Optometrist, Ms B

Optometry Clinic

A Report by the

Deputy Health and Disability Commissioner

(Case 16HDC01996)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. This report relates to the care provided to Mrs A by Ms B on 15 January 2013, 7 February 2013, and 10 June 2016.

2. On 15 January 2013, Mrs A attended an appointment at an optometry clinic as she had been experiencing blurred vision. Ms B had not obtained patient notes or clinical history from Mrs A's previous provider.

3. Ms B conducted testing and was unable to effectively examine Mrs A's retina due to Mrs A's small pupil size. Ms B reported that she offered Mrs A a dilated fundus examination. Her notes record that this was "deferred" but do not state the reason why. The level of discussion that took place between Ms B and Mrs A about the examination is disputed.

4. On 7 February 2013, Mrs A returned to the optometry clinic to have her reading glasses adjusted.

5. On 10 June 2016, Mrs A attended an appointment and Ms B identified macular scarring in Mrs A's right eye and recorded that Ms B had "a longstanding estoropia". The level of discussion that took place about Mrs A's condition and treatment plan is also disputed.

6. On 2 September 2016, Mrs A had an appointment with an ophthalmologist, who diagnosed Mrs A with an epiretinal membrane and referred her to a vitreoretinal surgeon.

Findings

7. Ms B failed to provide Mrs A with information that a reasonable consumer in Mrs A's circumstances would expect to receive, and breached Right 6(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1] It follows that Mrs A was not in a position to make informed choices about her care. Accordingly, Ms B also breached Right 7(1) of the Code.[2] Ms B also failed to provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code.[3] Adverse comment was made about Ms B's record keeping.

8. The optometry clinic was not found in breach of the Code.

Recommendations

9. It is recommended that Ms B provide HDC with a written report and a formal written apology addressed to Mrs A.

10. It is recommended that the Optometrists and Dispensing Opticians Board consider whether a review of Ms B's competence is warranted.

[1] Right 6(1) of the Code states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including — (a) an explanation of his or her condition …"
[2] Right 7(1) of the Code states: "Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise."
[3] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

11. It is recommended that the optometry clinic provide evidence of an update to its policies to reflect 2.5 of the Optometrists and Dispensing Opticians Board "Standards of Clinical Competence for Optometrists".

Complaint and investigation

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

- *Whether the optometry clinic provided Mrs A with an appropriate standard of care between 2013 and 2017.*
- *Whether Ms B provided Mrs A with an appropriate standard of care between 2013 and 2017.*

13. An investigation was commenced on 31 January 2018. This report is the opinion of Meenal Duggal, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

14. The parties directly involved in the investigation were:

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

Also mentioned in this report:

Dr C	Ophthalmologist

15. Independent expert advice was obtained from an optometrist, Brett Hooker (**Appendix A**).

Information gathered during investigation

Background

16. In 2013, Mrs A, aged 53 years, was experiencing distorted vision. She had a known family history of glaucoma and cataracts. On 15 January 2013, Mrs A attended an appointment with optometrist Ms B at the optometry clinic.

Examination on 15 January 2013

17. Prior to this appointment, Ms B had not obtained patient notes or clinical history from Mrs A's previous provider.

18. During the appointment, Ms B measured refractive error[4] and carried out an ophthalmoscopy. Ms B told HDC: "Ophthalmoscopy was performed to observe the posterior structure of [Mrs A's] eye, but her small pupil size prevented a thorough examination of the retina." Because of Mrs A's small pupil size, Ms B encountered difficulties in examining Mrs A's eye and was unable to examine her retina effectively using an ophthalmoscope. Retinal photography was also unsuccessful.

19. Ms B told HDC that she explained to Mrs A that in order to examine the posterior of the eye fully, a dilated fundus examination (DFE) would be necessary. A DFE uses eye drops to dilate or enlarge the pupil in order to obtain a better view of the fundus of the eye.

20. Ms B told HDC that she always explains the presence of side effects (including temporary blurred vision) and the additional appointment cost and time of a DFE. Ms B stated that on this occasion Mrs A refused the procedure. Ms B documented in the clinical notes that Mrs A had declined a DFE, but not the reasons why she declined.

21. In contrast, Mrs A told HDC that Ms B did not offer or mention a DFE. Mrs A said that in a meeting on 30 October 2016, Ms B said that she omitted to conduct the DFE because she did not have time.

