

A stylized, semi-transparent eye graphic in shades of green, positioned behind the 'OPR' text.

OPR

COLLEGE OF OPTOMETRISTS OF ONTARIO

**OPTOMETRIC
PRACTICE REFERENCE**

*Excellence in Optometric Care
Serving the Public Interest by Guiding the Profession*



Publishing History

The Guide to the Clinical Practice of Optometry

FIRST PUBLISHED November 1972
REVISED October 1975
September 1982
REPUBLISHED July 1987
REVISED January 1991

The Guide to the Practice of Optometry

FIRST PUBLISHED August 1998
REVISED January 1999

Optometric Practice Reference

FIRST PUBLISHED April 2007

All rights reserved. Copyright 2007 by the College of Optometrists of Ontario.
This Guide may not be reproduced in whole or in part without permission.

Table of Contents

PART 1. Optometric Practice Reference: The Fundamentals

1. Introduction and Purpose

- 1.1 Introduction
- 1.2 The Purpose of the OPR

2. The Practice of Optometry

- 2.1 Scope of Practice
- 2.2 Authorized Acts
- 2.3 The Practice of Optometry
- 2.4 The Practitioner/Patient Relationship

3. Standards and Guidelines: Definitions

- 3.1 Regulatory Standards
- 3.2 Professional Standards
- 3.3 Clinical Guidelines

PART 2. Optometric Care

4. General Clinical Matters

- 4.1 Clinical Equipment
- 4.2 Required Clinical Information
- 4.3 Delegation and Assignment
- 4.4 Guideline for the Use of Drugs by Optometrists
- 4.5 Referrals
- 4.6 Ocular Urgencies and Emergencies
- 4.7 Infection Control*
- 4.8 Collaboration and Shared Care

5. Documentation

- 5.1 The Patient Health Record
- 5.2 The Written Prescription

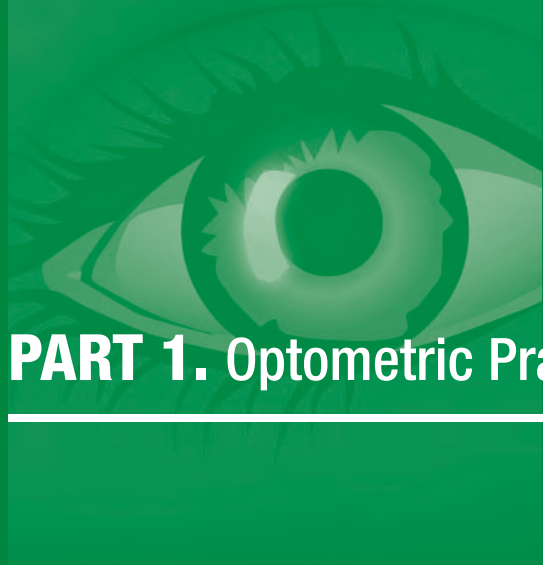
6. General Procedures

- 6.1 Anterior Segment Examination
- 6.2 Ocular Fundus Examination
- 6.3 Refractive Assessment and Prescribing
- 6.4 Spectacle Therapy
- 6.5 Contact Lens Therapy
- 6.6 Low Vision Assessment and Therapy*
- 6.7 Binocular Vision Assessment and Therapy*
- 6.8 Visual Field Assessment
- 6.9 Pharmaceutical Therapy*

7. Specific Diseases, Disorders and Procedures

- 7.1 Age-Related Macular Degeneration
- 7.2 Glaucoma*
- 7.3 Cataract*
- 7.4 Patients with Diabetes
- 7.5 Patients with Hypertension
- 7.6 Cycloplegic Refraction
- 7.7 Dilation and Irrigation of the Naso-Lacrimal Ducts
- 7.8 Refractive Surgery
- 7.9 Visual Perception/Learning Disabilities
- 7.10 Orthokeratology*

* Documents under development



PART 1. Optometric Practice Reference: The Fundamentals

1. Introduction and Purpose

1.1 Introduction

The College of Optometrists of Ontario is the regulatory body for the optometric profession in Ontario. In order to assist the College in meeting its objects, documents relating to optometric practice are periodically developed and published. This Optometric Practice Reference (OPR) represents a complete revision of The Guide to the Practice of Optometry and supersedes previous versions of The Guide. It will be periodically updated in response to changes in public need, economic forces, advances in health care sciences, and statutory and regulatory requirements.

1.2 The Purpose of the OPR

The OPR fulfills four key functions, as follows:

- **To provide information to the public and patients** and/or their representatives regarding the services and behaviour that can be expected from a member of the College.
- **To inform members of the College** of the principles and criteria which underlie the standards of practice and behaviour of the profession and to provide guidelines which the members may use in determining best practices for specific situations.
- **To assist committees of the College** to carry out their work. Some statutory committees of the College are required to assess the practice of members in the course of fulfilling their mandate to protect the public. The principles, standards, and guidelines described herein serve as a basis for their assessment. The Quality Assurance Committee employs regulatory and professional standards when assessing the practice of individual members and uses the clinical guidelines to help members move towards best practices. The Complaints and Executive Committees consider standards and guidelines for the purpose of case disposition. An alleged breach of a regulatory or professional standard is usually required before a member will be referred to either the Quality Assurance or Discipline Committee.
- **To promote ongoing discussion** and education among optometrists, ultimately leading to improvements in the quality of care and best practice for services provided to patients.

2. The Practice of Optometry

2.1 Scope of Practice

The *Optometry Act* specifies the scope of practice of optometry as follows:

The practice of optometry is the assessment of the eye and vision system and the diagnosis, treatment and prevention of:

- a) disorders of refraction;
- b) sensory and oculomotor disorders and dysfunctions of the eye and vision system; and
- c) prescribed diseases.

2.2 Authorized Acts

The Province of Ontario uses the concept of *controlled acts* to describe healthcare procedures and responsibilities that are not within the domain of the public. This forms the basis for regulation of healthcare services in the province. Thirteen of these *acts* are described in the *Regulated Health Professions Act* and each profession-specific act, such as the *Optometry Act*, specifies those that are authorized to the professional group.

In the course of engaging in the practice of optometry, an optometrist is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to perform the following:

1. Communicating a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system or a prescribed disease.
2. Applying a prescribed form of energy.
3. Prescribing or dispensing for vision or eye problems, subnormal vision devices, contact lenses or eye glasses.

2.3 The Practice of Optometry

There are several key principles that form the foundation for the optometric profession. The practice of optometry is:

Professionally based

Above all, the purpose of the optometric profession is to provide for the healthcare needs of patients, by placing the patient's best interest foremost.

Scientifically based

The profession of optometry is founded on research and education in the life and vision sciences, combined with scientific and technological expertise.

Primary health care

Optometrists are independent practitioners who work within Ontario's healthcare system in co-operation with other providers of related services for the ultimate benefit of patients.

Related to eyes and vision

The services generally provided in primary care optometry include:

- the assessment, diagnosis, management and prevention of conditions of the eye and vision system;
- the treatment, correction or rehabilitation of conditions of the eye and vision system;
- the dispensing of eye glasses, contact lenses, and low vision devices;
- referral to, or shared care with, allied health professionals; and
- the promotion of good vision and health through education.

Accountable to the public

The practice of optometry in Ontario is governed by the College of Optometrists of Ontario under the authority of the *Regulated Health Professions Act* and the *Optometry Act*. Accountability is assured in a number of ways including public representation on Council and College committees, and open (public) Council meetings and Discipline hearings. In addition, the College publishes an Annual Report and reports each year to the Minister of Health and Long-Term Care.

2.4 The Practitioner/Patient Relationship

With reference to the practitioner/patient relationship, the optometrist will:

Be accountable

An optometrist is accountable to the individual patient and to the College for all services provided, both personally and by others who are under their direction and supervision.

