Department of Corrections
General Practitioner, Dr B

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC00296)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided by a general practitioner (GP) and the Department of Corrections (Corrections) to a man with a history of issues in his right eye. Despite the man having symptoms of a potential ophthalmological emergency there was a four-day delay in him being seen by Corrections' healthcare staff, and a formal visual acuity test was not completed on several occasions. The report highlights the importance of ensuring that consumers are seen within an appropriate timeframe, and of completing the appropriate tests when consumers present with eye concerns.

2. The man was first seen by the GP for eye concerns four days after the man requested a medical review. During his assessment, the GP documented the man's eye symptoms but failed to carry out a formal visual acuity test. The GP also did not check the man's medical history, which included a specific eye condition (iritis). The GP prescribed two different topical antibiotic eye drops. The man continued to experience symptoms, and asked to be seen again. He was seen on two occasions by two different nursing staff, both of whom failed to record carrying out a formal acuity test. The man was later diagnosed with iritis.

Findings

Department of Corrections

3. The Deputy Commissioner found Corrections in breach of Right 4(1) of the Code for the initial four-day delay in the man being seen when he had symptoms of a potential ophthalmological emergency, and for the minor deficiencies in nursing care.

GP

4. The Deputy Commissioner found the GP in breach of Right 4(1) of the Code for failing to undertake a visual acuity test; for not accessing the man's health records; and for prescribing two different topical antibiotics (which did not represent good antimicrobial stewardship).

Recommendations

5. The Deputy Commissioner recommended that Corrections provide evidence of the staff training on assessment and management of acute red eye; report back on the outcome of its discussion around adherence to best practice, including an understanding of red flags and focusing on presenting symptoms and signs, instead of the behaviour or personality of the patient; undertake an audit of health chits to check for any discrepancies, and consider any improvements that can be made; and provide a written apology to the man.

6. The Deputy Commissioner recommended that the GP attend further training on the assessment and management of acute or emergency eye conditions, and provide a written apology to the man.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Mr A about the services provided to him by the Department of Corrections and by GP Dr B. The following issues were identified for investigation:

- *Whether the Department of Corrections provided Mr A with an appropriate standard of care in November 2019.*
- *Whether Dr B provided Mr A with an appropriate standard of care in November 2019.*

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

9. The parties directly involved in the investigation were:

Mr A	Consumer/complainant
Dr B	GP
Department of Corrections	Provider

10. Further information was received from:

Dr C	Medical officer
Registered Nurse (RN) D	Registered nurse
RN E	Registered nurse

11. Also mentioned in this report:

Dr F	GP

12. Independent expert advice was obtained from GP Dr David Maplesden (Appendix A) and RN Barbara Cornor (Appendix B).

Information gathered during investigation

Introduction

13. This report considers the care provided to Mr A while he was in a correctional facility in November 2019.

Mr A

14. Mr A (aged in his thirties at the time of events) had a history of issues in his right eye, including suspected trauma and inflammation of the middle layer of the eye (iritis).[1] The

[1] The middle layer includes the iris, and this type of inflammation is known as iritis or anterior uveitis. For ease of reference, the condition will be referred to as iritis throughout this report.

usual symptoms of iritis are blurred vision, eye pain, eye redness, and sensitivity to light. In 2018, Mr A had been seen by ophthalmologists at a public hospital for these concerns.

Health Centre

15. Corrections provides primary health care to prisoners, including GP and nursing services. The prison Health Centre is staffed by registered nurses who are employed by Corrections. Doctors are contracted by Corrections to provide medical care. Corrections has told HDC that Health Centre staff are easily able to access patients' past history by searching the Corrections records. Corrections confirmed that its records for Mr A included documentation relating to his 2018 iritis diagnosis and subsequent treatment at the public hospital.

16. Prisoners can make self-referrals to the Health Centre by submitting a "Health Request Form" (known as a health chit) into a secure deposit box. Corrections told HDC that health chits are taken from the deposit box on a daily basis and actioned by a nurse on that day with actions entered into Medtech (an electronic patient management system).

Dr B

17. Dr B is a vocationally registered GP. Dr B was contracted to provide eight hours a week of medical services at the Health Centre.

Mr A's initial health chits

18. On a health chit dated 17 November 2019, Mr A asked to be seen by a doctor to assess the pain he was experiencing in his right eye. Mr A also noted on this health chit that his right eye "looked different" to his left eye and he had pain in his temple.

19. On a second health chit dated 18 November 2019, Mr A stated that his eye was "even more painful" and "more bloodshot red". He asked to be scheduled to see Dr F (another GP who provided services at the Health Centre) as soon as possible.

20. On a third health chit dated 19 November 2019, Mr A again asked to see a doctor for his "eye injury" and noted that he was losing sight in his right eye. Mr A also stated on this health chit that he had submitted two previous health chits.

21. Corrections told HDC that the chit dated 17 November 2019 was received and actioned on 18 November 2019 with the next available nurse assessment date provided (22 November 2019 at 4.45pm). Corrections stated that the chit dated 18 November 2019 was not received (placed in the box) and actioned until 23 November 2019 (ie, there was a five-day delay in Mr A putting the chit into the box after he had filled it out), and that the health chit dated 19 November 2019 was not received and actioned until 29 November 2019 (ie, a 10-day delay). The electronic clinical notes show that both the 18 November and 19 November chits were added to the notes on 29 November 2019.

22. Mr A told HDC that because of the passage of time, he is not entirely certain when he submitted the health chits. However, he believes that he submitted the health chits on the day he filled them out, as he does not remember holding onto the chits at all.

Appointment with RN E on 22 November 2019

23. On 22 November 2019, Mr A presented to the Health Centre at 11am as a "walk-in" (as he had arrived before his scheduled appointment time of 4.45pm). He complained of right eye redness, blurring vision, and pain, and was seen by RN E. RN E documented his impression of eye inflammation (erythema) and booked Mr A to see a doctor as a "must see" for the following day. RN E irrigated Mr A's right eye with saline for around 10 minutes. RN E stated that Mr A verbalised relief and said that the redness had lessened after this. RN E noted that Mr A's eye was still painful and that his vision was still blurry.

24. No visual acuity[2] assessment was performed at this appointment. RN E told HDC that he was aware of the Snellen eye chart (typically used as part of a visual acuity assessment)[3] and acknowledged that he failed to complete a visual assessment. He said that this was because he was "not familiar with this method of assessment [and he] might [have] interpret[ed] the results the wrong way and might [have] cause[d] delay for more medical help/intervention".