22. Under the intraocular pressure test (IOP)[5] field in the clinical notes, Ms B documented that the test had been "deferred". No reason for the deferral has been recorded. Ms B also recorded in the clinical notes that reduced vision in Mrs A's right eye was due to anisometropic amblyopia.[6] Ms B also set a reminder for recall in two years' time.

Following appointments

23. On 7 February 2013, Mrs A returned to the optometry clinic to have her reading glasses adjusted. On 11 March 2014, Mrs A attended an appointment for the purpose of renewing her driver's licence, and her eyes met the standard required for driving.

10 June 2016 appointment

24. On 10 June 2016, Mrs A attended another appointment with Ms B. On this occasion, Ms B carried out a DFE and identified macular scarring in Mrs A's right eye. Ms B also recorded in her clinical notes that Mrs A had "a longstanding esotropia". Mrs A told HDC that Ms B informed her that she had some "scarring", but did not provide any further explanation. Mrs A stated that she assumed that the scarring was a result of previous laser eye surgery she had had in August 2006.

25. Ms B told HDC that Mrs A already had an appointment scheduled with an ophthalmologist, Dr C. Ms B documented in the clinical notes: "She has booked to see [Dr C] next week." Ms B stated:

[4] Inability of the eye to focus light correctly, causing blurred vision. Measurement of ocular refraction and identification of abnormalities is used as a basis for the prescription of corrective lenses.

[5] An IOP is the measure of the pressure of fluid within the eye, commonly used to test for the presence of glaucoma.

[6] Anisometropia is a condition where there is a significant difference in the focusing power of each eye. Amblyopia (commonly called "lazy eye") is a condition where the vision in one eye fails to develop fully in childhood.

> "I judged that it was not necessary to issue a written referral at this time, given that [Mrs A] advised she had already booked an appointment to see her ophthalmologist in September 2016."

26. In contrast, Mrs A told HDC that she did not already have an appointment scheduled with Dr C. Mrs A stated:

> "I eventually made an appointment for 2 September 2016 with [Dr C] … to try and determine if they could improve my vision. It was his examination that highlighted the scarring on the macula and my referral to [a specialist cataract surgeon]."

27. Dr C's practice told HDC that Mrs A contacted its office on 5 August 2016 to book an appointment. The appointment took place on 2 September 2016.

28. After the appointment with Dr C, Mrs A was diagnosed with an epiretinal membrane and referred to a vitreoretinal surgeon.

29. The specialist cataract surgeon, found that Mrs A had "a long history of a change in the quality of [her] right central vision due to progressive epiretinal membrane".

Responses from the optometry clinic and Ms B

30. Ms B told HDC that she accepts that she should have taken responsibility for scheduling an appointment for a DFE at a later date.

31. Ms B stated that her assumptions about amblyopia were incorrect, and she accepts that her diagnosis would have been better informed by reviewing Mrs A's previous clinical history.

32. The optometry clinic and Ms B accept that a measurement of Mrs A's IOP should have been taken, and that Ms B should have written the reason for deferring the IOP test.

33. The optometry clinic and Ms B also accept that Mrs A should have been scheduled for a shorter recall period, such as one, three, or six months.

Changes made to practice

34. The optometry clinic told HDC that it has made the following changes to its practice:

1. It has updated its process so that customers with eye conditions or other indications are now recalled in one year's time. This was communicated to staff on 9 January 2017.

2. In July 2017 it updated its clinical records system to a faster system with more capacity, to make it easier for practitioners to maintain comprehensive notes.

3. It is undertaking sampling and testing of a random sample of notes from practitioners at different store locations, to check whether notes comply with best practice.

4. A clinical conference is being scheduled for June/July 2018, where best practices will be reviewed and discussed, including best practice in clinical record-keeping. the optometry clinic intends to invite optometry professors from local universities to update staff about best clinical practice. The conference will be available in person and on line.

35. Ms B has made the following changes to her practice:

1. She now reviews the notes of each patient for the day in the morning. If the patient is new to the branch, Ms B will request all previous notes. If it is not possible to obtain notes until after the appointment, Ms B will check the notes for any inconsistencies and arrange any necessary follow-up appointments.

2. She now rearranges or shortens later appointments if an appointment runs over time, so that any timely but necessary procedures can take place. Where later appointments cannot be shortened or rearranged, Ms B will see patients during her lunch break or outside of her usual business hours.