Act in the patient's best interest

The optometrist is responsible for fostering a relationship of trust with the patient and puts the patient's interest above his or her own. The Professional Misconduct Regulations protect such interests. Examples of acts which are considered to be professional misconduct include:

- Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence. **(O.Reg. 859/93 1. (1) 12.)**
- Failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination. **(O.Reg. 859/93 1. (1) 13.)**

Encourage patient decision-making

Optometrists give patients the information and counselling necessary for them to make informed choices about treatment and ongoing care, and respect the choices their patients make.

Protect confidentiality

Historical and clinical information is gathered in a manner respecting patient privacy. All records are kept confidential and secure. Release of information requires the consent of the patient or their representative(s), except as required or allowed by law, such as the *Personal Health Information Protection Act*.

Be ethical

Optometrists' behaviour and business practices conform to the profession's accepted ethical standards. This is emphasized in the Professional Misconduct Regulation which includes the following as an act of professional misconduct:

- Engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical. **(O.Reg. 859/93 1. (1) 53)**

3. Standards and Guidelines: Definitions

The Optometric Practice Reference contains **standards of practice** (both regulatory and professional) and **clinical guidelines**.

3.1 Regulatory Standards

Regulatory standards are found in the legislation of the Province of Ontario, such as the *Regulated Health Professions Act*, the *Ontario Regulations (O.Reg.859/93)*, and the *Optometry Act*. These standards are mandatory requirements for the profession, and **must** be complied with by the optometrist. Non-compliance with these standards could result in an allegation of professional misconduct.

3.2 Professional Standards

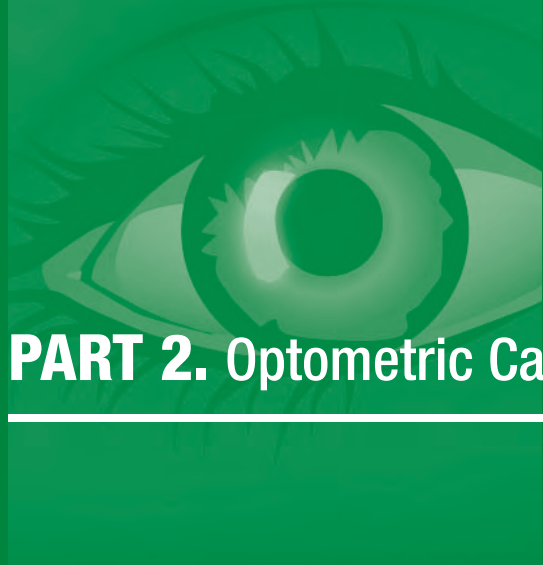
Professional standards describe *what a prudent practitioner would do in certain circumstances*. Every profession has unwritten standards of practice expected of members that are the generally accepted consensus of “right-thinking” practitioners. They come from a variety of sources such as educational programs, professional literature, informal “shop talk”, professional training, and the decisions of a College and the Courts. Rather than putting standards into a regulation, the College may publish documents that describe the existing generally accepted standard on recurring or significant issues. These types of standards do not have the force of law, yet are statements of what the prudent practitioner **usually** does in a given set of circumstances. While the strongest evidence of the professional standard of practice is usually expert testimony, College publications may support or reinforce the expert testimony and make it more likely to be accepted. The value of the publications is increased if they are the result of a consultation process with the members of the profession.

3.3 Clinical Guidelines

Guidelines are suggestions of voluntary behaviour that will assist prudent practitioners. They are not mandatory. They “raise the bar” and give the practitioner recommendations on how to practice at a higher, or “best practice” level.

Guidelines are found in various locations including journals and publications of associations or societies. While guidelines usually describe desirable practice methods and behaviour, their application may be limited by the legal scope of practice within the jurisdiction.

Given the changing nature of optometric care, scientific knowledge and public need, standards and guidelines are **evolutionary**.



PART 2. Optometric Care

4. General Clinical Matters

4.1 Clinical Equipment

Description

Optometrists are expected to be equipped with the instrumentation and supplies required to provide services that meet the standards of practice of the profession.

Regulatory Standard

The Professional Misconduct Regulation ([Regulation 859/93 under the *Optometry Act*](#)) includes the following acts of professional misconduct:

13. Failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination.
17. Failing to maintain the standards of practice of the profession.

Professional Standard

Every optometrist has access to, and ensures proficient use of equipment, instrumentation, drugs and supplies for the following:

- measurement of visual acuity at distance and near;
- evaluation of visual fields and colour vision;
- determination of refractive status of the eyes both objectively and subjectively;
- measurement of corneal curvature and thickness;
- assessment of ocular motility and binocular function;
- examination of the eye and ocular adnexa, including
 - a biomicroscope;
 - ophthalmoscopes (both direct and indirect);
 - accessory lenses;
- measurement of intraocular pressure;
- pupillary dilation, cycloplegia, topical ocular anesthesia, ophthalmic disclosing agents;
- measurement of the parameters of spectacles including refractive power, lens curvatures, lens thickness, and frame dimensions;
- measurement of the parameters of contact lenses including refractive powers and diameter;
- in-office treatment of common primary ocular emergencies;

Effective Date: June 2009

- disinfection of instruments and diagnostic contact lenses;
- infection control and cleanliness.

When optometrists do not have a specific instrument, they must have arrangements in place whereby the tests may be performed elsewhere and the results obtained for analysis and retention in the clinical record.

Optometrists are expected to maintain their equipment and instrumentation in good working order, including regular re-calibration.

Clinical Guideline

Scientific and technological advances will bring changes to the equipment available. It is recommended that optometrists stay current with the new technology.

First Published: September 2007

Revised: May 2009

4.2 Required Clinical Information

The provision of optometric care relies on acquiring, updating and maintaining a complement of information about a patient. Analysis of this data enables the optometrist to develop an accurate understanding of the patient's ocular status and to devise an appropriate management plan. Standards relating to required clinical information are intended to ensure the provision of optimal and efficient patient care.

Regulatory Standard

The Professional Misconduct Regulation (**Regulation 859/93 under the *Optometry Act***) includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.
3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.
13. Failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination.
16. Recommending or providing unnecessary diagnostic or treatment services.
17. Failing to maintain the standards of practice of the profession.

Professional Standard

Required clinical information to be obtained, when possible, at the patient's first presentation includes:

- the chief concern or request(s);
- a review of ocular or visual symptoms or experiences;
- a general health history, with emphasis on eyes and vision, including medications used and applicable family history;
- the occupational and avocational visual environment and demands;
- the measurement and description of the patient's ophthalmic appliances including purpose and effectiveness; and
- the results of the observation, examination or measurement of:
 - apparent and relevant physical, emotional and mental status of the patient;
 - the external eye and adnexa;
 - pupillary function;
 - the *anterior segment* (**OPR 6.1**) and, when indicated, corneal thickness;

Effective Date: June 2009

- ocular media;
- the *ocular fundus* (OPR 6.2);
- intraocular pressure in adults and, when indicated, in children;
- presenting monocular visual acuities at distance and near;
- refractive status and best-corrected monocular visual acuity;
- accommodative function;
- oculomotor status;
- other sensory functions, when indicated, such as visual fields, colour vision, stereoacuity, sensory fusion and contrast sensitivity.

All required clinical information must be clearly documented in the patient's health record (OPR 5.1).

In emergency or urgent situations it may be impractical to obtain all information at the first visit. In this case, a specific assessment is appropriate (see OPR 4.6-Ocular Urgencies and Emergencies). Also, the full complement of required clinical information may not be necessary when providing specific assessments or consultation services for a referring optometrist, physician or nurse practitioner. In such cases, the optometrist will determine what is clinically necessary based on the reason for presentation.