25. Corrections accepted that Mr A's wait of four days (after the initial health chit was received on 18 November 2019) to be seen is unacceptable.

Appointment with Dr B on 23 November 2019

26. On 23 November 2019, Mr A was seen by Dr B. Dr B documented Mr A's symptoms as follows:

> "[W]eepy red, R[ight] eye, says had it 3–4 d[ays] not sure how it came about … says eye uncomfortable but not really painful, blurred but not photophobia (can't tolerate direct light), R[ight] eye inflamed conjunctiva[4] and angry [episclera],[5] [anterior chamber — fluid-filled space towards the back of the eye] clear, pupil reacting but sluggish [compared with] L[eft], can see ok fingers at a distance."

27. Dr B diagnosed Mr A with conjunctivitis (inflammation or infection of the clear layer that protects the eyeball and the inner eyelid) or possible viral inflammation of the eye,[6] and prescribed him two different antibiotic eye drops (chloromycetin and fusidic acid) to be used together. Dr B told HDC that he chose to prescribe Mr A two different topical antibiotics, as he believed it would be more convenient given the twice-daily dose of the eye drops (fusidic acid), alongside the eye ointment (chloromycetin).

28. Dr B told HDC that at the time of the appointment he was aware that Mr A had a history of infection to his eye, and had been seen at a public hospital in the past. However, Dr B accepted that he should have accessed the historical specialist reports that were available.

[2] Visual acuity reflects a comparison against normal vision. A visual acuity test is an eye examination that checks how well the person sees the details of a letter or symbol from a specific distance.
[3] A chart with letters, numbers, or symbols printed in rows of decreasing size. It is used by eye-care professionals in distance visual acuity testing.
[4] Tissue that lines the inside of the eyelids and covers the sclera (the white part of the eye).
[5] The episclera is a thin layer of tissue that lies between the conjunctiva and the connective tissue layer that forms the white of the eye (sclera).
[6] Episcleritis (inflammation of the episclera (the clear layer on top of the white part of the eye).

In addition, Dr B did not record in the clinical notes Mr A's history of eye infection and that he had been seen at a public hospital in the past.

29. There is also no record in the clinical notes on this date that Dr B completed a visual acuity assessment, aside from stating that Mr A could "see ok fingers at distance". Dr B accepted that he should have undertaken a formal visual acuity test using a Snellen chart and a pinhole assessment (another method of testing visual acuity) to assist in formulating a diagnosis of Mr A's symptoms. Dr B also accepted that ideally he would have tested for damage to the cornea (by a fluorescein eye stain test, which involves placing a dye called fluorescein onto the eye's outer surface), but said that at the time he did not know whether fluorescein was available at the Health Centre.

30. Dr B documented in the clinical notes his plan for Mr A to be checked for any improvement in two days' time, and to be referred for specialist review if his symptoms were not resolving. Dr B told HDC:

> "[Mr A] was happy with this plan. However he also insisted on my [trawling] his past history of eye and gastric complaints as he believed he has been mistreated. I assured him I would do this at another time."

31. However, Mr A told HDC that he told Dr B that he did not believe that he had conjunctivitis, and that he asked Dr B to check his medical records, which would show that he had had iritis in the past. Mr A said that Dr B refused to check his records.

32. Mr A stated that he applied the medications prescribed by Dr B over the following days but experienced "excruciating pain", such that he was unable to sleep.

Appointment with RN D on 26 November 2019

33. On a fourth health chit dated 25 November 2019, Mr A asked to be reviewed by a doctor again. He wrote: "[The] current prescription medicine for my eye has not changed the situation. It is still sore and weeping." This health chit was added to the electronic notes on 3 December 2019.

34. On 26 November 2019, Mr A presented to the Health Centre again as a "walk in", and was seen by RN D. Mr A reported that he was not getting the right treatment and requested an urgent referral to the public hospital. RN D noted that Mr A said that he had been using the eye drops prescribed by Dr B for two days but the eye redness had not improved.

35. RN D examined Mr A's right eye and noted that it showed redness, normal pupillary reaction to light, and no issues with visual acuity, and her impression was that of a resolving eye infection. RN D acknowledged that she did not do a visual acuity check with the Snellen chart. However, she told HDC that she made the assessment of visual acuity based on Mr A's ability to read the drug chart to confirm the eye drops he was receiving, but she acknowledged that she did not document this. RN D also stated that she does realise the importance of completing a visual acuity check using the Snellen chart.

36. Mr A then asked to be reviewed by Dr C, who was on site. Dr C told HDC that he declined this request, as their patient–doctor relationship had ended (mutually) a few months previously because Mr A had become abusive and aggressive with him. Dr C said that he advised RN D that Mr A should be booked in to see Dr B the next day instead, as at the time he did not believe that it was an emergency. Dr C said that he also told RN D that if there was any increase in pain or redness, or deterioration of vision, Mr A should be sent straight to the public hospital. Dr C told HDC that, in hindsight, he should have seen Mr A that day.

37. Mr A declined to see Dr B, and instead decided to wait for Dr F's clinic on 2 December 2019.

Appointment with Dr F on 2 December 2019

38. On 2 December 2019, Mr A was seen by Dr F, who noted that Mr A's right eye was "very active and angry". Dr F undertook a visual acuity test and noted significantly reduced vision[7] in Mr A's right eye. He referred Mr A to the public hospital for suspected iritis.

39. On 3 December 2019, Mr A was seen at the public hospital and diagnosed with a reoccurring episode of acute iritis. In the discharge summary, it was noted that Mr A should be assessed by an ophthalmologist for future episodes of red eye.

Responses to provisional opinion

40. Mr A, Corrections, and Dr B were all given the opportunity to respond to relevant sections of my provisional opinion. Where appropriate, their responses have been incorporated into this report.

41. Mr A did not provide a response.

42. Corrections told HDC that it takes the Deputy Health and Disability Commissioner's decision very seriously and is fully prepared to comply with the recommendations in the provisional opinion, but otherwise had no further comments to make. Corrections also shared relevant sections of the provisional opinion with the staff members involved, and advised that the staff members also had no further comments.

43. Dr B told HDC: "I accept that there were deficiencies in the care I provided [to] [Mr A] and I have no hesitation in apologising for this and any upset and distress caused to him." Dr B also reiterated that he has reflected at length on what he could have done differently, and has amended his practice accordingly. Dr B added that he has reviewed the relevant BPAC guidelines[8] and the HealthPathways, and that he will attend the further training as recommended in paragraph 80 of this report.

