Follow-up visual field testing
17HDC00550, 24 August 2018

District health board ~ Eye clinic ~ Ophthalmologist ~ Ophthalmology service ~ Glaucoma ~ Follow-up testing ~ Delays ~Demand ~Prioritisation system ~ Right 4(1)

A man had been a patient of a DHB ophthalmology service since 2006 for the treatment of his complex glaucoma. In 2012, testing of the man's visual field showed that he had a visual field index (VFI) of 80% vision bilaterally. In November 2014 the man had visual field testing, following which he was referred for ongoing ophthalmology review. In October 2015, the man was seen by a locum consultant ophthalmologist who deferred the man's next visual field test scheduled for November 2015 to April 2016 (i.e., five months later). The DHB reported that this deferral was made without a documented reason and that there was no way to identify that the visual field testing regimen had been missed or extended. The locum explained that he thought it would be best to do the visual field testing after the man's cataract surgery, as a cataract can interfere with the outcome of a visual field test, and a more accurate representation could be obtained after the surgery. The man underwent left cataract surgery privately in November 2015.

As the man's visual field testing appointment in April 2015 approached, his wife contacted the ophthalmology service on several occasions regarding a specific appointment date. The planned April 2016 appointment did not go ahead for the man until the end of July 2016. At that stage, it had been approximately 18 months since the man's previous visual field test in November 2014. The July 2016 visual field testing showed advanced glaucomatous changes requiring urgent review. In early August a consultant ophthalmologist reviewed the man and advised that because of his glaucoma and visual field defects, the man was not fit to drive. Following further ophthalmology/surgical reviews the man's left eye was deemed to be extremely high risk and further surgery was performed.

The DHB stated that the reason for the delay in the visual field appointment was related to demand on the DHB service. In relation to processes in place at that time to clinically prioritise patients for specialist follow-up and visual field testing, the DHB told HDC that administration staff booked the short-term follow-ups and urgent patients into the regular appointment slots within the time frame identified by the ophthalmologist, and that the remaining slots were assigned to the patients who had been waiting the longest. At the time, an acuity tool was not utilised.

Findings

The DHB's failure to address the demands on its ophthalmology service let the man down. It was wholly inappropriate for the DHB booking staff to be tasked with the important responsibility of prioritising ophthalmology follow-up appointments without sufficient information on which to base prioritisation decisions, and clear direction about what might constitute a higher risk patient requiring clinical escalation.

Although the deferral of the man's visual field testing from November 2015 to April 2016 was clinically defensible owing to his surgery, the man still required effective prioritisation of his testing to ensure timely and ongoing monitoring of his glaucoma. The DHB reported that there was no way to identify that the visual field testing regimen had been missed or extended. The key failure in this case was the failure to prioritise the man's visual field testing in light of his established glaucoma. While the man's clinicians may have been aware

of his testing regimen and the date for the planned visual field testing, rather than prioritising the man's visual field testing based on clinical need, at the time of events administrative processes determined who was seen. In this context, the Commissioner considered that a further three-month delay in the man's visual field testing — from April to July 2016 — was not appropriate.

The DHB did not provide services to the man with reasonable care and skill and, accordingly, breached Right 4(1).

Recommendations

In an HDC case completed earlier this year, the Commissioner made a series of detailed recommendations in respect of the DHB regarding its ophthalmology service. The Commissioner indicated that the same recommendations apply to this case. The Commissioner also recommended that the DHB continue to audit the remedial actions being taken to shift patients to clinically appropriate times, and that the DHB apologise to the man.