Clinical Guideline

A practitioner may choose to employ ancillary procedures in addition to the normal complement of required clinical information in order to enhance or refine a clinical diagnosis or management plan. This is particularly true when the rapid pace of scientific and technological advancement in equipment and instrumentation is considered (OPR 4.1). Examples of such procedures include, but are not limited to:

- Fundus photography, retinal tomography, optical coherence tomography, scanning laser ophthalmoscopy, and similar high-technology imaging/mapping systems;
- Corneal topography, pachymetry;
- Ophthalmic ultrasonography (A or B scan), ultrasound biomicroscopy;
- Advanced refractive technologies (e.g. wavefront analysis, aberrometry, etc).

While these procedures may contribute valuable information in the assessment of specific clinical presentations, optometrists are reminded that patients should not be required or coerced to undergo ancillary procedures. Prior informed consent is necessary.

First Published: September 2007

Revised: May 2009

4.3 Delegation and Assignment Policy

Introduction

The Province of Ontario utilizes the concept of “controlled acts” to control who may perform healthcare procedures and responsibilities that have a high risk of harm associated with their performance. The controlled acts are listed in the *Regulated Health Professions Act, 1991* (RHPA). Each profession-specific act, such as the *Optometry Act, 1991*, specifies any controlled acts that the members of the profession are authorized to perform (the profession’s “authorized acts”). Each regulated profession has a defined scope of practice and some have corresponding authorized acts set out in the profession-specific Act.

There are also numerous non-controlled procedures, some of which are limited to objective data collection and others which carry a potential risk of harm to the patient. Although these procedures are in the public domain (i.e. they are NOT controlled acts), they may require specific training and skills.

The term *delegation* refers to the process whereby a regulated health professional (RHP), who has a controlled act within his/her scope of practice, orders another person who would not otherwise be authorized to do so to perform this act.

The term *assignment* refers to the process of an RHP assigning the performance of a non-controlled procedure to another person.

Both delegation and assignment of optometric procedures in appropriate circumstances may allow a more timely and efficient delivery of optometric care, making optimal use of time and personnel. In every instance of delegation and assignment, the primary consideration should be the best interests of the patient.

It is a general expectation that optometrists will be responsible for, and appropriately supervise, all delegated and assigned activities within their practices. The level of supervision varies with the risk associated with the delegated or assigned procedure. **Direct supervision** refers to situations in which the optometrist is physically present in the same clinical location. This allows the optometrist to intervene immediately when necessary. Direct supervision is expected for ALL delegation (controlled acts), and for any assigned activities which require interpretation in the performance of the procedure and/or may present a risk of harm to the patient. **Remote supervision** refers to situations in which the presence of the optometrist is not necessarily required since there is no potential risk of harm to the patient. This would be appropriate for certain clinical procedures and objective data collection.

The responsibility for all aspects of any delegated acts or assigned procedures always remains with the optometrist.

Optometrists may also *receive delegation* of a controlled act not authorized to optometry.

Collaboration with other health professionals

Collaboration with other health professionals is a common occurrence in clinical practice. When an optometrist collaborates with another health professional, the College standards and guidelines on collaboration (OPR 4.8) will apply.

Regulatory Standards

Controlled Acts

The *Regulated Health Professions Act* identifies 13 controlled acts that may only be performed by members of certain regulated health professions. Optometrists are authorized by the *Optometry Act* to perform 4 of the 13 controlled acts, as follows:

- i. communicating a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system, or a prescribed disease;
- ii. applying a prescribed form of energy;
- iii. prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses; and
- iv. prescribing a drug designated in the regulations.

The RHPA also discusses delegation of controlled acts:

- 27. (1)** No person shall perform a controlled act set out in subsection (2) in the course of providing health care services to an individual unless,
- a. the person is a member authorized by a health profession Act to perform the controlled act; or
 - b. the performance of the controlled act has been delegated to the person by a member described in clause (a). 1991, c. 18, s. 27 (1); 1998, c. 18, Sched. G, s. 6.
- 28. (1)** The delegation of a controlled act by a member must be in accordance with any applicable regulations under the health profession Act governing the member's profession.

Exceptions

- 29. (1)** An act by a person is not a contravention of subsection 27 (1) if it is done in the course of,
- b. fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is done under the supervision or direction of a member of the profession.

The *Optometry Act, 1991* includes the following Professional Misconduct regulations:

17. Failing to maintain the standard of practice of the profession.
18. Delegating a controlled act in contravention of the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts.
19. Performing a controlled act which has not been delegated to the member in accordance with the regulations.
20. Ordering a person who is under the supervision of a member to perform an act, or supervising an act, in the practice of optometry that is not consistent with the regulations.
21. Permitting, counselling or assisting any person who is not a member to perform an act which should be performed by a member.

Professional Standard

Delegation

Optometrist-Patient Relationship

Delegation will only occur after the optometrist has established a formal relationship with the patient, which normally will include an interview, an assessment, recommendations if appropriate, and informed consent about any clinical investigations and proposed therapy. In some cases where an established patient/practitioner relationship exists, delegation may take place before the optometrist sees the patient.

Presence of the Optometrist

Delegation of an authorized act must only take place when the optometrist is present in the same clinical location as the patient and is available to intervene when required.

Process for Delegation

The optometrist must establish a process for delegation that includes:

- education and assessment ensuring the currency of the delegate's knowledge, skills and judgement;
- documentation/references for performance of procedures; and
- ensuring the delegate has been delegated only those acts that form part of the optometrist's regular practice.

Informed Consent

Delegation occurs with the informed consent of the patient. Whether the consent is implicit or explicit will depend on the particular activity being proposed to be delegated.

Effective Date: June 2009

Supervision

The optometrist directly supervises the delegated procedure by direct supervision.

Quality Assurance

The optometrist is expected to ensure there is an ongoing quality assurance mechanism.

Assignment

Optometrist-Patient Relationship

Assignment of certain procedures that are not controlled acts may occur as part of the optometric examination and may occur prior to the optometrist assessing the patient. For example, pre-testing using automated instruments may occur prior to the optometrist seeing the patient.

Presence of the Optometrist

Procedures that are completely objective, present no inherent risk of harm and require no interpretation by the person performing the procedure may be performed without the presence of the optometrist and are considered to be *remotely supervised*. This could include automated procedures such as objective auto-refraction, auto-perimetry and non-mydratic retinal photography. However, the optometrist is expected to review the results of these remotely supervised procedures and communicate appropriately with the patient.

Direct supervision *must* occur whenever clinical interpretation is necessary during the procedure (i.e. subjective refraction), or when the procedure poses a potential risk of harm (i.e. applanation tonometry).

Process for assignment

As with delegation, it is expected that assignment will only occur with certain processes in place, including:

- education and assessment ensuring the currency of the assignee's knowledge, skills and judgement;
- documentation/references for performance of procedures; and
- ensuring only those procedures that form part of the optometrist's regular practice are assigned.

Professional Standard for Receiving Delegation of Controlled Acts

In the public interest, there are situations when an optometrist could receive delegation from another regulated health professional (RHP) to perform a controlled act not authorized to optometry. Other RHP's have delegation regulations and established protocols for delegation of which the member should be aware. In order for an optometrist to receive delegation from another RHP, all of the following criteria must be met:

- i. a process for receiving delegation is in place;
- ii. the member will have a reasonable belief that the RHP delegating the act is authorized to delegate the act, has the ability to perform the act competently, and is delegating in accordance with relevant regulations governing his or her profession;
- iii. the optometrist should be competent to perform the act safely, effectively, and ethically;
- iv. appropriate resources, such as equipment and supplies, are available and serviceable;
- v. the delegated act is clearly defined;
- vi. the delegated act is within the assessment of the eye and vision system and the diagnosis, treatment and prevention of disorders of refraction, prescribed diseases, and sensory and oculomotor disorders and dysfunctions of the eye and vision system;
- vii. the duration of the delegation will be clearly defined and relate to a specific patient;
- viii. the optometrist ensures that patient consent to having the act performed under delegation to the optometrist is obtained and recorded in the patient's health record;
- ix. a mechanism exists to contact the RHP who delegated the act if there is an adverse or unexpected outcome; and
- x. the identity of the RHP delegating the controlled act and of the member performing the controlled act will be recorded in the patient health record.