[7] Mr A had 6/60 vision in his right eye (compared with 6/6 vision in his left eye), which means that he was able to read only the top line (ie, the largest letters) of the Snellen chart. A person with 6/60 vision is considered to be legally blind.

8 "Causes, complications and treatment of a red eye", *Best Practice Journal* 2013, Issue 54. https://bpac.org.nz/bpj/2013/august/redeye.aspx

Opinion: Department of Corrections — breach

44. The Corrections Act 2004 (the Act) states that "a prisoner is entitled to receive medical treatment that is reasonably necessary". The Act requires that the "standard of health care that is available to prisoners in a prison must be reasonably equivalent to the standard of health care available to the public". In addition, in accordance with the Code of Health and Disability Services Consumers' Rights (the Code), Corrections has a responsibility to operate its health services in a manner that provides consumers with an appropriate standard of care.

45. Prisoners do not have the same choices or ability to access health services as a person living in the community. They do not have direct access to medication or to a GP. They are entirely reliant on the staff at Corrections' health services to assess, evaluate, monitor, and treat them appropriately.

46. In addition, I draw attention to the comment from my expert nursing advisor, RN Barbara Cornor, that from her own experience working in emergency departments and other prison health centres, "aggression and/or abuse does not result in good patient nurse/doctor relationships and patient outcomes". I agree, and consider that this reinforces the importance of good training and support for all clinical staff to focus on the key clinical issues, rather than the behaviour of the patient. I note that Corrections has implemented such training (as referred to in paragraph 76 below). I welcome this action and I encourage Corrections to include this training regularly as part of staff education.

Processing of health chits

Initial health chit

47. Mr A's initial health chit was dated 17 November 2019. In the health chit, Mr A asked to be seen by a doctor for an assessment of his painful right eye. Corrections told HDC that health chits are taken from the deposit box on a daily basis and actioned by a nurse on that day, with actions entered into Medtech. Corrections said that Mr A's initial health chit was received and actioned on 18 November, with the next available nurse assessment date provided (22 November 2019 at 4.45pm).

48. It is not clear when Mr A submitted his initial health chit, given the difference in the date on the chit and the date it was apparently received by the Health Centre staff. However, even if it is accepted that the initial health chit was not submitted until 18 November 2019, Mr A was not seen at the Health Centre until 22 November. RN Cornor advised that because the reason for Mr A's red and painful eye was unknown, the health chit should have been triaged as a priority for same-day assessment and treatment. RN Cornor considers the delay of four days in Mr A being seen to be a severe departure of the standard of care and accepted practice.

49. I accept RN Cornor's advice, and am very concerned that Mr A had to wait four days to be seen for an assessment of his eye. As pointed out by my clinical advisor, GP Dr David Maplesden, unilateral painful red eye should be regarded as a potential ophthalmological emergency until serious causes are excluded, particularly if it is associated with decreased

vision. In addition, I note that it would have been helpful if Corrections staff, when processing this health chit, had accessed Mr A's health records and seen that he had a history of iritis, as this may have prompted more urgent action in response to his health chit. In any event, even without a history of iritis, I agree with my expert advisors that there should have been a more timely response to Mr A's symptoms.

Further health chits

50. Mr A filled out a further three health chits dated 18 November, 19 November, and 23 November 2019. Mr A has told HDC that owing to the passage of time, he is not entirely certain when he submitted the health chits. However, he believes that he would have submitted the health chits on the day he filled them out, as his eye condition was urgent given that it was iritis, and he does not remember holding on to the chits at all.

51. Corrections stated that the health chit dated 18 November was not received until 23 November 2019, and the chit dated 19 November was not received until 29 November 2019 (although the electronic record shows that both the 18 November and 19 November chits were added on 29 November). In addition, the health chit dated 25 November was not added to the notes until 3 December 2019.

52. I agree with Dr Maplesden's comment that it is unclear why (and in my opinion it seems unlikely) Mr A would have delayed submitting his chits when his eye was causing him such concern. However, on the evidence before me, I am unable to determine exactly when the health chits were submitted. I would be extremely concerned if they were submitted on the date on which they were written and not actioned for another five to ten days. This would raise the significant risk that prisoners' health needs, which at times could be urgent, were not being responded to within appropriate timeframes. In light of the discrepancies in the dates written on Mr A's health chits compared with the dates on which they were documented as having been received, I will recommend that Corrections look closely at its health chit system in relation to this facility and other Corrections' facilities to identify if there are any systemic issues the department needs to address.

Nursing Care

Care provided by RN E

53. On 22 November 2019, Mr A presented to the Health Centre at 11am as a "walk-in" and was seen by RN E with right eye redness, blurred vision, and pain. RN E documented his impression that Mr A had eye inflammation, and booked him to see a doctor as a "must see" for the following day. RN E also irrigated Mr A's right eye with saline. RN E stated that Mr A verbalised relief after his eye had been flushed out, and said that the redness had lessened. No visual acuity assessment was performed at this appointment, and RN E told HDC that this was because he was not familiar with this method of assessment and did not want to misinterpret the results, which may have delayed further help for Mr A.

54. RN Cornor advised that the failure to complete a visual acuity assessment was a departure from expected standards. She further advised that RN E should have documented the reason why he did not complete a visual acuity assessment. RN Cornor considered the deficiencies

in RN E's assessment and documentation to be a mild departure from the accepted standard. I accept RN Cornor's advice.

55. I also note RN Cornor's comment that RN E's documentation was otherwise professionally written, and that RN E booking Mr A to see a doctor the following day was consistent with accepted practice.

Care provided by RN D

56. On 26 November 2019, Mr A was seen by RN D. Mr A reported that he was not getting the right treatment and requested an urgent referral to the public hospital. RN D noted that Mr A's eye redness had not improved despite using the medication prescribed by Dr B. RN D also noted that Mr A's right eye was red and reacted normally to light, and that Mr A had no issues with visual acuity. Her impression was that of a resolving eye infection. RN D acknowledged that she did not do a visual acuity check with the Snellen chart. However, she told HDC that she made the assessment of visual acuity based on Mr A's ability to read the drug chart to confirm the eye drops he was receiving, but she acknowledged that she did not document this.