3. She will now instruct staff to arrange any follow-up procedures such as visual field tests, IOP review, and therapeutic aftercare.

Responses to provisional opinion

36. Mrs A was given an opportunity to comment of the "information gathered" section of the provisional opinion and had no further information to provide.

37. Ms B was given an opportunity to comment on the provisional opinion and had no further information to provide.

38. The optometry clinic was given an opportunity to comment on the provisional opinion. It confirmed that it had no further information to provide.

Opinion: Ms B

39. This opinion considers the care provided to Mrs A by Ms B on 15 January 2013 and 10 June 2016.

Breach

Information provided in relation to DFE testing

40. On 15 January 2013, Ms B did not carry out a DFE on Mrs A when it became clear that her pupils were too small for standard retinal photography. She also did not request Mrs A's clinical history from her previous healthcare provider, ophthalmologist Dr C.

41. Expert advice was obtained from an optometrist, Mr Brett Hooker. Mr Hooker advised that given Mrs A's reduced vision and small pupil size, accepted practice would have been to arrange a DFE or to find out Mrs A's previous clinical history, including visual acuity,[7] from Dr C. Mr Hooker advised that failing to do so would be considered a significant departure from accepted practice.

[7] Clarity of vision.

42. Mr Hooker stated:

> "It is not unusual for a DFE to be declined at an initial examination as the side effects of blurred vision can last a few hours. Given the findings of reduced vision in one eye it would be usual to arrange a DFE at a more convenient time.
>
> …
>
> If pupil dilation is declined then the Optometrist should record why it was declined as well as documenting what they have told the client regarding the need for pupil dilation."

43. Ms B and Mrs A have different recollections about whether a DFE was mentioned or offered by Ms B during this appointment. Ms B documented in the clinical notes that the procedure was offered and declined, whereas Mrs A has told HDC that the DFE was never mentioned or offered.

44. On the basis of the clinical notes provided to me, I accept that some discussion about a DFE occurred. However, owing to the brevity of the clinical notes, I am not convinced that Mrs A was fully and comprehensively advised about the risks involved in declining the procedure. No evidence has been provided to me that an alternative appointment date was offered.

45. I acknowledge that Ms B has now accepted that she should have taken extra steps to confirm that Mrs A had secured a follow-up appointment for DFE.

46. Based on the information available to me, I consider that inadequate steps were taken to explain to Mrs A the importance of having a DFE, and the risks involved in declining the procedure.

Incorrect diagnoses

47. On 15 January 2013, Ms B recorded in the clinical notes that Mrs A was suffering from anisometropic amblyopia, and prescribed Mrs A reading glasses.

48. Mr Hooker advised HDC that Ms B's diagnosis was incorrect, and he considers that most optometrists would not have come to this conclusion. Mr Hooker said that his peers would consider this to be a "small" departure from accepted practice. Mr Hooker advised:

> "It is clear from [Dr C's] letter dated 2 September 2016 that the RE [right eye] was not amblyopic and that no anisometropia was present prior to refractive surgery. This information would have been available in 2013 but was not sought. If the optometrist had sought that information in 2013 then she would not have come to the conclusion that the reduced vision was due to anisometric amblyopia. It would then be expected that the Optometrist would follow through with further examination as to the cause of the reduced vision."

Pinhole testing

49. Mr Hooker also advised that a pinhole test[8] should have been carried out during this appointment. However, there is no record of pinhole testing having taken place.

50. Guided by Mr Hooker's advice, I accept that Ms B should have undertaken pinhole testing.

Intraocular pressure (IOP)

51. Ms B's records state "deferred" in the field that would usually note the result of IOP testing.

52. Mr Hooker advised that it is usual practice to provide a reason for deferral of the procedure. He also considers that an appointment should have been set for checking Mrs A's IOP in the near future, rather than two years later. Mr Hooker advised: "Failure to measure IOP in this case would be considered a significant departure from accepted practice."

53. I accept that Ms B should have measured and recorded Mrs A's IOP on or soon after 15 January 2013. Guided by the advice of Mr Hooker, I accept that there has been a significant departure from accepted practice.

54. I am highly concerned that Ms B diagnosed Mrs A without obtaining information from Dr C, and without carrying out the further examinations outlined above. I accept Mr Hooker's advice that Ms B did not have a sound basis for making her diagnosis, and that she should have sought Mrs A's ocular history from her previous eye specialist, Dr C.