Guideline for Delegation by an Optometrist

The optometrist remains responsible for all activity within his/her office, including delegated and assigned procedures. It is always prudent to ensure that any activities being delegated or assigned are appropriately supervised and performed in a safe, effective and accurate manner.

Good communication skills for the optometrist and staff members are essential for effective delivery of patient care, particularly when procedures are delegated or assigned. Formal courses in procedures and communication are very helpful to complement appropriate staff training. Regular staff training, assessment and an

4. General Clinical Matters

Effective Date: June 2009

effective office policy and procedure manual are also helpful resources to promote competence.

It is also wise to ensure that the person performing the delegated or assigned procedure is clearly indicated within the patient health record. This is essential for both quality assurance and medico-legal reasons.

First Published: February 2005

Revised: May 2009

4.4 Guideline for the Use of Drugs by Optometrists

Introduction

This Guideline is to inform College members of the appropriate use of drugs in their practices. Such use may be for either diagnostic or therapeutic purposes, but does not include prescribing or dispensing such drugs.

Background

Under Part V of the *Health Disciplines Act*, the use of drugs by optometrists was regulated by listing the drugs that optometrists could use (i.e. topical anaesthetics, 0.5% tropicamide, and 0.5% cyclopentolate), and their purposes. Under the *Regulated Health Professions Act* and the *Optometry Act*, the regulation of the use of drugs requires a *restrictive* regulation. In other words, unless a regulation is developed restricting the use of a drug by an optometrist, such use is permitted. Currently, there is no regulation restricting the use of drugs by optometrists. The result is that optometrists are now able to use a wider range of drugs in their practices for both diagnostic and treatment purposes.

The College will continue to work with the Ministry of Health and Long-Term Care and other stakeholders to develop a new regulation consistent with the *Optometry Act* that both protects and serves the public interest. Until a regulation is brought into force, the College has developed the following Guideline to assist optometrists in the use of drugs in their practices. The Guideline is intended to provide practitioners with the best practices in this area.

Guideline

The College recognizes that there are many ways drugs may be used. In the context of this Guideline, *use* means the administration of a drug to a patient by the optometrist in his or her practice. The administration of the drug may be for either diagnostic or therapeutic purposes.

In all cases where an optometrist is using drugs in his or her practice, the optometrist should have taken appropriate training, be competent in the administration of the drugs being used, be able to recognize and treat common adverse reactions to their administration, and limit the use to the eye and vision system.

The College wants to make it clear that although there is now a wider range of drugs that optometrists may use in their practices, members cannot *prescribe* or *dispense* drugs, since *prescribing* and *dispensing* drugs are controlled acts not authorized to optometry. Furthermore, the College believes that *sampling* a drug is the same as *prescribing* or *dispensing* within the meaning of the *Regulated Health Professions Act*. Accordingly, optometrists may not initiate therapy and then provide

the remainder of the bottle or tube of the drug to the patient for their continued use.

This Guideline applies only to drugs that are not available over-the-counter. Accordingly, optometrists may continue to recommend and provide samples of over-the-counter drugs to their patients.

To further assist optometrists in understanding how certain classes of drugs may be appropriately used in the practice of optometry, the College is providing the following specific Guidelines:

Table 1. Diagnostic Pharmaceutical Agents (DPAs)

DPAs	EXAMPLES	USES	ADVERSE EFFECTS	CONTRAINDICATIONS
Mydriatics	tropicamide 0.5%, 1%; phenylephrine 2.5%, 5%, 10%; hydroxyamphetamine 1%.	Pupillary dilation, Horner's Syndrome differentiation.	Photophobia, cycloplegia, headaches, blurred vision.	Narrow or closed angles, dislocated or subluxated crystalline lens or IOL, iris- supported/iris-clipped/iris- sutured/iris-stapled IOL.
Cycloplegics	cyclopentolate 0.5%, 1%; tropicamide 0.5%, 1%; homatropine 2%, 5%; atropine 1%.	Suspension of accommodative function.	Stinging, photophobia, accommodative suspension, increased IOP, ACG, dry mouth, respiratory suppression, dry skin, rash, tachycardia, hyperemia, cardiac arrhythmias, hypotension, fever, confusion, dizziness, drowsiness, tiredness, psychotic and behavioural reactions.	Cardio-vascular disease, Hx of CVA, HBP, hypotension, use of reserpine or guanethidine. For hydroxyamphetamines: patients on tricyclic antidepressants. Known sensitivity to belladonna alkaloids.
Miotics	pilocarpine 1%, 2%, 4%.	Pupillary dilation reversal, provocative testing for Horner's Syndrome, denervation supersensitivity testing.	Stinging, irritation, ciliary spasms, miosis (vision), pupillary block, retinal detachment, headache, pain, bradycardia, arrhythmia, dyspnea, increased BP, tachycardia, anxiety.	History of retinal detachments, severe myopia, cataracts, inflammation/infection, aphakia/ pseudophakia, asthma, ulcers, bladder infections, Parkinson's disease.
Anaesthetics	proparacaine HCl 0.5%; proparacaine HCl 0.5% with 0.25% fluorescein; tetracaine HCl 0.5%; benoxinate HCl 0.4% with 0.25% fluorescein.	Tonometry, gonioscopy, contact lens fitting.	Over-use reduces re- epithelization.	Suspected abuse.

Table 2. Therapeutic Pharmaceutical Agents (TPAs)

DRUG CLASS	EXAMPLES	USES	ADVERSE EFFECTS	CONTRAINDICATIONS
Anti-Infectives* (including Anti-Bacterials, Anti-Fungals, Anti-Protozoans, and Anti-Virals)	gentamicin or erythromycin ointment.	Initial treatment and prophylaxis of corneal or conjunctival abrasions.	Stinging or irritation on application.	Known sensitivity to any component.
Anti-Inflammatories* (including Steroidal, Non-steroidal and combination drugs)	dexamethasone sodium phosphate; fluorometholone; prednisolone; diclofenac; flurbiprofen; ketorolac.			
Anti-Allergics*	emedastine difumarate; ketotifen fumarate; levocabastine; lodoxamide; nedocromil; sodium cromoglycate.	Acute or chronic allergy.		
Cycloplegics	tropicamide 0.5%, 1%; cyclopentolate 1%; homatropine 2%, 5%; atropine 1%.	Cycloplegia	Stinging, photophobia, accommodative suspension, increased IOP, ACG, dry mouth, respiratory suppression, dry skin, rash, tachycardia, hyperemia, cardiac arrhythmias, hypotension, fever, confusion, dizziness, drowsiness, tiredness, psychotic and behavioural reactions.	Narrow or closed angles, dislocated or subluxated crystalline lens or IOL, iris-supported/iris-clipped/iris-sutured/iris-stapled IOL; known sensitivity to belladonna alkaloids.
Anti-Glaucomas*	Beta-Blockers: timolol 0.25%, 0.5%; betaxolol 0.25%, 0.5%; levobunolol 0.5% Cholinergics: pilocarpine 1%, 2%, 4% Selective Alpha Agonists: apraclonidine 0.5%, brimonidine 0.2% Prostaglandins: lantoprost 0.005%, bimatoprost 0.03%, travoprost 0.004% Carbonic Anhydrase Inhibitors (CAI's): dorzolamide 2%, brinzolamide 1%, acetazolamide (Diamox), methazolamide (Neptazane).	Angle Closure Glaucoma, Primary Open Angle Glaucoma.	See Table 3.	See Table 3.

* Treatment of conditions with drugs in these classes is usually over a period of time requiring the issuance of a prescription. However, optometrists may initiate treatment until a referral is arranged.

