Optometrist, Ms B

Optometry Clinic

A Report by the

Deputy Health and Disability Commissioner

(Case 19HDC00346)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report relates to the care provided by an optometrist to a woman who had a floater suddenly appear in her right eye. In this report, the Deputy Commissioner commented on the need for optometrists to undertake thorough assessments, including further diagnostic tests as required, and to adequately document those assessments, when consumers present with floaters alongside significantly reduced visual acuity.

2. The woman was away on holiday when the floater suddenly appeared. Her usual optometrist recommended that she get her eye checked immediately rather than waiting until she returned home. She made an appointment with an optometrist, who undertook a visual acuity test, which indicated significantly reduced vision in the woman's right eye. The optometrist also undertook a dilated retinal examination. The optometrist diagnosed a posterior vitreous detachment. She did not document all her assessment findings, including that she dilated the eyes, nor did she record the method of examination used.

3. The woman continued to experience reduced vision in her right eye. Subsequently, she was diagnosed with posterior vitreous detachment and a large full thickness macular hole in the right eye.

Findings

4. The Deputy Commissioner considered that the optometrist failed to investigate the finding of significantly reduced visual acuity in the woman's right eye adequately, which meant that the cause of the woman's symptoms were not identified, and surgery to address her degenerating sight was delayed. Accordingly, the optometrist was found in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code). The Deputy Commissioner also found the optometrist in breach of Right 4(2) of the Code because of her failure to document her assessment findings in accordance with professional standards.

5. The optometry clinic was not found to have breached the Code.

Recommendations

6. The Deputy Commissioner recommended that the optometrist undertake a documentation audit to confirm that all clinical assessments have been documented fully, and provide a written apology to the woman.

7. The Deputy Commissioner also recommended that the Optometrists and Dispensing Opticians Board of New Zealand consider whether a review of the optometrist's competence is warranted based on the information contained in this report.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided by an optometrist, Ms B. The following issues were identified for investigation:

- *Whether Ms B provided Mrs A with an appropriate standard of care in October 2018.*
- *Whether the optometry clinic provided Mrs A with an appropriate standard of care in October 2018.*

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

10. The parties directly involved in the investigation were:

Mrs A	Consumer/complainant
Ms B	Optometrist/provider
Optometry clinic	Provider

11. Further information was received from:

Mr C	Optometrist
Dr D	Opthalmologist

12. Independent expert advice was obtained from an optometrist, Mr Geraint Phillips, and is included as Appendix A.

Information gathered during investigation

Introduction

13. This report concerns the optometry care provided to Mrs A after she sought advice when a "floater" suddenly appeared in her right eye.

Background

14. On 14 October 2018, while Mrs A was on holiday travelling by car as a passenger, a floater[1] appeared in Mrs A's right eye. She arrived at her destination on 18 October.

15. On 19 October 2018, Mrs A contacted her usual optometrist to make an appointment to be seen on her return from holiday. However, Mrs A was advised to get her eye checked immediately, rather than to wait until she returned home.

[1] A floater is a spot in the field of vision. Most floaters are caused by opacities or changes to the vitreous (the cavity between the back of the lens and retina), but they can also be caused by separation of the vitreous from the retina, or a retinal tear/detachment.

16. Mrs A then contacted an optometry clinic and scheduled an appointment for that day with optometrist Ms B.[2] Ms B told HDC that it is clinic policy for an urgent, same-day appointment to be made for anyone who reports the sudden onset of a floater or a flash. Ms B told HDC: "My reception staff are acutely aware that sudden occurrence of floaters can be a symptom of harmful and sight threatening eye conditions."

Appointment with Ms B

17. On the afternoon of 19 October 2018, Mrs A presented to the optometry clinic and was seen by Ms B.

18. Ms B documented in the clinical records that Mrs A reported a history of a right eye floater for the past five days, with no headaches, no flashes,[3] and no curtains of darkness. The word "vision" is recorded with a tick next to it, indicating that Mrs A reported no change in her vision. Ocular (eye) health, general health, and family history have all been ticked. In her statement to HDC, Ms B said that Mrs A reported that she was in good general health and on no medications.