57. RN Cornor has advised that if RN D had documented the details of her visual acuity assessment (ie, that Mr A had been able to read the medication chart), there would have been no departure from accepted standards. RN Cornor considered the failure to document the visual acuity assessment to be a mild departure from accepted practice. I accept RN Cornor's advice.

58. I also note RN Cornor's comment that RN D's documentation was otherwise professionally written, and that RN D booking a follow-up appointment with the doctor, and providing an eye patch and advice on pain relief, was consistent with accepted practice.

Conclusion

59. Both Dr Maplesden and RN Cornor concluded that aspects of the care provided to Mr A by Corrections and its staff did not meet the appropriate standard.

60. I consider that the management of Mr A's eye symptoms, for which ultimately Corrections is responsible, was unacceptable. In particular, the initial four-day delay in Mr A being seen when he had symptoms of a potential ophthalmological emergency is very concerning. In addition, there were some minor deficiencies in the nursing care Mr A received. In my opinion, Corrections failed to provide services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Follow-up on Dr B's plan to review Mr A — adverse comment

61. On 23 November 2019, Dr B documented a plan to review Mr A in two days' time. Dr B noted that if there was no improvement, Mr A was to be referred for specialist review. There is no evidence to suggest that Dr B's plan to review Mr A in two days' time (ie, on 25 November 2019) was put into action. Mr A was seen the following day, on 26 November, but only because he presented to the Health Centre as a "walk in". In addition, despite Dr B documenting in the clinical notes that Mr A was to be referred for specialist review if his

symptoms were not resolving, there was no reference to this plan in the notes from 26 November.

62. It is vital that Corrections has a robust system for ensuring that clinicians' management plans are followed through. In addition, it is important for staff to review a patient's medical history and plans made by other providers, and especially when a patient re-presents with similar ongoing issues.

Opinion: Dr B — breach

Vision assessment

63. On 23 November 2019, Mr A was seen by Dr B at the Health Centre. Dr B documented Mr A's eye symptoms, noting that his right eye was red, uncomfortable, and had blurred vision. However, Dr B did not complete a visual acuity test. Dr B accepted that he should have undertaken a formal visual acuity test using a Snellen chart and a pinhole assessment to assist in formulating a diagnosis of Mr A's symptoms. Dr B also accepted that, ideally, he would have carried out fluorescein testing to check for any damage to the cornea.

64. Dr Maplesden advised that the most important omission in Dr B's assessment of Mr A was the lack of a formal visual acuity test using the Snellen chart, given that Mr A was "a patient … presenting with acute unilateral red eye and … complaining of decreased vision". Dr Maplesden considers that Dr B's failure to assess Mr A's vision formally in the clinical scenario described was a moderate departure from accepted practice.

65. I agree with Dr Maplesden. Dr B had noted Mr A's symptoms of red eye, discomfort, and decreased vision, which are some of the symptoms of iritis — a condition that Mr A had had in the past and subsequently was diagnosed with again. As Dr Maplesden has pointed out, in such cases the appropriate management is urgent specialist advice or review. Dr B should have at least undertaken a visual acuity test using a Snellen chart.

66. I also note Dr Maplesden's advice that in addition to the visual acuity test, best practice would have been for Dr B to undertake fluorescein testing to check for any damage to the cornea. Dr B has accepted this. I expect Dr B to consider fluorescein testing for any consumers who present with similar symptoms in the future.

Review of medical history

67. In Dr B's notes, there is no mention of a check of Mr A's medical history having been undertaken. Mr A told HDC that he asked Dr B to check his medical records, as they would show that he had had iritis in the past. Mr A said that Dr B refused to check his records. Dr B told HDC that at the time of the appointment, he was aware that Mr A had a history of eye infection and had been seen at a hospital in the past. However, Dr B acknowledged that he should have accessed the historical specialist reports relating to this past diagnosis and

treatment. Corrections has told HDC that prison health unit staff are able to access patients' past history easily by searching Corrections' records.

68. Dr Maplesden advised:

> "New reduction of corrected vision in a patient with unilateral painful red eye with a degree of photophobia also described required urgent ophthalmological assessment. In a patient with past history of iritis, the presentation described is likely to represent another episode of iritis.
>
> … [Mr A's] history of previous presentation to the [public hospital's] Eye Clinic deserved further exploration as if he had been previously diagnosed with iritis there should have been a low threshold for suspecting recurrence of the condition."

69. Dr Maplesden is mildly to moderately critical that Dr B did not access Mr A's records, which were readily available, and especially given that Mr A had informed Dr B that previously he had required hospital treatment for an eye condition.

70. I agree with Dr Maplesden. I am critical of Dr B's failure to check Mr A's history, given that the patient records would have been easy to access through Corrections' system. Had Dr B done so, he would have noted Mr A's previous diagnosis and treatment for iritis. This was highly relevant information that would have better informed Dr B's clinical decision-making, and may well have resulted in Mr A being referred for specialist treatment earlier.

Prescribing two different topical antibiotics

71. After diagnosing Mr A with conjunctivitis, with possible viral inflammation, Dr B prescribed Mr A two different antibiotic eye drops (chloromycetin and fusidic acid) to be used together. Dr B told HDC that he chose to prescribe Mr A two different topical antibiotics as he believed it would be more convenient given the twice-daily frequency of the drops and different eye ointment.

72. Dr Maplesden advised that even if bacterial infection was suspected, he does "not believe co-prescribing of two different antibiotic eye preparations concurrently in the clinical situation described represents good antimicrobial stewardship". Dr Maplesden was mildly critical of this decision, and advised that "[a] non-antibiotic eye lubricant could have been used at night for comfort if required".

73. I accept Dr Maplesden's advice, and I remind Dr B of the need to prescribe antibiotics thoughtfully to ensure the safe and effective use of antimicrobials.

Conclusion

74. As detailed above, I have a number of concerns about the care Dr B provided to Mr A on 23 November 2019. Specifically, Dr B:

- Failed to undertake a visual acuity test using a Snellen chart;
- Did not access Mr A's records, which were readily available, and especially given that Mr A told Dr B that previously he had required hospital treatment for an eye condition; and
- Prescribed two different topical antibiotics, which did not represent good antimicrobial stewardship.

75. I consider that the above deficiencies amount to a failure to provide services to Mr A with reasonable care and skill. Accordingly, I find that Dr B breached Right 4(1) of the Code.