Examples of TPA Use for Emergency Optometric Treatment

The diagnosis and treatment of diseases of the eyes and vision system is within the *scope of practice* (OPR 2.1) of optometry. However, the controlled act of prescribing drugs has not been authorized to optometrists. In some cases, effective treatment of ocular diseases dictates that the treatment continue over a period of time requiring a prescription to be given to the patient. Optometrists should treat only those conditions for which “in office” treatment is appropriate, or initiate therapy for those conditions that are of an emergency nature. In case of emergency, the goal should be to stabilize the condition until a referral for continued treatment by another health care provider is arranged.

The following are examples of situations when an optometrist might use a therapeutic pharmaceutical agent. This list is not exhaustive.

Example A:

A patient presents with iritis. It would be appropriate for the optometrist to treat the patient with 1% atropine and refer to a physician for further care.

Example B:

A patient presents with a corneal abrasion. It would be appropriate for the optometrist to initiate treatment with an anti-infective ointment, pressure patch or apply a bandage contact lens as required, and refer to a physician for further care.

Example C:

The patient presents with acute angle closure glaucoma. It would be appropriate for the optometrist to initiate treatment to break the attack, and refer to a physician for further care (see [Primary ACG Treatment Flow Chart](#)).

Table 3. Major Adverse Reactions and Contraindications of Pharmaceuticals used in the Treatment of Glaucoma

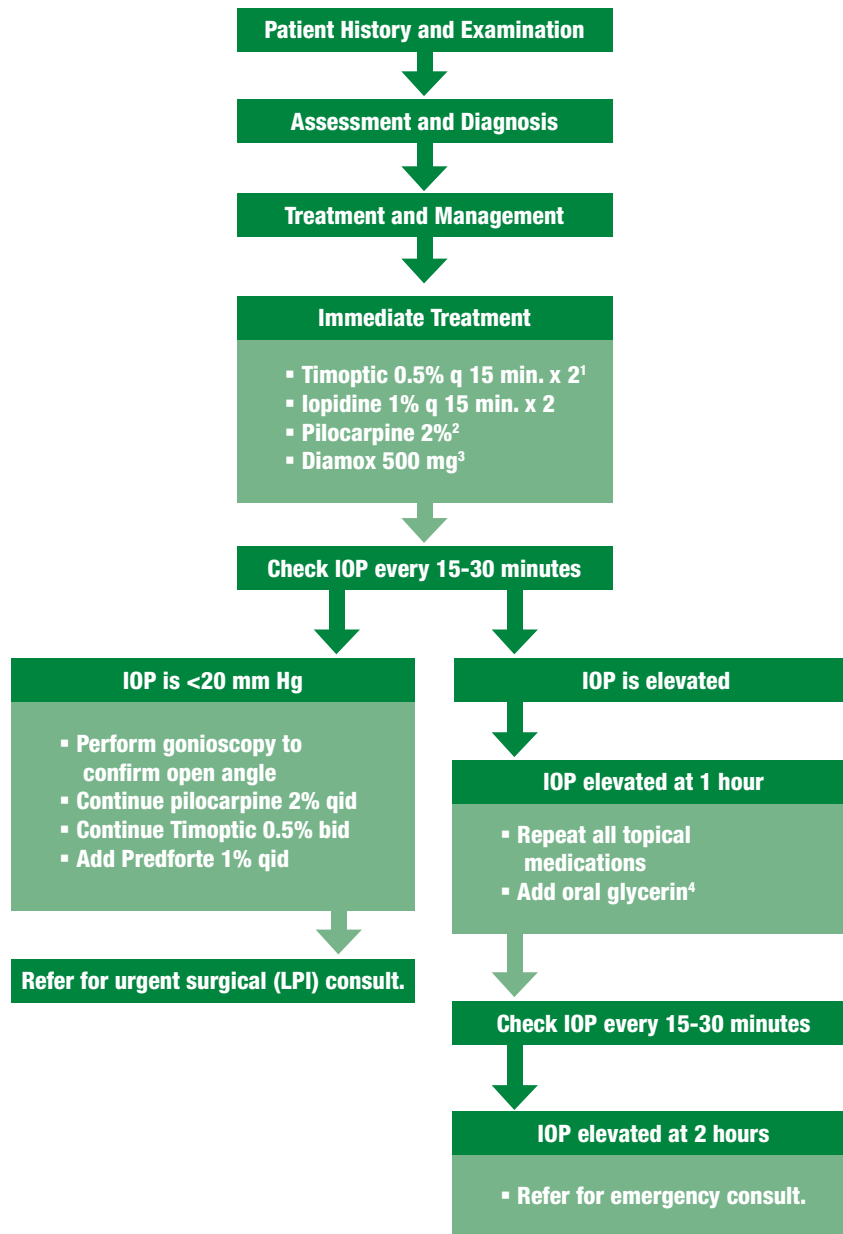
PHARMACEUTICAL AGENTS	ADVERSE REACTIONS		CONTRAINDICATIONS	
	OCULAR	SYSTEMIC	OCULAR	SYSTEMIC
Pilocarpine	Stinging, irritation; ciliary spasms (myopia); miosis (vision); pupillary block; retinal detachment.	Headache; sweating; vomiting and diarrhea; salivation; bradycardia; arrhythmia; dyspnea.	History of retinal detachment; high myopia; cataracts; inflammation/infection; aphakia/pseudophakia.	Asthma; ulcers; bladder dysfunction; Parkinson's disease.
Epinephrine¹	Stinging and burning; mydriasis; allergic sensitivity; pigment deposits; cystoid macular edema; increased IOP.	Increased BP; increased pulse; severe headaches; anxiety.	Aphakia/pseudophakia; narrow angles.	Systemic hypertension; heart disease; hyperthyroidism; diabetes mellitus; certain medications.
Alpha-2 agonists	Allergic sensitivity ² ; minimal mydriasis ² ; lid retraction ² ; conjunctival vaso-constriction ² ; stinging and burning; foreign body sensation; hyperemia; conjunctival follicles.	Gastrointestinal discomfort; taste abnormalities; headache; fatigue and drowsiness; oral dryness.	None.	None.
Topical beta-blockers	Stinging and burning; superficial punctate keratitis; allergic sensitivity; decreased corneal sensitivity; uveitis.	Dyspnea ³ ; bronchiole constriction ³ ; increased heart rate ³ ; arrhythmias ³ ; decreased BP; depression and confusion; gastrointestinal discomfort; impotence; sleep disturbances; serum lipoprotein alterations; masking of symptoms of diabetes and hyperthyroidism.	Narrow angles.	Chronic obstructive pulmonary disease; systemic hypotension; bradycardia; diabetes mellitus; myasthenia gravis; certain medications.
Oral carbonic anhydrase inhibitors	None.	Malaise; depression and confusion; metallic taste; anorexia; diarrhea; paresthesias; kidney stones; metabolic acidosis; blood dyscrasias.	None.	History of kidney stones; liver disease; sulfonamide allergy; cardiac disease; Addison's disease; renal disease; severe chronic obstructive pulmonary disease.
Topical carbonic anhydrase inhibitors	Stinging and burning; allergic sensitivity; blurred vision; superficial punctate keratitis; corneal edema.	Altered taste.	Compromise of the corneal endothelium.	Sulfonamide allergy.
Prostaglandin analogs	Blurred vision; stinging and burning; hyperemia; foreign body sensation; itching; increased iris pigmentation; eyelash changes; punctate epithelial keratitis; cystoid macular edema; iritis; herpes simplex keratitis.	Headaches; upper respiratory tract symptoms.	History of uveitis, cystoid macular edema, herpes simplex, complicated cataract surgery.	None.

¹ Adverse ocular reactions and contraindications are less with dipivefrin than with epinephrine.

² Adverse ocular reactions are less common with brimonidine.

³ May be less severe with betaxolol.