19. Ms B carried out a visual acuity assessment [4] with Mrs A wearing her corrective glasses. In the clinical records, Ms B documented her findings of 6/60+ in the right eye, indicating significantly reduced vision, and 6/6 in the left eye, indicating normal vision. There is no record of Mrs A's visual acuity having been assessed without her corrective glasses.

20. Mrs A told HDC that when Ms B tested her visual acuity she was "shocked" when she covered her left eye and could not see anything on the eye chart with her right eye, even with her glasses on.

21. In her response to HDC, Ms B said that in addition to assessing visual acuity, she also examined the anterior and posterior structures of Mrs A's eyes with a slit lamp. Ms B said that she commenced this assessment by dilating Mrs A's pupils using tropicamide 1.0% eye drops. Ms B said that after dilating Mrs A's pupils, she examined the pupils, "which included a careful examination of the macular region[5]".

22. Ms B acknowledged that her examination of the anterior and posterior structures via a dilated retinal examination is not documented in the clinical records, but noted that Mrs A was charged for a "dilated retinal examination", confirming that it was carried out. Ms B told HDC that her assessment showed the following:

> "The presence of multiple floaters with good movement;
>
> There were no abnormalities of the anterior or posterior structures of the eyes;

[2] Ms B is the sole director and optometrist of the optometry clinic. Ms B has worked as a private practice optometrist for 25 years.
[3] A flash is a spot of light that appears in the field of vision. Flashes are often the result of a change inside the eye pulling on the retina.
[4] A visual acuity test is used to determine the smallest letters that can be read on a standardised chart.
[5] The macula is part of the retina.

There was no presence of a foreign body;

There was no blood or pigment in vitreous gel; and

There was no sign of a retinal tear/break/detachment."

23. Ms B said that she also carried out ophthalmoscopy[6] "to examine the fundi,[7] A/V,[8] C/D,[9] macula and periphery", which "confirmed that there was no sign of a retinal tear/break or detachment".

24. Ms B also took retinal photographs, which she said "confirmed that there were no retinal abnormalities". Ms B noted that the photographs were "somewhat underexposed", most likely because the settings on the camera were wrong. Copies of the photographs were provided to HDC.

25. In the clinical records, headings of "Lids",[10] "Cornea",[11] "Pupils",[12] and "Conj [conjunctivae]"[13] have been ticked, indicating normal appearance and functioning. Under "Media", which are the structures between the cornea and retina,[14] Ms B documented: "R [right] large floaters, good movement."

26. No further assessment findings are recorded in the clinical records.

27. In her statement to HDC, Ms B accepts that it is not clear that her findings were the results of her examination of the fundi, A/V, C/D, macular, and periphery, and she also accepts that she did not record the method of examination used.

28. Ms B explained that she did not complete a "full refractive assessment"[15] because "there was not enough time at the appointment". She said that the appointment was shorter than usual because it was booked as an urgent appointment, "and therefore had to be squeezed in between two scheduled appointments".

29. Ms B told HDC that she diagnosed Mrs A with a posterior vitreous detachment, based on the following:

"— There was acute onset of floater multiple floaters (with good movement) and no associated trauma, pain, discomfort or headaches;

— There was reduced visual acuity;

[6] Opthalmoscopy looks at the inside structures of the eye.
[7] The fundi refers to the interior surface of the eye opposite the lens, and includes the retina, macular, and optic disc.
[8] The A/V refers to the retinal arteriovenous ratio, which is used to assess narrowing of the blood vessels.
[9] The C/D refers to the cup-to-disc ratio, which is used to assess loss of optic fibres.
[10] Eyelids.
[11] The cornea is the transparent front part of the eye that covers the iris, pupil, and anterior chamber.
[12] The pupil is the opening at the centre of the eye (coloured part of the eye) that allows light through to the retina.
[13] Conjunctivae are the clear membranes that cover the surface of the eyes.
[14] The retina is the layer at the back of the eye that receives light and converts it to neural signals.
[15] Vision assessment.