Changes made

76. Since these events, the Department of Corrections has made, or is in the process of making, the following changes:

- In November 2020, Corrections' Chief Medical Adviser led an education session for nursing staff regarding the assessment and management of acute red eye and the use of the Snellen Chart.
- Also in November 2020, a discussion around adherence to best practice, including an understanding of red flags and focusing on the presenting symptoms and signs, instead of the behaviour or personality of the patient, was held with the wider Health Services team (including the medical team and external providers) at the Quarterly Clinical Governance meeting.
- The prison has initiated a new system of triaging "Request for Health Services" forms (health chits), whereby if an enrolled nurse collects the health chit, the nurse will meet with the Clinical Team Leader to discuss any health chits outside the scope of the nurse's work, or if the nurse is unsure of what further action is required. Corrections told HDC that the aim of this change is to provide greater oversight of the health chits and to ensure that triaging is undertaken accurately, to minimise the occurrence of missed acute presentations.
- All clinical staff have reviewed the HealthPathways Eye Assessment in Adults and Red Eye.
- The Health Centre Manager is to write to Mr A to apologise for the four-day delay between submitting his health chit and being seen by a nurse.

Recommendations

77. In accordance with the proposed recommendations in my provisional opinion, Corrections has:

a) Provided a written apology to Mr A, which has been forwarded to him.

b) Provided HDC with evidence of the training provided to staff in November 2020 on the assessment and management of acute red eye and the use of the Snellen chart.

78. Bearing in mind the changes already made, as noted above, I recommend that the Department of Corrections:

a) Report back to HDC on the outcomes, if any, from the Quarterly Clinical Governance meeting discussion around adherence to best practice, including an understanding of red flags and focusing on the presenting symptoms and signs, instead of the behaviour or personality of the patient. Any outcomes, including identification of any further training needs for staff, should be provided to HDC within two months of the date of this report.

b) Undertake an audit of a random selection of 30 health chits at the Health Centre from the preceding 12 months to check for discrepancies in the date recorded on the chit versus the date on which the chit was received and actioned. Where the audit identifies discrepancies in any of the chits, Corrections is to consider what improvements can be implemented to reduce the risk of delay in health chits being actioned by the Health Centre staff. Corrections is to report back to HDC with the results of the audit, and details of any improvements identified as a result, within six months of the date of this report.

c) In light of my comments in paragraph 52 above, I recommend that Corrections replicate the health chit audit referred to in paragraph 78(b) above for health centres at two other Corrections' facilities that are a comparable size to this correctional facility. Corrections is to report back to HDC with the results of these audits, and details of any improvements identified as a result, within six months of the date of this report.

79. In accordance with the proposed recommendation in my provisional report, Dr B provided a written apology to Mr A. The apology has been forwarded to Mr A.

80. I also recommend that Dr B attend further training on the assessment and management of acute or emergency eye conditions. Dr B is to provide evidence of this further training to HDC within three months of the date of this report.

Follow-up actions

81. A copy of this report with details identifying the parties removed, except the Department of Corrections and the experts who advised on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr B's name.

82. A copy of this report with details identifying the parties removed, except the Department of Corrections and the experts who advised on this case, will be sent to the Ministry of Health and the Office of the Ombudsman, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to the Commissioner

The following expert advice was obtained from Dr David Maplesden:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mr A] about the care provided to him by staff of the Prison Health Unit (PHU). In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. I have reviewed the documentation on file: complaint from [Mr A]; response from Department of Corrections (DoC); statements from [Dr B] and [Dr C]; PHU clinical notes.

2. [Mr A] complains about management of an acute eye condition in November and December 2019:

- [Dr B] incorrectly diagnosed [Mr A] with conjunctivitis on 23 November 2019 and refused to check [Mr A's] clinical records related to a similar previous eye condition which required specialist intervention
- [Dr C] refused to review [Mr A] on 26 November 2019 despite [Mr A] relaying symptoms of ongoing eye pain

3. A letter from DoC to [Mr A] dated 9 December 2019 includes the following points:

(i) [Mr A] was seen by [Dr B] on 23 November 2019 and prescribed treatment for conjunctivitis. [Mr A] was to be reviewed again on 27 November 2019 (Monday) to review progress with a plan for referral to the eye clinic if symptoms were not resolving.

(ii) [Mr A] was seen by a nurse on 26 November 2019 and advised he would be reviewed by [Dr B] later that day. [Mr A] declined to see [Dr B] and requested review by [Dr F] who would not be at the clinic until 2 December 2019. [Mr A] decided to wait to be seen by [Dr F].

(iii) [Mr A] saw [Dr F] on 2 December 2019. His eye condition was not responding to treatment and arrangements were made for review at the [public hospital] Eye Clinic the next day 3 December 2019.

4. [Dr B] includes the following points in his response:

(i) [Mr A] presented on 23 November 2019 (Friday) with a 3–4 day history *of a weepy inflamed red eye … his vision was not impaired. I noted that he has a history of infection to his eye and has been seen at the [public hospital] Eye Clinic in the past.*

(ii) A diagnosis was made of *conjunctivitis with ?viral episcleritis*. Prescription was provided for antibiotic drops during the day and antibiotic ointment at night. *I discussed with him that if it did not improve in the next couple of days he can be reviewed on Monday and be referred for review at the Eye Clinic.*

(iii) [Mr A] was happy with the management plan. However, *he also insisted in my trolling his past history of eye and gastric complaints as he believed he has been mistreated. I assured him I would do this at another time.*

5. [Dr C] includes the following points in his response:

(i) Clinic nurse [RN D] saw [Mr A] on 26 November 2019 as [Mr A] wanted an eye patch and Panadol as his eye was not improving. He requested a referral to the Eye Clinic and wanted to complain about his management by [Dr B].

(ii) Examination of the right eye (by [RN D]) showed *redness, normal pupillary reaction to light, tolerance to direct light and no issues with visual acuity. [RN D's] impression was a resolving eye infection.*

(iii) [RN D] asked [Dr C] if he would like to review [Mr A] as an unbooked addition to his clinic list. [Dr C] declined as he felt [Mr A's] symptoms did not constitute an emergency and he had previously ended his professional relationship with [Mr A] after being abused by [Mr A].

(iv) [Dr C] advised [RN D] to book [Mr A] in to [Dr B's] clinic the next day (27 November 2019) and advised that should [Mr A] experience a deterioration in his symptoms or in his vision prior to that time he should be sent straight to [the public hospital] for specialist review.