Primary ACG Treatment Flow Chart



Notes

¹ Use Betoptic 0.25% if patient has COPD.

² Use every 15-60 minutes up to a total of 2-4 doses; if IOP is > 40 mm Hg, iris sphincter muscle may be ischemic, so pilocarpine may not cause miosis until IOP is reduced below this level by other drugs.

³ Use two 250 mg tablets; avoid if patient has sulpha allergy; if patient has a kidney condition, use 100 mg Neptazane; if nauseated, consider IV Diamox.

⁴ Doseage 1.5 mL/kg body weight; serve over ice; if nauseated, consider IV Mannitol.

(April 2004)

4.5 Referrals

Description

A referral is a request for consultation and/or the provision of treatment made to another regulated health professional (most often an ophthalmologist) when a patient requires care that exceeds the optometrist's scope of practice or ability.

Regulatory Standard

The Professional Misconduct Regulation ([Regulation 859/93 under the *Optometry Act*](#)) includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.
3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.
12. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.
13. Failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination.
16. Recommending or providing unnecessary diagnostic or treatment services.
17. Failing to maintain the standards of practice of the profession.

Professional Standard

Optometrists must be proficient in determining the necessity of appropriate referral for care. An optometrist's decision about the urgency and choice of consultant will be influenced by the patient's ocular and/or systemic condition, risk factors, the community in which the optometrist is practising and the availability of appropriate consultation.

Once the decision has been made to make a referral, appropriate documentation in the patient's *clinical record* ([OPR 5.1](#)) is necessary, including:

- confirmation of when the referral was requested (e.g. fax information or written documentation of telephone conversation);
- appointment date, time, and consultant;
- confirmation with the patient of the appointment time and location; and
- a copy of the pertinent clinical information forwarded to the consultant.

Timeliness of Referral

Acute conditions which pose an immediate threat to the health and/or vision of the patient require a prompt referral. Examples of these conditions include:

- acute glaucoma;
- retinal detachment;
- papilledema;
- central corneal ulcer;
- sudden, unexplained vision loss; or
- vision-threatening trauma.

If the referral appointment is not available within an appropriate amount of time, putting the patient at risk, the optometrist is required to advocate on the patient's behalf to attempt to arrange a more timely appointment. Otherwise, the optometrist may need to seek an alternative source of care such as a hospital emergency department.

Clinical Guideline

When a referral letter has been written, it is appropriate in most cases to send a copy to the patient's primary healthcare provider.

Many consultants have printed material that includes maps, directions, and office policies. Making these available may be helpful to patients attending these appointments.

If the patient has a specific request regarding the choice of consultant, this request should be honoured where possible and/or appropriate.

(Jan. 2007)

4.6 Ocular Urgencies and Emergencies

Description

Urgencies and emergencies represent potential threats to the ocular and/or systemic health and well being of a patient if not dealt with appropriately. Accordingly, a specific examination is performed to provide prompt assistance, intervention, and/or action to limit potential sequelae.

Regulatory Standard

The Professional Misconduct Regulation ([Regulation 859/93 under the *Optometry Act*](#)) includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.
3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation which a consent is required by law, without such a consent.
12. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.
13. Failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination.
17. Failing to maintain the standards of practice of the profession.

Professional Standard

In urgent or emergency situations, any treatment initiated by the optometrist will be within the profession's *scope of practice* ([OPR 2.1](#)), and will not exceed his or her experience or competence. An exception to this would be if a controlled act has been *delegated* ([OPR 4.3](#)) to a member by a member of another regulated health profession with that authority, and the member is properly trained to perform the delegated act. Generally, the optometrist is expected to:

- conduct a specific examination to evaluate the immediate problem;
- counsel 'at-risk' patients about signs and symptoms that may require further care (for example, possible retinal detachment symptoms following a posterior vitreous detachment); and
- establish appropriate protocols and ensure that staff members are trained to recognize and respond to urgent and emergency situations.

If the treatment involves a *referral* ([OPR 4.5](#)) to another health professional, the timeliness of the appointment will be appropriate to the condition and remains the responsibility of the optometrist even if a staff member makes the appointment.

Effective Date: June 2009

Clinical Guideline

When a *referral* (OPR 4.5) to another health professional is required, the optometrist is expected to attempt to arrange the most appropriate consultation available. In all cases, information concerning the nature of the urgency or emergency is expected to be communicated to the practitioner receiving the referral. Unless the patient is sent to the local emergency department for care, urgent or emergency referral appointments usually require a greater degree of assurance that the appointment time and date are accurately communicated to the patient, and that the patient attends the appointment. In cases where it is not possible to confirm an appointment, referral to the local emergency department with a note stating the reason for referral, may be necessary. In addition, it is highly recommended that the optometrist follow up with the patient on the results of the appointment.

The optometrist may establish an after-hours communication strategy to guide patients in need of urgent or emergency ocular care. This may be in the form of additional recorded phone messages or signs on the office door. Instructing patients what to do, such as going to the local emergency department, or to a walk-in clinic that is known to deliver after-hours care, is appropriate.

Additional information on urgent and emergency care is available on the American Optometric Association website (www.aoa.org) and includes the following clinical practice guidelines:

- CPG 5 Care of the Patient with Primary Angle Closure Glaucoma
- CPG 7 Care of the Patient with Anterior Uveitis
- CPG 10 Care of the Patient with Ocular Surface Disorders
- CPG 11 Care of the Patient with Conjunctivitis
- CPG 13 Care of the Patient with Retinal Detachment and Peripheral Vitreoretinal Disease

First Published: September 2007

Revised: May 2009

4.8 Collaboration and Shared Care

Description

The term “collaboration” has arisen to describe sharing of care between professionals. Such shared care is usually complementary. It has become apparent that professionals who provide complementary healthcare services to patients often will find ways to work together to co-manage/share care of patients. This is often beneficial to patients as it may allow better accessibility to the health care system, lower costs to the system and patients and allow more specialized practitioners to devote more time to their area of expertise.

Optometrists collaborate with many healthcare professionals including other optometrists, ophthalmologists, family physicians, other medical practitioners, nurse practitioners and opticians. This document describes the characteristics and conditions of collaboration as they apply to the profession of optometry.

History

Optometrists have the regulatory obligation to refer patients to an appropriate regulated health professional (RHP) when the patient’s condition and/or treatment is beyond the scope of practice of the optometrist. This has usually resulted in referral to family physicians or ophthalmologists to institute medical and/or surgical care. Various shared care relationships have developed in this regard including glaucoma management (OPR 7.2), cataract surgery (OPR 7.3) and refractive surgery (OPR 7.8). Although these relationships are common, formal arrangements are usually not developed.

The Health Professions Regulatory Advisory Council (HPRAC) made recommendations in its New Directions report (2006) that optometrists and physicians develop formal collaborative relationships with opticians regarding the latter professional group providing refractive data to assist in the development of a prescription (OPR 6.3) for vision correction. HPRAC also recommended that optometrists and ophthalmologists develop collaborative relationships with regards to the management of glaucoma patients. (OPR 7.2)

Regulatory Standards

Controlled Acts

The *Regulated Health Professions Act* (RPHA) identifies 13 controlled acts that may only be performed by members of certain regulated health professions. Optometrists are authorized by the *Optometry Act* to perform 4 of the 13 controlled acts, as follows:

- communicating a diagnosis identifying as the cause of a person’s symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system, or a prescribed disease;

Effective Date: June 2009

- applying a prescribed form of energy;
- prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses; and
- prescribing a drug designated in the regulation.