- Mrs A's age;
- There were no abnormalities of the anterior structures of the eye (lids, cornea, pupil reactions, conjunctiva);
- There was no presence of a foreign body;
- There was no blood or pigment in the vitreous gel[16]; and
- There was no sign of retinal tear or break or detachment."

30. Ms B said that she believed Mrs A's decreased visual acuity was "due to visual disturbances in the vitreous gel due to the vitreous fibres".

31. Ms B said that at the completion of the assessment, she told Mrs A that she had a posterior vitreous detachment, and explained the symptoms of retinal tear, break, or detachment, and told her to seek further treatment if her symptoms worsened. However, Ms B noted that she should have told Mrs A "that an OCT scan[17] would confirm if there was any traction on the macular, giving rise to the decreased vision and referred her for this". Ms B also noted that she should have advised Mrs A that she should arrange for a follow-up appointment with her usual optometrist, "as even in uncomplicated posterior vitreous detachment cases a retinal tear can occur within 3 months". Ms B said that she is "at a loss to explain" why she did not recommend that Mrs A schedule a follow-up appointment.

32. Mrs A said that Ms B told her that she had a posterior vitreous detachment "for which there was no treatment". Ms B told her that it was common at her age and could happen again and produce more floaters, and that a floater might drop to the bottom of the eye with gravity, but otherwise her brain would get used to it. Mrs A said that Ms B advised her that it was still possible for her retina to detach, and if she experienced "strong 'flashes'" to go to the hospital's Accident and Emergency Department.

33. Ms B documented in the clinical records: "No retinal tear, No RD [retinal detachment], Large PVD [posterior vitreous detachment] explained symptoms of RD [retinal detachment], if any change to go to A&E."

34. Ms B said that she did not carry out tonotomy,[18] fields,[19] or keratometry[20] examinations. She told HDC that "it is not usual and/or necessary to carry out tonometry or keratometry examinations on a patient presenting with [Mrs A's] symptoms", but accepts that it would have been "best practice" to carry out fields testing.

35. Ms B stated that she did not carry out Amsler grid testing[21] or arrange for Mrs A to have an OCT scan because, based on her assessment findings, she did not consider it necessary to

[16] Vitreous gel is the substance that fills the eye.
[17] OCT (optical coherence tomography) is a non-invasive imaging test.
[18] Measuring the pressure in the eye.
[19] The extent of the peripheral visual field or side vision.
[20] The curvature of the cornea.
[21] An Amsler grid test is used to detect vision problems resulting from damage to the macula.

carry out such testing at that time, as she was sure that Mrs A had a posterior vitreous detachment. However, Ms B said that "with the benefit of hindsight" she accepts that she should have taken these steps.

Appointment with optometrist Mr C — 17 December 2018

36. Mrs A told HDC that two months after seeing Ms B she was still unable to see objects in the middle of her right eye, and made an appointment to see her usual optometrist, Mr C, on 17 December 2018.

37. Mr C assessed Mrs A and noted her history of a floater in her right eye since 14 October 2018, and that Mrs A had been seen by Ms B at the time and diagnosed with a posterior vitreous detachment.

38. On examination, Mr C noted visual acuity in Mrs A's right eye of 6/48, and in her left eye of 6/6, and diagnosed a "[f]ull thickness macular hole [right eye] with a large floater over the disc", and "no clear sign of PVD [posterior vitreous detachment]" in her left eye. Mr C organised an urgent referral for Mrs A to see ophthalmologist Dr D.

Appointment with Dr D

39. Dr D saw Mrs A on 18 December 2018. In his clinic letter to Mr C, Dr D stated:

> "It is extremely disappointing that the optometrist she [Mrs A] saw [while on holiday] didn't action any further investigation for the fact that the vision on the right eye got so bad."

40. Dr D confirmed Mr C's findings of a posterior vitreous detachment and a large full thickness macular hole in the right eye.