6. Review of clinical notes

(i) There is a Health Chit from [Mr A] on file dated 17 November 2019 which includes: *To be referred to the doctor to assess why my right eye is sore and looks different to my left eye. My temple is sore as well.* Symptom duration is listed as one night. On 18 November 2019 [Mr A] submitted a second Health Chit stating: *My eye is even more painful now and even more bloodshot red. I believe it [is] caused from having to blow my nose too many times because the nose spray I was prescribed does not work. Please schedule me to see [Dr F] as soon as it is possible*. Symptom duration was listed as two days. On 19 November 2019 [Mr A] submitted a third chit stating: *Please let me see a doctor for my eye injury. I am losing sight in my right eye. I have privately put in 2 health chits. Symptom duration is listed as three days.*

Comment: Unilateral painful red eye should be regarded as a potential ophthalmological emergency until serious causes are excluded, particularly if associated with decreased vision. [Mr A's] symptoms warranted urgent clinician review from 18 November 2019, with a heightened degree of urgency when he complained of decreasing vision in the affected eye from 19 November 2019. It is unclear why there was no physical review of [Mr A] until 22 November 2019 and I regard this delay as unacceptable, but further information will be required regarding this issue as later notes indicate the chits were not received by health unit staff until 29 November 2019.

(ii) Nurse review is recorded as having taken place on 22 November 2019 after [Mr A] presented to the health centre as a 'walk-in'. Notes include: *stated he kept on blowing air/[s]ecretions out from the nose, then he thinks it affected his eyes … R eye redness started 4 days ago, nil known allergies as per patient, nil exposure to chemicals. Stated blurring vision, itchy sharp irritating pain, added felt something wrong with it … Both eyes, nil strabismus, nil anisocoria, PERLA 3mm, nil bulging, L eye normal, R eye erythema, watery eyes with conjunctival inflammation and redness, mild lower eyelid*

swelling, nil visible eye trauma or foreign objects, bright light sensitivity. Irrigated with saline for 8–10 minutes, verbalised relief, eye redness minimised, still with pain and blurry vision … Imp: unilateral eye erythema. Plan: booked for Doctor as must see in central clinic 23/11/2019.

Comment: The documented review of [Mr A] is mostly adequate apart from the important omission of formal assessment of visual acuity, and [Mr A] was complaining of reduced vision (health chit and verbal history). New reduction of corrected vision in a patient with unilateral painful red eye with a degree of photophobia also described required urgent ophthalmological assessment. In a patient with past history of iritis, the presentation described is likely to represent another episode of iritis[1]. It does not appear [Mr A] was questioned regarding his past ophthalmic history.

(iii) [Mr A] was reviewed by [Dr B] on 23 November 2019. Notes include weepy *red R eye, says had had it 3–4d and not sure how it came about*. There is reference to [Mr A's] belief the symptoms were related to nasal issues which he felt had been mistreated in the past. Further notes include: *request to go to hospital stat … says eye uncomfortable but not really painful, blurred but no photophobia (cant tolerate direct light [sic]), R eye — inflamed conjunctiva and angry episcleral, AC clear, pupil reacting but sluggish cf L, can see ok fingers at distance …* Discussion regarding diagnosis of viral episcleritis is noted with [Mr A] persisting with his belief the issue was nose or even bowel related. Plan was *fucithalmic gutt BD and nocte chlorsig — review Mon and ?any improvement or refer for Eye review.*

Comment: There are omissions in the assessment of [Mr A] as documented by [Dr B], the most important of these being formal assessment of corrected visual acuity (Snellen chart) in a patient with acute unilateral red eye who is complaining of decreased vision. Best practice would be to check for corneal ulceration (post minor trauma or secondary to herpes infection) with fluoroscein in the clinical scenario described (uncomfortable or painful unilateral red eye). [Mr A's] history of previous presentation to the Eye Clinic deserved further exploration as if he had been previously diagnosed with iritis there should have been a low threshold for suspecting recurrence of the condition. I believe the failure by [Dr B] to formally assess [Mr A's] vision in the clinical scenario described was a moderate departure from accepted practice in the assessment and management of acute unilateral red eye, taking particular account of [Mr A's] complaint of reduced vision and discomfort in the eye[2] and the clinical findings of reduced pupillary reactivity and unilateral inflammation. It is difficult to see the clinical rationale for prescribing two different topical antibiotics concurrently (chloromycetin and fusidic acid) even if bacterial infection was suspected. Adequate safety netting advice was provided. However, had iritis been suspected as the diagnosis, appropriate management is urgent

[1] HealthPathways. Section on 'Iritis (Anterior Uveitis)'.
[2] BPAC. Causes, complications and treatment of a red eye. Best Practice Journal. 2013; Issue 54. https://bpac.org.nz/bpj/2013/august/redeye.aspx Accessed 20 May 2020

specialist advice/review. I recommend [Dr B] review the cited BPAC guidance and relevant [regional] HealthPathways guidance[3].

Addendum 7 July 2020 — There is no change in these comments following receipt of further information from DoC but see additional comment in section 7(i).

Addendum 18 May 2021 — In a response dated 22 September 2020 [Dr B] explained he prescribed fusidic eye drops BD because of the convenience of twice daily dosing, and an ointment was prescribed at night for eye lubrication. I do not believe co-prescribing of two different antibiotic eye preparations concurrently in the clinical situation described represents good antimicrobial stewardship but this is a minor criticism. A non-antibiotic eye lubricant could have been used at night for comfort if required.

(iv) On 25 November 2019 [Mr A] submitted another Health Chit stating: *May I be seen by a doctor again because current prescription for my eye has not changed the situation. It is still sore and weeping.* Nursing action on the chit is unclear but [Mr A] was seen as a walk-in at the nurse clinic on 26 November 2019. Notes include: *[Mr A] stated he was using the prescribed eye drops for the past 2 days and redness is not going down, wants writer to refer him to eye clinic right away, wants an eye patch and Panadol.* Objective findings included: *R upper eye lid: slightly swollen as if its scratched but he denies this; noted reddened sclera and inner eyelids … PEARLA, smooth and coordinated eye movements, tolerated direct light, no issues with acuity* [no visual acuity documented] … *Imp: resolving eye infection*. Note is made of [Mr A's] request to see the onsite doctor who declined to see him. A review with [Dr B] was offered but [Mr A] wanted to see [Dr F]*. Informed that [Dr F] not available till next week, ready to wait till he see [Dr F], booked in. Gave a spare eye patch and advised to take PRN Panadol from unit.* There is no 'safety-netting' advice documented. On 29 November 2019 there is reference to the chits described in section 6 (i) being reviewed with the action being confirmation [Mr A] had a scheduled GP review on 2 December 2019.