55. In addition, on 10 June 2016 Ms B recorded in her clinical notes that Mrs A had "a longstanding esotropia". Mr Hooker advised that this conclusion was incorrect. I accept this advice and am critical that Ms B formed this diagnosis, given the information available to her.

Lack of referral to an appropriate specialist

56. On 10 June 2016, Mrs A attended another appointment with Ms B. On this occasion, Ms B carried out a DFE and identified macular scarring in Mrs A's right eye. Mrs A told HDC that Ms B informed her that she had some "scarring", but did not provide any further explanation. Mrs A stated that she assumed that the scarring was a result of previous laser eye surgery she had had in August 2006.

57. Ms B and Mrs A have different recollections about whether Mrs A told Ms B during the appointment of 10 June 2016 that she had already booked to see an ophthalmologist, Dr C. Mrs A contacted Dr C's clinic on 5 August 2016 to book an appointment with Dr C, and that appointment took place on 2 September 2016. For this reason, it is evident that a booking had not been made by 10 June 2016. However, I cannot determine for certain whether a future appointment was discussed.

58. Mr Hooker advised that referral to an ophthalmologist would have been appropriate following the discovery of macular scarring.

59. I am unable to ascertain whether Mrs A indicated to Ms B that she had an upcoming appointment with Dr C. However, I am concerned that Mrs A left the appointment without

[8] A test used to differentiate vision that can be corrected with lenses from vision that cannot.

an appropriate level of understanding of her condition, and without understanding that consultation with an ophthalmologist was required.

Conclusion

60. By not providing Mrs A with adequate information about DFE testing, the reasons for the DFE testing, and the implications of refusing the testing, Ms B failed to provide Mrs A with information that a reasonable consumer in Mrs A's circumstances would expect to receive, and breached Right 6(1) of the Code. It follows that Mrs A was not in a position to make informed choices about her care. Accordingly, Ms B also breached Right 7(1) of the Code.

61. Ms B failed to request appropriate information from Mrs A's previous healthcare provider, and failed to undertake standard procedures and appropriate testing, including pinhole testing, IOP testing, and a DFE. Therefore, Ms B did not have the information necessary to make an informed diagnosis, and was unable to make an appropriate diagnosis or take the appropriate follow-up actions. Accordingly, Ms B failed to provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code.

Adverse comment

Record-keeping

62. Clinical records are central to ensuring safe, effective, and timely care.

63. Ms B's clinical records of the assessments she carried out lack sufficient detail. Ms B did not record a reason for Mrs A declining a DFE, or a reason for the IOP examination being deferred.

64. Mr Hooker advised that this is an unusual omission, particularly in circumstances such as these where Mrs A had a family history of glaucoma.

65. I am guided by Mr Hooker's advice, and consider that Ms B's failure to provide full reasoning for omitting standard procedures was suboptimal.

Opinion: Optometry clinic — other comment

66. As a healthcare provider, the optometry clinic is responsible for providing services in accordance with the Code.

67. My expert advisor, Mr Hooker, has indicated that the optometry clinic's policies could be improved by the adoption of section 2.5 of the Optometrists and Dispensing Opticians Board "Standards of Clinical Competence for Optometrists", as follows:

> "2.5 Obtains and interprets relevant patient information from sources other than the patient.
>
> 2.5.1 Understands the need to obtain, interpret and integrate information appropriately from different sources (with appropriate consent), to assist in determining the management of the patient."

68. Other than the above recommendation, Mr Hooker has not raised any issues with the optometry clinic's broader systems or organisation. I accept that the optometry clinic had appropriate policies in place. I therefore consider that the optometry clinic did not breach the Code directly.

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

70. In 2012, Ms B was an employee of the optometry clinic. Accordingly, the optometry clinic is an employing authority for the purposes of the Act. As set out above, I have found that Ms B breached right 4(1) of the Code.

71. Ms B has been a registered optometrist since 7 December 1994. I am of the opinion that Ms B had an appropriate level of clinical experience to identify the appropriate procedures and tests that should have been carried out in 2013, and to consider the results of those tests adequately to form an appropriate diagnosis. As outlined above, Ms B was also supported at the optometry clinic by the policies that were in place. I consider that the optometry clinic was entitled to rely on Ms B to carry out appropriate examinations and investigations to establish the cause of Mrs A's reported blurred vision.