41. Dr D arranged for Mrs A to have a vitrectomy, membrane peel, and gas bubble,[22] which was carried out on 24 January 2019.

Ongoing care

42. On 7 March 2019, Dr D reviewed Mrs A and noted that the visual acuity in her right eye had improved — "Right 6/120 but improving to 6/30 with pinhole[23]".

43. In his clinic letter, Dr D noted that the macular hole had closed, but that as a result of the delay in having it treated, "it may be that that delay is what's causing the poor sight". Dr D noted "a bit of a cataract" and suggested that cataract surgery might need to be done "sooner rather than later" to try to improve Mrs A's vision.

[22] A vitrectomy is the surgical removal of the vitreous gel; a membrane peel removes retinal traction, and a gas bubble is then inserted to hold the retina in position.
[23] Pinhole acuity testing uses an eye shield with several small holes that allow light to reach the retina without the interference of optical problems of the eye.

Comment from Mrs A

44. Mrs A told HDC that as the result of the advice given by Ms B, she assumed that the loss of eyesight was temporary and related to the floater. Mrs A stated:

> "If I hadn't bothered to get another check done by my own optometrist, and been fortunate enough to have [health] insurance so I was able to proceed with my fast-tracked surgery, another patient in my position may have been left with severely impaired sight."

Further comment from Ms B

45. In her statement to HDC on behalf of Ms B, Ms B's lawyer said:

> "[Ms B] is disappointed and regretful that she missed this [full thickness macular hole] diagnosis. Since the complaint was made, [Ms B] has spent significant time reflecting on the case, both personally and with her colleagues, and now understands that she should have carried out further investigations, given the results of the visual acuity test. [Ms B] accepts that by not doing so, her actions fell short of best practice. [Ms B] understands that her actions have likely caused [Mrs A] significant stress and upset, and for this, she unreservedly apologises to [Mrs A]."

46. Further, Ms B's lawyer stated:

> "[Ms B] strives to do her best by her patients, and is very upset that she failed to do so on this occasion. … [Ms B] is very sorry for any harm and upset her actions have caused [Mrs A]."

Changes made to Ms B's practice

47. Since this complaint, Ms B has made the following changes to her practice:

- If a person presents with sudden onset of a floater and/or a flash, and has had significantly reduced visual acuity, a full assessment is carried out, including Amsler grid testing and/or an OCT scan.
- If a person presents with sudden onset of a floater and/or a flash, and there are no full appointments available that day, reception staff will advise the person to seek an urgent appointment elsewhere.
- If a person is diagnosed with a posterior vitreous detachment, the person is informed of the symptoms of retinal detachment and told to seek urgent help if the symptoms change. The person is also given the New Zealand Optometrists Association booklet on floaters, spots, and flashes.
- Ms B now prioritises documentation, ensuring that clinical records are completed "to a high standard at the conclusion of each appointment".
- Ms B now obtains previous ocular history/notes for new patients prior to the appointment.

48. Ms B told HDC that she has also reviewed her professional and ethical obligations "and other related material" on the Optometry Board of New Zealand and New Zealand Optometrists Association websites.

49. Ms B is completing a professional education module on "degenerative floaters — a practical approach".

50. Ms B has also reflected on this case and her practice, including "with other senior members of the profession".

Responses to provisional opinion

51. Mrs A and Ms B, both in her capacity as sole director of, and as optometrist at, the optometry clinic, were provided with relevant parts of the provisional opinion and given the opportunity to comment. Where relevant, their responses have been incorporated into this report.

52. In addition, Mrs A stated:

> "I am very happy at the thorough information contained therein, and that [Ms B] has not only accepted that my treatment should have been better but she has introduced changes in her practice to avoid this situation happening to another patient."