Comment: I am critical there is no documented formal assessment (Snellen chart) of [Mr A's] visual acuity. It is unclear on what basis the nurse has made the statement 'no issues with acuity' noting [Mr A's] previous complaint of decreased vision and blurred vision. Assuming the information the nurse has recorded is what was conveyed to [Dr C] (no vision disturbance, no photophobia, no pupillary abnormalities, and impression of resolving infection) I think it was reasonable for [Dr C] to assess the situation as non-urgent although, in hindsight, it was an urgent situation and [Mr A] should have been reviewed. With the knowledge of [Mr A's] final diagnosis and the clinical findings both before and following the nurse assessment on 26 November 2019, questions might be raised regarding the nurse's competency in completing an adequate and accurate assessment of the unilateral acute red eye. It is apparent [Mr A] was offered a GP review

[3] HealthPathways. Sections on 'Red Eye' and 'Unilateral Red Eye'

for 27 November 2019 but he declined this review in preference to review by another provider several days hence.

(v) [Mr A] attended his scheduled GP appointment with another provider on 2 December 2019. Notes include: *R eye no better … painful, increasing redness and teary, poor sleep … PHx iritis Jan 2018 (meds taken off Testsafe) … OE R eye 6/60 L 6/6 R eye very active and angry, PERL. Discussed with Ophthalmology — will see at [the public hospital] Eye Clinic tomorrow …* Treatment for suspected iritis was commenced with Pred Forte (steroid) eye drops and referral sent to the Eye Clinic. I do not have a record of Eye Clinic reports.

Comment: Formal assessment of [Mr A's] visual acuity was recorded for the first time and was significantly reduced in his symptomatic eye. The past history of iritis was also noted for the first time. Management was clinically appropriate (acute specialist advice/referral).

7. I recommend further information is obtained from DoC **[Addenda 7 July 2020 based on further response from Department of Corrections in bold]**

(i) How accessible to prison health unit staff were any notes relating to [Mr A's] past history of iritis? Please provide a copy of any such information on [Mr A's] file.

Historical specialist reports are easily available on searching records held by DoC. These include eye specialist reports dated 29 and 30 January and 9 February 2019 when [Mr A] required treatment for a severe acute anterior uveitis which was felt to be possibly related to preceding eye trauma. I am mildly to moderately critical that [Dr B] did not access these records, which were apparently readily available, when he saw [Mr A] on 23 November 2019 noting [Mr A] had apparently informed [Dr B] that he had previously required hospital treatment for an eye condition.

(ii) Please provide a copy of Eye Clinic reports following [Mr A's] referral to the clinic on 2 December 2019.

See above. Eye clinic letters dated December 2019 and January 2020 confirm [Mr A's] right eye symptoms were due to a further episode of acute anterior uveitis. He was found to be HLA-B27 positive which was likely to be associated with his recurrent uveitis. At initial clinic assessment on 3 December 2019 the vision in [Mr A's] right eye was reduced to 6/48 (improved to 6/30 with pinhole).

(iii) Please clarify the process for processing and management of health chits provided by prisoners. Please explain why the three health chits signed by [Mr A] on 17, 18 and 19 November 2019 were apparently not actioned by unit staff until 29 November 2019.

Health chits are taken from the deposit box on a daily basis and actioned by a nurse on that day with actions entered into Medtech. The chit dated 17 November 2019 was received and actioned on 18 November 2019 with next available nurse assessment date provided (22 November 2019). The DoC response states the chit dated 18 November 2019 was not received (placed in the box) until 23 November 2019, and

that dated 19 November 2019 was not received until 29 November 2019. It remains unclear why [Mr A] might have delayed returning his chits to the PHU when his eye was causing him such concern.

(iv) Please provide statements from nursing staff assessing [Mr A] on 22 and 26 November 2019 regarding their recollection of the symptom history provided by [Mr A] and the assessment undertaken. Please clarify if formal assessment of visual acuity using a Snellen chart was undertaken on either occasion and, if not, why this was not done.

Statements from the two nurses who assessed [Mr A] are currently awaited. I expect nursing advice will be required as below. Note my comment in section 9.

8. I think it is likely nursing advice will be required regarding the following issues:

(i) The timeliness of initial nursing assessment following [Mr A] providing his health chits (or the process for handing of chits if they were not actually received at the health unit until 29 November 2019)

(ii) The standard of nursing assessment on 22 November 2019 and nursing actions taken following the assessment

(iii) The standard of nursing assessment on 26 November 2019 and nursing actions taken following the assessment

9. If there is a decision not to seek further EA, or any departure from nursing practice does not meet the threshold for investigation, I think it is important both nursing and medical staff receive further education on assessment and management of the acute red eye (perhaps using the cited resources)."

Appendix B: External clinical advice to the Commissioner

The following expert advice was obtained from RN Barb Cornor:

"Complaint: [Mr A]/Department of Corrections

Ref: C20HDC00296

Background

[Mr A] had a past history of uveitis and complains about management of an acute eye condition in November and December 2019.

[Mr A] was experiencing pain and redness in his right R) eye and submitted a health chit (dated 17 November 2019) requesting a doctor review. He subsequently submitted two more health chits, dated 18 and 19 November 2019 as his symptoms had not resolved and he had begun to lose sight in the affected eye.

[Mr A] was seen in the health centre for a nursing review twice during this period, on 22 and 26 November, when referral was made to the [public hospital] Eye Clinic where it was confirmed that [Mr A's] R) eye symptoms were due to a further episode of acute anterior uveitis.

Expert advice requested

1. The timeliness of initial nursing assessment following [Mr A] providing his health chits

On 18 November 2019, a Health Request Form (Health chit) dated 17 November 2019 was received and triaged by a nurse. The 'Action/Response' was that [Mr A] be 'booked for nurse'. There is no evidence this 'booking' was made.

[Mr A's] chit which complained of a sore right eye, that looked different from his left eye, with accompanying temple pain, would be expected to be triaged as priority (same day) for assessment and treatment.

That the reason for the red, painful eye is unknown to the triage nurse should determine priority for assessment and treatment. If it is identified as an injury or foreign body causing the pain all research and documentation (including 'Your Health' on the Ministry of Health NZ website) which all members of the public are encouraged to use, advises 'if you or your family member injures an eye, basic first aid can prevent further damage or loss of sight' and 'you must go to your doctor or emergency department for all eye injuries'. Ministry of Health NZ website also states 'the eye is very complex and injury or disease can easily damage your eye beyond repair' and to 'Find out what to do and how to use treatments like eye drops'.

