated 26 July 2016. [Dr D] states at the end of point 1: 'yet your presentation with a large central floater and a visual field abnormality imply that posterior vitreous detachment would have been present'.

[Dr D] also states in point 2: 'this does not categorically mean there is a retinal tear or detachment at the time. However, the shadow in the right visual field is highly suggestive of rhegmatogenous retinal detachment at that time'.

Furthermore in point 2, [Dr D] states: 'Your description of the visual field abnormality in conjunction with the sudden onset of a floater in the right visual field the large floater and visual field abnormality warrants concern and a thorough examination of your peripheral retina in order to exclude a retinal tear or detachment. The previous ocular history of myopia that has been lasered to correct your vision, in addition to these symptoms, makes detailed peripheral retinal examination all the more important in your situation.'

The only way to thoroughly examine the peripheral retina is via a dilated retinal examination.

Given the presenting symptoms reported by [Mrs A], the failure to undertake a dilated retinal examination at the earliest opportunity and certainly within the day, would be viewed as a departure from the accepted level of care and would be regarded as a serious departure of standards. For the reasons given above, my opinion on the need to undertake a dilated retinal examination remains unchanged.

[Ms B's lawyer] responded to the HDC on behalf of [Ms B] in his letter dated 20 September 2017.

Point 12.1 of this letter states:

'Clinical notes — the external advisor considers that the clinical notes presented are sparse in detail and well under the standard expected of a reasonable optometrist. [Ms B] does not accept the criticism of the external clinical advisor ...'.

Point 12.8 states: '[Ms B] is absolutely confident that [Mrs A] did not report deteriorating vision or an inferior obstruction as [Ms B] would have recorded such matters in [the clinic] notes had they been reported.'

However in [the lawyer's] reply dated 2 July 2018, point 8, [he] states 'As noted [Ms B] has accepted that her note taking in respect of [Mrs A's] consultation was less than ideal'.

Returning to the letter from [Ms B's lawyer] dated 20 September 2017, I draw the Commissioner's attention to page 6, point 17. [The lawyer] states:

'We consider the more likely scenario is that [Mrs A] has conflated the two consultations at [the clinic], (the one with [Ms B] on 5 December 2015 and the one with [Mr C] on 7 January 2016), the latter visit being most likely when she was suffering reduced vision and large floaters due to her then existing retinal detachment. Whilst [Ms B] accepts that her notes could be more fulsome, they do

adequately record the history, examination and outcome and she is confident that she carried out the examination appropriately and identified any issues of concern.'

Please note, it is simply a matter of fact that the clinical notes recorded by [Ms B] for the consultation on 5 December 2015 state: '… developed floaters a few days ago in RE, no history of cause, no flashes, no migraines ...'

There is no doubt that [Mrs A] was examined by [Ms B] on 5 December 2015 and presented with these symptoms. The issue is that, given these findings, [Ms B] did not follow the accepted standard of care and undertake a dilated retinal examination.

There is not a conflict between the symptoms [Mrs A] described and those recorded by [Ms B]. [Mrs A's] description is simply more detailed. Both acknowledge new onset floaters.

In [Ms B's] letter to [Mrs A] dated 16 September 2016, [Ms B] states: 'It seems I was remiss in not recording more detailed notes as to my findings or instructions to you. I appreciate you bringing the matter to my attention as it has highlighted the importance of detailed record taking and patient instruction I must make in future.' [Ms B] acknowledges that she had not recorded detailed notes.

When a patient presents to a practice with new floaters, a thorough peripheral dilated retinal examination should be undertaken. This is the accepted standard of care.

Considering the 4F's of risk of retinal detachment being Flashes, Floaters, Failing vision, veil Falling over vision, when any one of these symptoms are reported, a thorough dilated retinal examination needs to be undertaken to eliminate any peripheral pathology beyond where the retina can be seen through an undilated pupil. [Mrs A] was a previous myope which means she will have a life-long increased risk of retinal detachment regardless of having laser surgery.

Whilst I acknowledge and agree with [Dr D] that it is possible that a retinal tear may or may not have been present at the time of consultation with [Ms B], [Mrs A's] presenting symptoms were highly suggestive of a rhegmatogenous retinal detachment being present as reported by [Dr D].

Given her previous myopia and life-long increased risk of retinal detachment in conjunction with the sudden onset of floaters, a dilated retinal examination should have been undertaken.

[Ms B] reports that no dilation was undertaken, even though [Ms B's] clinical notes state 'developed floaters a few days ago in RE'. The accepted standard of care requires a dilated retinal examination. Per [Ms B's lawyer's] letter dated 2 July 2018, point 4, '[Ms B] remains of the view that a dilated retinal examination was not necessary at the time that [Mrs A] consulted with her. The symptoms upon presentation involved only one of the 4F's, that being a developed floater'.

This view does not comply with the accepted standards of care.

This is supported by both [Dr D] and the expert clinical advisor for ACC.

Also, in the letter from [the lawyer] dated 2 July 2018, point 3.6 states: '[Ms B] considers that she definitely would have warned [Mrs A] of the importance of the symptoms of the 4F's as this is her invariable practice'.

However, there was no clinical documentation that advice of the 4F's was given nor the urgency of treatment should further symptoms arise. It would be normal practice to record in the consultation notes that this information had been given to the patient. Also, written documentation would ideally be given to the patient outlining the urgency of further care should symptoms change.

[Mrs A] reports (page 3 of [Mrs A's] letter to the HDC, dated 13 June 2016) 'I was sure my vision had deteriorated even more'. Had [Mrs A] been aware of the risks and symptoms of retinal detachment she should have understood the urgency to attend the emergency department at the local hospital over the statutory holidays and not wait until [the clinic] reopened.

It appears that [Mrs A] did not understand the potential serious nature of the floaters or a further deterioration of vision/symptoms.

Even if the presenting symptoms were only as [Ms B's] notes state: 'developed floaters a few days ago in RE', it is my opinion and the opinion of the expert clinical advisor for ACC and [Dr D], that [Ms B] should have arranged an appointment to undertake a dilated retinal examination. The dilation should have been at the earliest opportunity and certainly within two weeks, or urgently (same day) if any further symptoms of the 4F's were present or developed subsequently. A failure to arrange an appointment for a dilated retinal examination for new and sudden onset floaters would be regarded as a moderate departure from accepted standards.

In response to [the clinic's] reply it states that they have undertaken a clinical practice review and in addition they have fortnightly clinical peer reviews on case studies. The response from [the clinic] states that the clinical structure allows the optometrist as much time as necessary to conduct appropriate tests. It is my opinion that [the clinic] has the systems in place to allow extra time for further testing such as a dilated retinal examination should it be required.

Therefore there was no time constraint reason for [Ms B] to omit undertaking a retinal dilated examination.

In summation

- It is my opinion that a dilated retinal examination should have been undertaken because [Mrs A] presented with new floaters in the right eye.

- [Ms B] has not followed accepted standard of care when diagnosing one of the 4F's.
- [Mrs A] was previously myopic (short sighted) prior to laser surgery, which means she has a life-long increased risk of retinal detachment.
- There is no evidence that [Ms B] gave information to [Mrs A] outlining the importance of seeking urgent care should a change in [Mrs A's] symptoms occur.
- [Ms B] has reported that she has made positive changes to her clinical practice as noted in her response to the HDC dated 2 July 2018."