53. Mrs A also stated that she is still receiving treatment for the reduced eyesight in her right eye.

Relevant standards

54. The Optometrists and Dispensing Opticians Board *Standards of Clinical Competence for Optometrists* (2018) states:

> "Task 7. Recording and maintaining of clinical data and records
>
> …
>
> 7.1.1 Records all relevant information pertaining to the patient in an individual patient record promptly and in a format which is understandable and useable by another optometrist …"

Opinion: Ms B — breach

Introduction

55. On 19 October 2019, Ms B carried out an assessment of Mrs A after she reported a five-day history of a floater in her right eye.

56. At the completion of the assessment, Ms B diagnosed Mrs A with a posterior vitreous detachment but failed to identify that Mrs A also had a full-thickness macular hole. As a result, there was a delay in Mrs A receiving the appropriate treatment.

57. Overall, guided by expert advice obtained from optometrist Mr Geraint Phillips, I consider that Ms B did not provide services to Mrs A with reasonable care and skill. In addition, I consider that Ms B failed to comply with professional standards by failing to document her assessment findings fully. I discuss the reasons for my views in more detail below.

Assessment and diagnosis

58. On assessment, Ms B noted Mrs A's five-day history of a floater in her right eye, with no other significant symptoms. Ms B carried out a visual acuity test with Mrs A wearing her corrective glasses. The findings indicated a significant reduction in the vision of Mrs A's right eye.

59. Mr Phillips advised: "Given the presentation of a new floater and significantly reduced vision in one eye, it is my opinion that further diagnostic steps should have been undertaken." He said that this should have included "very careful examination of the macular region with indirect lens views to optimize the visualization of any swelling or holes". Mr Phillips stated:

> "Although the records note that there were no retinal tears or retinal detachments detected, there is no indication that the peripheral retinae were examined with pupil dilation. As a [posterior vitreous detachment] can cause a retinal tear … in my opinion, it is standard of care for Optometrists to undertake a dilated retinal examination to ensure optimal views are obtained in order to diagnose a [posterior vitreous detachment] and to rule out any accompanying retinal changes. … The standard photographs taken in this case do not include the peripheral retinae and would not have been useful in ruling out a retinal tear or retinal detachment."

60. Mr Phillips also advised that Amsler grid testing should have been completed and an OCT scan obtained.

61. Ms B told HDC that she did carry out a more comprehensive examination than is recorded in her clinical records, including a dilated eye examination and "a careful examination of the macular region" using a slip lamp. She said that in addition, she examined the "fundi, A/V, C/D. macula and periphery" using ophthalmoscopy.

62. Having undertaken her assessment, Ms B diagnosed a posterior vitreous detachment. Ms B said that she believed that the decreased visual acuity was "due to visual disturbances in

the vitreous gel due to the vitreous fibres", and at the time she did not consider that further testing, including Amsler grid testing or an OCT scan, was necessary. However, Ms B said that "with the benefit of hindsight" she accepts that she should have taken these steps.

63. While I accept Ms B's submission that she did undertake a dilated retinal examination, I note Mr Phillips' advice that although a posterior vitreous detachment was a "reasonable diagnosis in this case", a posterior vitreous detachment "is very unlikely to reduce vision in the affected eye to the recorded level". Mr Phillips advised that in the circumstances, "further steps should have been taken to investigate the cause of the 6/60+ reduced vision". I accept Mr Phillips' advice.

64. I conclude that by failing to undertake an adequate assessment of Mrs A and, as a result, failing to undertake testing that could identify the cause of Mrs A's 6/60+ vision, Ms B did not provide services to Mrs A with reasonable care and skill.

65. I note that Mr Phillips considers Ms B's failure to undertaken further testing in the circumstances to be a significant departure from the accepted standard of care.

Advice provided

66. At the completion of the assessment, Ms B informed Mrs A of her diagnosis and advised her of the symptoms of retinal detachment, and told her that should she experience these, to go straight to the Emergency Department.

67. Mr Phillips advised:

> "In my opinion, the safety netting provided in this case for the floater and any subsequent spontaneous peripheral retinal tear was appropriate. The advice meets the standard of acceptable care."