The *Optometry Act*, 1991 includes the following Professional Misconduct regulations:

2. Exceeding the scope of practice of the profession.
3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.
8. Practicing the profession while the member is in a conflict of interest.
12. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.
13. Failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination.
16. Recommending or providing unnecessary diagnostic or treatment services.
17. Failing to maintain the standards of practice of the profession.
18. Delegating a controlled act in contravention of the Act, the Regulated Health Professions Act, 1991 or the regulations under either of those Acts.
19. Performing a controlled act which has not been delegated to the member in accordance with the regulations.
20. Ordering a person who is under the supervision of a member to perform an act, or supervising an act, in the practice of optometry that is not consistent with the regulations.
21. Permitting, counselling or assisting any person who is not a member to perform an act which should be performed by a member

Professional Standard

When an optometrist establishes a collaborative relationship with another RHP, that relationship must be in the best interests of the patient. A formal collaborative relationship will:

- have a verifiable agreement between collaborating professionals which outlines the various responsibilities, accountabilities and exchange of appropriate information for each person;
- ensure that patients fully understand the roles and responsibilities of the professionals involved and any associated fees;

- ensure that patients understand their options for care;
- have a mechanism for conflict resolution amongst all parties; and
- ensure the collaborating professionals adhere to any applicable standards of practice and conflict of interest regulations for each profession.

Clinical Guideline

Although all health professionals are required to maintain the standards of practice set by their own profession, optometrists entering into formal collaborative relationships should take all necessary steps to ensure that the other professionals involved are competent to perform the necessary procedures and services. This could include:

- ensuring that formal qualifications and provincial licensure exist;
- jointly participating in training/education activities;
- developing a joint quality assurance process; and
- regularly reviewing and revising the collaborative agreement.

Conflict of Interest and Fee Issues

When health professionals collaborate, a potential for various conflicts of interest will develop. These include:

- inappropriate referrals (for example referral to your collaborating professional when another RHP would be more appropriate); and
- fee sharing and/or referral fees.

Optometrists should ensure that any potential conflicts of interest are minimized by ensuring that patients fully understand the roles, responsibilities and fees for each professional.

Responsibility

In a collaborative relationship, the professionals providing care share joint responsibility for the assessments and care provided. The formal collaborative agreement will outline this, but members should ensure that all parties involved have a complete understanding. Although the collaborative agreement would not necessarily be in writing, it should be verifiable to a third party if the question arose. It is expected that collaborating professionals will agree on a process for resolving patient problems. If any inconsistency or irregularity in clinical findings and/or care arise, it is the responsibility of all the professionals involved to ensure that appropriate clinical investigations and treatments are performed, however the prescribing professional should take the leading role in these steps.

First published: May 2009

5. Documentation

5.1 The Patient Health Record

Description

The patient health record, or clinical record, provides comprehensive documentation of the patient's health and oculo-visual history. An optometrist maintains the information contained within the record in trust, and in compliance with Ontario's *Personal Health Information Protection Act*.

Regulatory Standard

The optometrist shall take all reasonable steps necessary (including verification at reasonable intervals) to ensure that records in relation to his or her practice are kept in accordance with the regulations.

The regulations guiding record keeping are contained in O.Reg.119/94, Part IV, s. 7-12 and include the following provisions:

An optometrist must keep:

1. A daily appointment record that sets out the name of each patient whom the optometrist examines or treats or to whom the optometrist provides any service.
2. A financial record for each patient. This record must include the optometrist's fees for services and any commercial laboratory costs charged to the member.
3. A patient health record for each patient which must include the following:
 - the name and address of the patient;
 - the name of the optometrist who provided the service;
 - the date of each visit of the patient;
 - the date of every entry in the record;
 - the name and address of any referring health professional;
 - the patient's health and oculo-visual history;
 - the clinical procedures used;
 - the clinical findings obtained;
 - the diagnosis, when possible;
 - every order made by the optometrist for examinations, tests, consultations or treatments to be performed by any other person;
 - particulars of every *referral* (OPR 4.5) to or from another health professional;
 - information about every *delegation* (OPR 4.3) of a controlled act within the

meaning of subsection 27(2) of the *Regulated Health Professions Act* delegated by the optometrist;

- information about a procedure that was commenced but not completed, including reasons for non-completion; and
- a copy of every written consent to treatment.

The patient health record shall also:

- be dated and include patient identification information on each part;
- include a date for each entry and identify the person making the entry; and
- be retained for at least 10 years following the patient's last visit or 10 years after the patient became or would have become 18 years old.

An optometrist using computer, electronic or other equipment for recording, storing and retrieval of records shall:

- have ancillary equipment readily available for the making of hard copies of the record at no expense to an authorized investigator, inspector or assessor of the College; and
- use equipment or software that allows no amendment, correction, addition or deletion to be made to any record that obliterates the original record or does not show the date of the change.

Access to a Patient Health Record

An optometrist must restrict access to a patient health record and is not permitted to give a copy of a document or any information from a patient health record to any person except as required by law or regulation.

An optometrist shall provide copies from a patient health record for which the optometrist has primary responsibility to any of the following persons on request:

- the patient;
- an authorized personal representative of the patient;
- a deceased patient's legal representative; or
- an incapacitated patient's representative as outlined in O.Reg. 119/94 Part IV 11.(2)4.i-v.

Ready access to the patient record shall be provided to an authorized investigator, inspector, or assessor of the College.

An optometrist may, for the purpose of providing health care, allow a health professional to examine the health record or give a health professional a copy of a document or any information from the record.

An optometrist may refuse to provide copies from a patient health record until he or she is paid a reasonable fee.

Professional Standard

A legible and complete optometric record serves to assist in the provision of care to a patient. The record also has a purpose in meeting professional regulatory requirements, and shall be available for use in Complaints, Discipline, Quality Assurance and other legal applications.

In addition to the regulatory requirements, the College expects that the patient health record shall also:

- include the proposal for care and advice offered to the patient;
- include a description of the care rendered and recommendations for ongoing care;
- allow easy identification and location of all documentation related to the provision of care to the patient, including professional correspondence, laboratory invoices, billing information, and fees charged;
- indicate deviations from usual care due to patient refusal or inability to cooperate; and
- make specific notation in the event that a test was performed or a question asked and the result was negative or normal.

Relocation of a Patient Health Record

Relocation of a clinical record requires that the optometrist entrusted with the maintenance of the record make a reasonable attempt to inform the patient of the intention to relocate the record. The optometrist is expected to comply with any direction of the patient to have that record maintained by another optometrist.

Clinical Guideline

Reliable records allow the optometrist to deliver quality patient care, as well as providing a documentation of patient interactions (i.e. administrative, clinical, correspondence and dispensing). They are also legal documents and the optometrist would want to ensure their authenticity for his or her own legal protection.

The use of computerized records has brought several regulatory requirements with respect to those files.

When using electronic records the following requirements must be followed:

- a) the record keeping system must provide ready access to the records by an authorized investigator, inspector or assessor of the College, or the patient or the patient's representative;
- b) ancillary equipment must be readily available for the making of hard copies of the record at no expense to an authorized investigator, inspector or assessor of the College;

- c) the equipment or software being used is such that no amendment, correction, addition or deletion can be made to any record which obliterates the original record or does not show the date of the change; and
- d) reliable backup systems are in place and are used on a regular basis.

Hardware and software provisions for data protection are often part of the manufacturer's purchase options. Such protection varies as follows:

- the safety of the hardware from lightning strikes, hydro brownouts, water damage or theft;
- restrictions to access through passwords, the positioning of terminals to restrict the observation of sensitive data by unauthorized people (i.e. the data terminal at the front desk being seen by other patients standing there), and read-only format of data for the protection of its original content;
- back-up of files on removable media, allowing data recovery should a catastrophic system failure occur; and
- ensuring the patient's privacy of personal information through the maintenance and transfer of data in compliance with Ontario's *Personal Health Information Protection Act*.

As new software technologies occur, the sophistication of programming allows for enhancements with the ease of use of the programs offered to the optometrist.