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

Recommendations

73. I recommend that Ms B:

a) Reflect on her failings in this case and provide a written report to HDC within three months of the date of this report. Ms B should reflect on the importance of:

i) informed consent

ii) undertaking standard procedures and testing; and

iii) providing full and clear documentation.

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

74. I recommend that the Optometrists and Dispensing Opticians Board consider whether a review of Ms B's competence is warranted.

75. I recommend that the optometry clinic provide evidence that the recommendation set out in Mr Hooker's advice dated 2 March 2018 regarding section 2.5 of the Optometrists and Dispensing Opticians Board "Standards of Clinical Competence for Optometrists" has been

implemented, and report back to HDC on any further changes that occurred following Mr Hooker's advice, within six months of the date of this report.

Follow-up action

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

77. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from Brett Hooker, optometrist:

"HDC Independent Advisor Report prepared by Brett Hooker for case C16HDC01996

I have been asked to provide an opinion to the Commissioner on case number C16HDC01996, I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

My qualifications, training, relevant experience:

BOptom, University of Auckland, New Zealand, 1993; Cert Oc Pharm (Therap) TAPIOT, University of Auckland, New Zealand, 2005; 24 years of Optometry Practice experience, primarily in a privately owned group practice.

Background

On 15 January 2013 [Mrs A] underwent an eye-check at [the optometry clinic]. She was tested and advised that she required glasses.

[Mrs A] advises that the glasses did not improve her vision, so she returned to [the optometry clinic]. [The optometry clinic] informed her that new prescriptions require time to adjust and that she should persevere with them.

[Mrs A] returned to [the optometry clinic] in June 2016, after learning about macular degeneration. She was informed that there was no change to her prescription, but that some scarring in the eye was seen.

[Mrs A] arranged an appointment to see another ophthalmologist and was informed that she had a progressive epiretinal membrane. She was scheduled for a right vitrectomy with membrane peeling on 3 November 2017. She considers [the optometry clinic] should have identified this in 2013.

Expert advice requested

Please review the enclosed documentation and advise whether you consider the care provided to [Mrs A] by [the optometry clinic] was reasonable in the circumstances, and why. In particular, please comment on:

1. The adequacy of [Mrs A's] eye examinations, both in 2013 and 2016.
2. Whether you consider there was any evidence of scarring in the eye.
3. Whether you consider there was any evidence of issues with [Mrs A's] eye membrane.
4. The provision of pupil dilation procedures, and information given to [Mrs A] about these.
5. Any other matters in this case that you consider warrant comment.

For each question, please advise:

a. What is the standard of care/accepted practice?

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?
c. How would it be viewed by your peers?
d. Recommendations for improvement that may help to prevent a similar occurrence in future.

Response to questions:

1. The adequacy of [Mrs A's] eye examinations, both in 2013 and 2016.
I have reviewed copies of hand written clinical records dated 15.1.2013 and electronic clinical records dated 10.6.2016.

Examination on 15.1.2013
Most of the procedures of a stand eye examination have been recorded.

Amsler grid testing is recorded as normal, which is an unusual finding given that 'Mono Vision — Distorted' is listed as a reason for the examination.

Reduced vision was recorded in the RE. Pinhole vision is usually measured when reduced vision is found but there is no record of this. Pinhole can help determine whether reduced vision is due to a refractive condition or other reasons such as pathology. In this case I would not expect pinhole to improve the vision, which would then indicate the need to look further for a cause.

The reduced vision in the RE is explained as due to anisometropic amblyopia. This conclusion is incorrect and I do not believe that most optometrists would have come to this conclusion. Anisometropia is a condition where there is a significant difference in the focussing power of each eye. Amblyopia (commonly called lazy eye) is a condition where the vision in one eye fails to develop fully in childhood. The clinical records show that the client had laser refractive surgery (LASIK) in 1997 with a monovision outcome.

Monovision LASIK would almost certainly not be performed on somebody with amblyopia because the vision in the amblyopic eye would not be good enough to read with. Without obtaining copies of clinical records prior to the refractive surgery, it is very difficult to determine the presence of either anisometropia or amblyopia. There is no record as to whether previous records were sought at the time of this examination.

The difficulty getting adequate retinal photos due to small pupils and that the client had declined a DFE (dilated fundus examination) was recorded. It is not unusual for a DFE to be declined at an initial examination as the side effects of blurred vision can last a few hours. Given the findings of reduced vision in one eye it would be usual to arrange a DFE at a convenient time. No reason for declining the DFE was recorded & no arrangements to perform a DFE at a more convenient time have been recorded.