68. I accept Mr Phillips' advice. Based on Ms B's diagnosis of a posterior vitreous detachment, the advice and follow-up provided to Mrs A was reasonable. While, as noted above, the symptom of reduced visual acuity should have been investigated further, I note that Ms B did not appreciate the significance of this finding at the time.

Documentation

69. As noted above, Ms B did not document all her assessment findings, including that she dilated the eyes, nor did she record the method of examination used. Ms B accepts this.

70. I note that Clause 7.1.1 of the Optometrists and Dispensing Opticians Board *Standards of Clinical Competence for Optometrists* (2018) states:

> "[The optometrist] 7.1.1 Records all relevant information pertaining to the patient in an individual patient record promptly and in a format which is understandable and useable by another optometrist …"

71. Ms B's failure to document her assessment of Mrs A fully was a departure from these professional standards.

72. I note that as a result of this complaint, Ms B now ensures that she has sufficient time to document her examinations fully.

Conclusion

73. Overall, as discussed above, I consider that Ms B failed to investigate the finding of significantly reduced visual acuity in Mrs A's right eye adequately. As a result, the cause of Mrs A's symptoms was not identified, and surgery to address her degenerating sight was delayed. Accordingly, I find that Ms B breached Right 4(1) of the Code by failing to provide services to Mrs A with reasonable care and skill.

74. I also find that Ms B breached Right 4(2) of the Code by failing to document her assessment findings in accordance with professional standards.

Opinion: Optometry clinic — no breach

75. Ms B is the sole director and optometrist practising at the optometry clinic.

76. Ms B told HDC that all employees at the optometry clinic are expected to follow and comply with the Optometrists and Dispensing Opticians Board's Standards of Clinical Competence, Cultural Competence, and Ethical Conduct, as well as the New Zealand Association of Optometrists' Code of Ethics. Ms B advised that copies of these documents are kept in the clinic, and are easily accessible to staff.

77. Overall, it is my view that the failings in the care provided to Mrs A are the result of individual clinical error and cannot be attributed to the systems in place at the optometry clinic at the time. Accordingly, I find that the optometry clinic did not breach the Code.

Recommendations

78. I recommend that Ms B:

a) Provide a written apology to Mrs A for the breaches of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A.

b) Undertake a documentation audit, looking at clinical records over a six-month period, to confirm that all clinical assessments have been documented fully. The results of the audit, and any additional changes in light of the findings of the audit, should be sent to HDC within three months of the date of this report.

79. I recommend that the Optometrists and Dispensing Opticians Board of New Zealand consider whether a review of Ms B's competence is warranted based on the information contained in this report. The Board should report to HDC on the outcome of its consideration once this has been completed.

Follow-up actions

80. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Optometrists and Dispensing Opticians Board of New Zealand, and it will be advised of Ms B's name.

81. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will 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, Mr Geraint Phillips:

"I have been asked to provide advice on case number C19HDC00346 concerning the care provided by [the optometry clinic] to [Mrs A] on 19th October 2018.

I can confirm I have no personal or professional conflict of interest in this case.

I have been supplied with:

i. The Letter of complaint dated …
ii. [The optometry clinic's] response dated …
iii. The Clinical records from [the optometry clinic] for 19th October 2018
iv. Retinal photographs taken by [the optometry clinic] for 19th October 2018

From this information, I have been asked to provide an opinion on the following:

1. Steps undertaken to diagnose [and] treat [Mrs A] when she presented to [the optometry clinic] with a floater in her eye on 19th October 2019
2. Clinical reasoning for [Mrs A's] diagnosis of Posterior Vitreous detachment in her right eye
3. Safety netting advice provided to [Mrs A] by [the optometry clinic]

1. Steps undertaken to diagnose [and] treat [Mrs A] when she presented to [the optometry clinic] with a floater in her eye on 19th October 2019

Clinical History
The clinical record for the 19th October visit states that [Mrs A] presented with a five day history of a floater in her right eye. The tick following the word 'vision' in the history would suggest that she hadn't noticed any changes in her vision. There were no reports of headaches (H/As), flashes or curtains. The ticks following ocular health (OH), General Health (GH) and Family History (FH) suggest that there were no issues with these aspects of her case history. 'No med' suggests [Mrs A] reported not taking any medications.