That [Mr A] had to wait four days for assessment and treatment of a red painful eye, is determined as a severe departure of standard of care or accepted practice.

2. The standard of the nursing assessment on 22 November 2019 and nursing actions taken following the assessment

22 November 2019 [Mr A] was seen and assessed by [RN E]. Although [RN E] appears in the 'Doctor Legend' of the clinical documentation, the writer is unsure if this person is a doctor or nurse as the 'Doctor Legend' appears to have all health staff identified (…). Also, [Mr A's] 'reason for presentation' is documented as 'came as a walk-in from …'. The writer is unsure if this was an appointment made on the 18 November or as it states 'a walk-in' which one assumes is just that, walking in.

According to documentation by [RN E], [Mr A's] focus as the reason for his affected eyes was that the type of nasal spray being used for his sinuses was incorrect.

An eye assessment was completed by [RN E]. The assessment was done well but unfortunately, even though [Mr A] stated he had blurring vision, no Visual Acuity was completed.

Visual acuity test is an eye exam that checks how well the person sees the details of a letter or symbol from a specific distance. It refers to the ability to discern the shapes and details of things seen. It is only one factor in the overall vision of the person being assessed.

In a statement provided by [Corrections], [RN E] stated 'I am not familiar with this method of assessment as I might interpret the results the wrong way and might cause delay for more medical help/intervention'.

Although there was no 'visible eye trauma or foreign objects' [RN E] 'irrigated' the eye with 'saline for 8–10 minutes' after which [Mr A] 'verbalised relief' and 'eye redness minimized' although 'pain and blurry vision' continued. Due to the extent of [Mr A's] symptoms, he was 'booked for Doctor as must See in central Clinic' the following day.

Eye Irrigation treats the inflammatory process of conjunctiva (which [Mr A] had) and removes foreign objects or harmful chemicals from the conjunctiva and cornea. Following the retraction of the eyelid, fluid (saline) is poured slowly and steadily, from no more than 5 centimetres away onto the front surface of the eye, inside the lower eyelid and under the upper eyelid.

Visual Acuity is a factor missing from the required standard for examination of eyes, although the rest of the assessment of [Mr A's] eyes is well within required standards. If [RN E] had documented the reason why he had not completed a visual acuity, documentation standards would have been met, although standards required of assessment, not. The author defines this as a mild departure from accepted practice.

It is recommended [RN E] and any other staff not confident with Visual Acuity and the Snellen chart should be provided with education and practical training.

Eye irrigation provided as treatment for [Mr A's] conjunctivitis (inflammation of the conjunctiva) is the standard of care and is a well-accepted practice for treatment of

conjunctivitis of unknown origin (not able to determine the cause). It is documented that [Mr A] felt relief following this procedure, therefore, providing evidence of its effectiveness.

An appointment was made to see a doctor the following day which is accepted practice and a standard that would be expected following the nurse assessment, treatment and unknown cause.

3. The standard of nursing assessment on 26 November 2019 and nursing actions taken following the assessment

[Mr A] was seen by [Dr B] on 23 November 2019. His symptoms continue as a right eye, red, weepy. He 'claims it is a result of him blowing his nose for a long time and Drs not giving him correct nasal prescription'. He also provided several other symptoms/issues and requested to go to hospital for these. [Dr B] documented [Mr A's] 'eye uncomfortable but not really painful' and conducted an assessment. The focus of [Mr A's] input at the consultation reads as nasal and colorectal issues and [Dr B] suggested it 'best to treat his current presenting problem' and prescribed medication for his eye.

Also, on 23 November 2019 a health chit was received which described [Mr A] had 'severe chest pain & back pain' which he had had for '2days'.

On 26 November 2019 [Mr A] was seen by [RN D] (? nurse/? doctor) as 'a walk in from … unit due to ?eye issues'. [Mr A] suggested he did not think he was getting the right treatment, stating he told the doctor 'on Saturday' it was not a viral infection, but 'a rupture due to him blowing his nose'. The treatment prescribed was not working and [Mr A] requested a referral to 'the eye clinic straight away'.

[RN D] completed and documented a subjective and objective eye assessment and examination although included is, there were 'no issues with acuity'. Unfortunately, there is no evidence of the acuity being completed.

Visual acuity results are documented as the sight distance (standard 6 metres) by the line read on the Snellen chart. As an example, normal visual acuity is identified and recorded at 6/6 and legally blind is identified at 6/60.

[RN D] provided a statement on 13 August 2020 via [Corrections] which identifies he made the decision of visual acuity on the fact [Mr A] 'could read the drug chart which I was holding to confirm the eye drop he was getting'.

[RN D] also reflected in the statement, the consultation was very distracting due to [Mr A's] uncooperative approach and him being more focussed on issues with the prison health service and doctors than his eye. This situation is also documented to some degree in the Medical Notes of 26 November 2019.

[RN D] offered an appointment with the doctor the next day which was declined as [Mr A] did not want to see the available doctor and agreed to wait for a week to see another

and the appointment was made. [Mr A] was provided with a 'spare eye patch' and advised to take Panadol (pain relief) as required.

[RN D] has documented the visual acuity as 'no issues'. If it had been documented the assessment was determined on [Mr A] being able to read the medication chart all requirements of the assessment and accepted standards for documentation would have been met. The assessment completed and documented by [RN D] is otherwise within required standards and therefore, the writer defines this as a mild departure from accepted practice.

[RN D] provided a follow-up appointment, with the doctor requested by [Mr A] and eye patch and advice on pain relief. This is within accepted practice and standards required.

4. Any other matters in this case that, in your opinion, warrant comment or amount to a departure from the standard of care/accepted practice

Documentation completed by [RN D] and [RN E] is professionally written and from previous experience of Corrections Department Health documentation has seen extensive improvement. Prison Health Centres are to be commended on this.

The writer felt [Mr A] has several issues (health and complaints) of which he jumps to and from and reading medical documentation it can be a confusing consultation and not meet the required outcome.

From my own previous experience in Emergency Departments and Prison Health Centres, aggression and/or abuse does not result in good patient nurse/doctor relationships and patient outcomes.

Barb Cornor
Registered Nurse
Master Nursing
T051169
25 September 2020."