Accepted practice would be to investigate the cause of reduced vision by arranging a DFE and/or contacting the client's previous eye care professional (in this case [Dr C]) to find out what the visual acuity was when last seen by him. [Dr C's] letter dated 2 September 2016 states that the best corrected vision in September 2012 was R 6/7.5+,

L 6/4 and therefore the RE is not amblyopic. It also references the Pre-LASIK refraction which does not show any anisometropia.

Failing to arrange a DFE or find out previous visual acuity would be considered a significant departure from accepted practice. I believe that my peers would view that an adequate examination had not been completed.

Intraocular Pressure (IOP) is routinely measured on clients over the age of 40 and is particularly important to measure if there is a family history of glaucoma.

The word 'deferred' is written where the IOP is normally recorded but no explanation as to why this measurement was deferred. This is unusual, particularly as the client had stated a family history of glaucoma. If the measurement was to be deferred due to time constraints then normal practice would be arranging to have this measurement taken at another time. The record card indicates that a reminder for re-examination was to be in 2 years which is a typical routine recall period. Failure to measure IOP in this case would be considered a significant departure from accepted practice. I believe that my peers would consider that arrangements should have been to record IOP on another day in the near future and that it not be deferred until the next scheduled examination in 2 years. It should be noted that IOP measurement is not clinically relevant in the context of diagnosing an epiretinal membrane (ERM).

My recommendation for improvement is that any tests or examinations that were not performed are recorded with an adequate explanation as to why this was the case, as well as a record of when these tests should be performed. A logical process of elimination needs to be followed before a diagnosis as to the cause of reduced vision needs to be followed.

7.2.2013

The chronology provided by [the optometry clinic] states that the client returned to [the optometry clinic] on 7.2.2013 to have the 'prescription strength fine-tuned'. I have requested a copy of [the optometry clinic's] records for this date but there does not appear to be any records relating to this visit. This may have represented an opportunity to review previous findings/diagnosis.

Standard practice is to record all such client interactions.

Examination on 10.6.2016
Reason for visit recorded as routine check and that client was happy with spectacles.

Most procedures of a standard eye examination have been recorded.

In the patient history field the following is recorded: '1997 L LASIK Planned R no Tx to achieve monovision. L dist vision and R near vision. Longstanding L esot'. This is relatively self explanatory and indicates that it was the Optometrist's understanding that [Dr C] had performed laser refractive surgery on the LE only in 1997 with an aim to provide good distance vision in the LE while leaving the RE short-sighted and to be used for reading. The recording of a longstanding L esotropia is not consistent with the examination in 2013 that recorded an esophoria, not tropia (a phoria is normally

considered an eye muscle imbalance whereas with a tropia, the eyes are not aligned). This summary is not an accurate representation of the actual ocular history in this case and may be a result of incorrectly drawn conclusions from the examination in 2013.

Internal — Media, Discs, BVs, Macula, Fundus records: 'cd0.5 nrr pale pink follows ISNT. large ppa. no cupping OU. Large gray-white memb over surface of R macula. some traction visible. L mac smooth+red. tessellate retina OU'. These notes correctly record the presence of the epiretinal membrane in the RE. 'cd0.5' and 'no cupping OU' however are contradictory terms in the assessment of the optic disc and while not related to the epiretinal membrane does bring in to doubt the accuracy of the record keeping.

It is my opinion that the outcome of this examination is adequate because the client ended up seeing an Ophthalmologist following the observation of an ERM. The diagnosis of R amblyopia is still not an adequate explanation for the reduced vision in the RE. I believe that my peers would consider this to be a small departure from accepted practice.

2. Whether you consider there was any evidence of scarring in the eye
An epiretinal membrane (ERM) is usually described as a thin sheet of fibrous tissue that can form on the surface of the retina. It is not unusual for an eye care professional to refer to it as a 'scar', as this is a term that is more easily understood.

2013: there is no record of scarring in the eye. Specifically the macula is recorded as 'red & flat' which is considered normal. The reduced vision recorded at that time is an indication that further examination was needed.

2016: the presence of an epiretinal membrane is recorded.

3. Whether you consider there was any evidence of issues with [Mrs A's] eye membrane.
2013: there is no record of an ERM. Specifically, Amsler grid testing is recorded as normal in both eyes. The reduced vision recorded at that time is an indication that further examination was needed.