The case history as recorded suggests that the only presenting symptoms were of a five day history of a floater(s) in the right eye. Asking specifically about flashes is often used to try to identify the risk of a posterior vitreous detachment, retinal tear(s) and/or retinal detachment(s) being present. The symptoms of flashes cannot on their own, differentiate between these three conditions.

Asking specifically about a 'curtain' is often used to identify the risk of retinal detachment(s) being present, as a significant retinal detachment can obscure the vision relating to the area of the detachment and give the impression of the vision being blocked to some extent. The lack of symptoms of a 'curtain' cannot, on its own, indicate the absence of a retinal detachment. Some retinal detachments can be present without this symptom.

Clinical findings

Under 'Spec Rx' there is a recording of 6/60+ for the right eye and 6/6 for the left. Presumably these are levels of vision measured with [Mrs A] wearing her spectacles as there is an area on the record for visual acuity findings from the Optometrist conducting a full refractive assessment. As there are no recordings in this area, presumably a full refractive assessment was not done.

The finding of 6/60+ means that the vision in the right eye was significantly reduced. The finding of 6/6 in the left eye indicates normal central visual acuity in this eye.

Other recordings indicate the normal appearance and functioning of the lids, corneae, pupils and conjunctivae.

Under 'Media' (the structures between the cornea and retina) there is the recording of a right eye 'large floaters, good movt' (movement). The phenomenon of floaters, which are often caused by opacities within the vitreous (the cavity between the back of the lens and retina) can be caused by natural non-pathological processes, as well as separation of the vitreous from the retina (posterior vitreous detachment) or a retinal tear/detachment.

There are no recordings of findings in the areas of the record specifically for the examination of the 'Fundi' (retinae), 'A/V' (retinal blood vessels), 'C/D' (ratio of cup-to-disc of the optic nerves), 'Macular' or 'Periphery' (areas of the retinae outside the central zones).

There are also no recordings for findings related to 'Tonometry' (the pressure within the eyes), 'Fields' (the extent of the peripheral visual field or side vision), 'Keratometry' (the curvature of the corneae).

In a separate area of the record there is the recording of 'No Retinal tear, RD' (retinal detachment) 'Large PVD' (Posterior Vitreous Detachment). This would indicate that no retinal tears or retinal detachments were found and a 'Large' PVD was identified. There is no indication on the record as to what methods of examination were used and there is no recording of drops being used to dilate the pupils to obtain the optimal views.

The final recordings are those of the outcome of the examination. These outcomes are that there was an explanation given about the symptoms of an 'RD' (retinal detachment) and to go to 'A&E' if there are any changes.

Retinal photographs for the right and left eyes were taken. These are labelled as Date: 10/19/2018, 14:16:14 2:16:14 Pm and Date: 10/19/2018, 14:15:45 2:15:45 PM.

They cover the retinal area of a standard retinal photograph, each of about 45 degrees of eccentricity. Both photographs are somewhat underexposed, with shadowing affecting both maculae and some areas of the surrounding retinae. They do not

provide a useful view of the macular region in either eye. They are not wide-field and so do not cover the more peripheral views of either retina.

A recall of 1 year is recorded.

Opinion on the steps taken to diagnose the presentation of a floater.
Given the presentation of a new floater and significantly reduced vision in one eye, it is my opinion that further diagnostic steps should have been undertaken.

The examination lacked a dilated retinal examination which should have been undertaken to definitively establish the cause of the floater and to rule out any complications of a PVD. The lack of history of flashes and curtains does not on its own rule in a PVD and/or rule out retinal changes.

In this case, as there was also a significant reduction in vision in one eye, in my opinion a dilated retinal examination was indicated and not to do so, represents a significant departure from the standard of care.

