Assessment of eye injury
18HDC00253, 15 October 2019

Ophthalmologist ~ Senior medical officer ~ District health board ~ Eye injury ~ Assessment ~ Telephone consultation ~ Right 4(1)

A man attended the emergency department (ED) at a public hospital after being hit in the eye by a firework. He was examined by a senior medical officer (SMO), who telephoned an ophthalmologist to consult about diagnosis and treatment of the injury. The SMO told the ophthalmologist that the man's injury had been caused by a firework, and listed the following symptoms:

- The left eyelid was swollen (oedema);
- There were first-degree burns to the skin of the lower eyelid;
- Several lower eyelid lashes were burnt, singed, or missing;
- The left pupil was non-reactive and in a mid-fixed position;
- There was no laceration;
- The contour of the eye felt normal;
- The man could not visualise anything out of the left eye; and
- The pH level of the left eye was 10.

The ophthalmologist advised the SMO to diagnose the man's eye injury as superficial and to commence a treatment plan appropriate for someone with a superficial eye injury. However, it was found that the man had a serious eye injury.

Findings

It was found that the SMO gave the ophthalmologist sufficient information to alert him to the possibility that the man's eye injury might be severe, and that the ophthalmologist needed to attend the ED to assess the man himself. The failure to attend meant that the injury was not assessed appropriately, in a timely manner. Accordingly, the ophthalmologist failed to provide care to the man with reasonable care and skill and breached Right 4(1).

Comment was made on the duty that all DHBs owe to staff who have been educated outside of New Zealand, to ensure that they understand the functions and responsibilities of different practitioners in the New Zealand health sector.

Recommendations

It was recommended that the ophthalmologist apologise to the man, confirm the implementation of his new practice of managing telephone consultations and review the effectiveness of that practice, and reflect on his failure to seek sufficient information from the SMO.

It was recommended that the DHB:

- Implement procedural guidelines for firework-related ocular injuries to ensure that those injuries that require immediate specialist ophthalmological review receive that review.

- Review its procedures related to employed medical staff to ensure that staff are aware of the contracts and procedures for contracted specialist on-call services. This review should include consideration of the specific training needs that staff educated outside of New Zealand may have.
- Confirm that improved lines of communication and education between the eye clinic and the emergency department have been implemented, and conduct a review of the effectiveness of those improved lines.