2016: The ERM was recorded, as was some traction on the retina. Traction on the retina from an ERM is an issue that can cause distorted vision. Amsler grid testing is recorded as 'R hazy view' which indicates an issue at the macula of the right eye. The Optometrist concluded that this had not been noticed by the client due to the eye being amblyopic.

4. The provision of pupil dilation procedures, and information given to [Mrs A] about these
There is no record of pupil dilation (DFE) having being performed in 2013 or 2016. The only reference to pupil dilation is on the 2013 records '*px declined DFE'. There is no record of what information was given to the client regarding the need for a DFE. One indication for pupil dilation is a poor view of the posterior pole and another is reduced vision without an adequate explanation. I do not believe that in this case amblyopia is an adequate explanation and I am sure that my peers would agree with

this assessment. Failure to perform a DFE in this situation would be considered a significant departure from accepted practice.

My recommendation is that if pupil dilation is declined then the Optometrist should record why it was declined as well as documenting what they have told the client regarding the need for pupil dilation.

5. Any other matters in this case that you consider warrant comment.
It is clear from [Dr C's] letter dated 2 September 2016 that the RE was not amblyopic and that no anisometropia was present prior to refractive surgery. This information would have been available in 2013 but was not sought. If the Optometrist had sought that information in 2013 then she would not have come to the conclusion that the reduced vision was due to anisometric amblyopia. It would then be expected that the Optometrist would follow through with further examination as to the cause of the reduced vision. It is my impression that the reduced vision in 2013 was likely due to the presence of an epiretinal membrane."

Further expert advice was obtained from Mr Hooker on 2 March 2018:

"
- Staff training and supervision;
  There weren't any documents provided that specifically dealt with staff training & supervision
- organising and setting of appointment recalls
  The recall policy is comprehensive and appropriate.
- staff obtaining previous clinical records/notes from previous providers who have reviewed consumers.

Below are the relevant excerpts from the documents you provided

History Taking

History is taken to identify the client's needs and is usually ongoing during the consultation. The history will also identify important information about the patient's vision, eye health and related background general medical health.

As mentioned above, the clinician should use the history taking time to establish a rapport with the patient.

A thorough history is one that is tailored to the patient's individual problems and should use an appropriate order of open and then closed questioning to elicit the required information and put the client at ease. All histories should include:

- Demographic information (name, DOB, gender etc)
- Chief complaint and its history
- Visual history including self-assessment of visual status and needs, any recent or current symptoms, any use of spectacles or lenses using NEAT (see Appendix One)
- Probing for any hidden fears, doubts or concerns or preconceived ideas

- Ocular history including medications/nutritional supplements, allergies and other health care providers, especially any medications or diseases that may impact the ocular health
- Family Ocular and medical history with specific probing for any hereditary diseases relevant to the ocular health
- Vocational and Lifestyle requesting including driving and hobbies

[The optometry clinic]
Recording Keeping and Disclosure of Information to Third Parties
Date of last review: January 2017
Customer Records
Customer records must be maintained in a legible and logical form. Records held must contain such clinical information sufficient to allow another optometrist to assume management of the customer.

The record should include the following relevant information:

- Initial reason for consultation
- Previous prescription power and lens form
- General health and family history of illness including eye disease
- Occupation, hobby, leisure interests and lifestyle
- Date of birth
- Current refraction
- Slit lamp, ophthalmology and IOPs and where applicable perimetry results

When completing patient records, Optometrists need to ensure that they are legible, identify the author of every entry, and do not contain disparaging or inappropriate comments about the patient. To help ensure accuracy, they should be completed as soon as possible after the consultation.

A clear and accurate patient record should contain:

- Sufficient information to identify the patient;
- What the patient tells you about their condition;
- Any concerns the patient has;
- An objective examination, diagnosis and management plan;
- Results of any tests or investigations;
- A note if a patient has not decided to proceed with a test that you have recommended;
- Copies of imaging results and reports;
- Copies of referral letters (both to and from); and
- Copies of notes of all relevant patient correspondence.

They don't specifically deal with obtaining information from previous providers. Generally speaking, if an Optometrist doesn't feel as though they have obtained enough relevant information directly from the client, then they will seek to obtain that information from a previous provider.

Below is the relevant excerpt from the Optometrists and Dispensing Opticians Board Standards of Clinical Competence for Optometrists.

The Policies appear appropriate in general but it is my opinion that they could be improved if they reflected 2.5 above."