It is very unlikely that a PVD alone would reduce the vision to the extent it did and so further steps should have been taken to investigate the cause of the 6/60+ reduced vision. This should have included a very careful examination of the macular region with indirect lens views to optimise the visualisation of any swelling or holes. Amsler grid testing and an OCT scan should have been obtained if there was uncertainty about the diagnosis.

My recommendations for future practice would be to ensure a dilated retinal examination was undertaken in all cases where the peripheral retina needs to be assessed. Also, any reduced vision that is not immediately diagnosable should be further investigated.

2. <u>Clinical reasoning for [Mrs A's] diagnosis of Posterior Vitreous detachment in her right eye</u>
[Mrs A] presented with a five-day history of a right eye floater. There were no other symptoms. She was found to have significantly reduced vision in her right eye and subsequently diagnosed with a floater and PVD in that eye. Although the records note that there were no retinal tears or retinal detachments detected, there is no indication that the peripheral retinae were examined with pupil dilation. As a PVD can cause a retinal tear (which in turn can lead to a retinal detachment) in my opinion, it is the standard of care for Optometrists to undertake a dilated retinal examination to ensure optimal views are obtained in order to diagnose a PVD and to rule out any accompanying retinal changes. Alternatively, the peripheral retinae can sometimes be visualised adequately without pupil dilation using a wide field-type camera. The standard photographs taken in this case do not include the peripheral retinae and would not have been useful in ruling out a retinal tear or retinal detachment. A diagnosis of PVD is often made by visualising a typical opacity in the vitreous that corresponds to the area of vitreous that detaches from the optic nerve. This floater (a

Weiss ring) is typically partly or fully circular and is often mobile due to movement of the detached vitreous. Any accompanying retinal tears or detachments are assessed with a careful peripheral retinal check.

Opinion on the reasoning.
In this case, a diagnosis of a PVD was made, presumably from the presence of a floater. This is a reasonable diagnosis in this case. However, a PVD is very unlikely to reduce the vision in the affected eye to the recorded level and so further investigations should have been undertaken to investigate the cause of the 6/60+ vision, particularly to look for the accompanying retinal changes that can occur as the result of a PVD. In the course of the vitreous detaching from the retina, there can be traction between the vitreous and the macular region that in turn can lead to a macular hole.

In my opinion, further investigations should have been undertaken to diagnose the cause of the reduced vision. As a minimum, this should have included a careful examination of the macular region, an Amsler grid test and better still, an OCT scan. I consider that the standard of Optometric care was not met in this case and this was a significant departure from accepted practice.

My recommendation for future improvement is that all cases of reduced vision should be carefully investigated, including a careful assessment of the macular region.

3. Safety netting advice provided to [Mrs A] by [the optometry clinic]
The safety netting provided in this case was to explain the symptoms of retinal detachment (RD) and to go to A&E if there were any changes. This is the appropriate advice for cases of uncomplicated PVD, where there are no retinal changes found. Any further progression of a PVD can cause a retinal tear or macular traction. A peripheral retinal tear can occur spontaneously and is therefore unpredictable. Vitreo-macular traction secondary to a PVD can result in a macular hole and can sometimes be found to be present before the vision is significantly affected. In this case, the presence of the floater probably meant that the vitreous had already detached from the optic nerve region and so the symptoms of the floater might not have changed much from then on.

In my opinion, the safety netting provided in this case for the floater and any subsequent spontaneous peripheral retinal tear was appropriate. This advice meets the standard of acceptable care. However, the finding of reduced vision should have been further investigated with some urgency.

My recommendation for improvements in future care is to ensure all clinical findings paint a consistent picture. In this case, the level of reduced vision did correlate with the diagnosis of a PVD.

I would be happy to clarify any of the above comments if you would like me to do so.

Yours sincerely.

Geraint Phillips"

The following further advice was received from Mr Phillips:

> "I have now reviewed the response letter from [Ms B's lawyer] dated 11 September 2019. I have also reviewed my letter of advice dated 26th July 2019.
>
> I can confirm that the response does not raise any new issues or any changes to my original advice."