(Sept. 2006)

5.2 The Optometric Prescription

Description

A prescription is a written document produced by an optometrist and provided to the patient. A prescription is based upon the diagnosis and analysis of all available clinical information obtained from an optometric examination(s). A prescription, when combined with further appliance specific information, enables the patient to obtain spectacles, contact lenses or a sub-normal vision device.

Regulatory Standard

The *Optometry Act* states that the optometrist has three Authorized Acts that can be performed subject to the terms, conditions and limitations on his or her certificate of registration, and one of those acts is:

- prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eyeglasses. (1991, c. 35, s. 4)

The Professional Misconduct Regulation (O. Reg. 859/93 under the *Optometry Act, 1991*) includes the following acts of professional misconduct:

14. Failing to make available to a patient who requests one a written, signed and dated prescription for a subnormal vision device, contact lenses or eyeglasses.
16. Recommending or providing unnecessary diagnostic or treatment services.
17. Failing to maintain the standards of practice of the profession.

Professional Standard

An optometrist is responsible to ensure that clinical support exists for all of the information contained in the prescription. An optometrist is responsible for counselling a patient in the use of any prescribed appliance. In the event that a patient has difficulties arising from a prescribed appliance, an optometrist will provide additional diagnostic and counselling services and, if required, make appropriate modifications to the prescription.

A prescription must contain information that:

- clearly identifies the prescriber including address, telephone number, and signature;
- clearly identifies the patient; and
- is used by a dispenser to fabricate spectacles, contact lenses or a sub-normal vision device that will provide the required vision correction for the patient.

On the conclusion of the examination, the optometrist may determine that the refractive result should have a finite life span. That determination is based upon the optometrist's assessment of the patient and application of clinical judgement

based on the knowledge of the patient and typical growth and development of the eyes and vision system. When an optometrist specifies a 'fill before' date on a prescription, information is communicated to the patient so the patient understands why it is not appropriate to fill the prescription after the specified date.

If an optometrist determines that vision correction is required, he or she will issue a prescription as part of the assessment without additional charges, regardless if the examination is an insured or uninsured service. Charges for additional copies of the prescription are at the discretion of the optometrist.

Clinical Guideline

It may be advantageous for the optometrist to include contact information on the prescription other than that required under the standard. This may include fax and email information, office hours, etc.

The optometrist should consider retaining a copy of every issued prescription with the *patient health record* (OPR 5.1).

Clinical justification should exist whenever a prescription contains appliance-specific information.

When a member has performed the necessary services to prescribe a specific appliance, the parameters of that appliance should be provided to the patient upon request.

(Sept. 2006)

6. General Procedures

6.1 Anterior Segment Examination

Description

The anterior segment consists of the front third of the eye, including the structures in front of the vitreous humour such as the cornea, iris, ciliary body and lens.

The anterior segment examination consists of a thorough assessment of these structures to facilitate the diagnosis of diseases, disorders and dysfunctions of the eye and vision system. Information obtained from an anterior segment examination is part of the *required clinical information (OPR 4.2)*.

Regulatory Standard

The Professional Misconduct Regulation ([Regulation 859/93 under the Optometry Act](#)) includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.
13. Failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination.
16. Recommending or providing unnecessary diagnostic or treatment services.
17. Failing to maintain the standards of practice of the profession.

Professional Standard

Optometrists must be proficient in and equipped for examining the anterior segment. The equipment customarily used for the assessment is the slit-lamp biomicroscope.

A complete anterior segment examination must include an inspection of the following anatomical areas:

- lids, lashes and adnexal structures;
- conjunctiva and sclera;
- cornea and tear film;
- anterior chamber and angle;
- iris; and
- crystalline lens.

All patients will receive an anterior segment examination as a part of initial and ongoing optometric care. Emphasis is given to the evaluation of the anterior chamber angle prior to pupillary dilation and in patients with diagnosed or suspected glaucoma. The optometrist's decision regarding the frequency and extent of the examination and the specific techniques utilized will be influenced by a patient's signs, symptoms and risk factors.

An anterior segment examination is an essential component of all *contact lens assessments* (OPR 6.5).

Clinical Guideline

Gonioscopy is the preferred technique when a detailed assessment of the anterior chamber angle is required. Additional technologies and techniques are available for specialized assessment, including corneal topography, specular microscopy, optical coherence tomography and ultrasound biomicroscopy. Vital dyes and appropriate filters are often helpful in diagnosing diseases and disorders affecting the ocular surface.

American Optometric Association (www.aoa.org) documents relevant to this topic include:

- Care of the Patient with Open Angle Glaucoma (CPG 9); and
- Care of the Patient with Ocular Surface Disorders (CPG 10).

(Jan. 2007)

6.2 Ocular Fundus Examination

Description

An ocular fundus examination aids in the diagnosis of diseases, disorders, and dysfunctions of the eye and vision system. It is a procedure to provide *required clinical information* (OPR 4.2).

Regulatory Standard

The Professional Misconduct Regulation (Regulation 859/93 under the *Optometry Act*) includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.
13. Failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination.
16. Recommending or providing unnecessary diagnostic or treatment services.
17. Failing to maintain the standards of practice of the profession.

Professional Standard

Optometrists must be proficient in, and *equipped for* (OPR 4.1), various methods of examining the ocular fundus, including both direct and indirect ophthalmoscopes.

An optometrist's decision about the frequency of examination, extent of view and methods of examination of the ocular fundus, including the use of pupillary dilation, will be influenced by a patient's signs, symptoms and risk factors.

Pharmacologic Dilation

Pharmacologic dilation (OPR 4.4) of the pupil is generally required for a thorough evaluation of the ocular media and posterior segment. The results of the initial dilated fundus examination usually indicate the appropriate timing for subsequent pupillary dilation. Dilation can facilitate examination of the anterior segment structures when certain conditions are present or suspected.

The following lists some of the situations/patient symptoms that indicate dilation is required (unless contraindicated) with the informed consent of the patient. These situations/patient symptoms include but are not limited to:

- flashes of light or photopsia;
- onset of or a change in number or size of floaters;

- unexplained or sudden vision change or loss, or onset of metamorphopsia;
- medication or systemic disease that may affect ocular tissues;
- a history of significant ocular trauma, or ocular surgery that increases risk to the posterior segment;
- a history of moderate to high axial myopia;
- an increased risk of peripheral retinal disease exists;
- a better appreciation of the nature of a fundus anomaly is required;
- the ocular fundus is not clearly visible through an undilated pupil;
- the size of a fundus anomaly necessitates an increased field of view for its interpretation;
- a disease of the ciliary body is suspected; and/or
- disorders of the vitreous.

Clinical Guideline

In general, patients should receive a dilated fundus examination (DFE) upon their initial presentation to a practitioner. DFE should also be performed periodically thereafter as circumstances warrant.

Fundus Examination Procedures

METHOD	CHARACTERISTICS
1 Direct Ophthalmoscopy	<ul style="list-style-type: none"> ▪ high magnification ▪ small field of view
2 Binocular Indirect Ophthalmoscopy	<ul style="list-style-type: none"> ▪ low magnification ▪ large field of view ▪ scleral indentation view
3 Monocular Indirect Ophthalmoscopy	<ul style="list-style-type: none"> ▪ moderate magnification ▪ moderate field of view
4 Slit Lamp Biomicroscopy (slit lamp photography)	<ul style="list-style-type: none"> ▪ high magnification ▪ very bright light source
5 Fundus Camera View and Photography	<ul style="list-style-type: none"> ▪ moderate magnification ▪ moderate field of view ▪ wide range of filters and recording media ▪ colour or black and white ▪ film or digital recording
6 New Technology Mapping Systems	<ul style="list-style-type: none"> ▪ retinal tomography (i.e. Heidelberg Retinal Tomography) ▪ optical coherence tomography (i.e. Zeiss OCT Stratus) ▪ scanning laser ophthalmoscope ▪ confocal scanning laser polarimeter

(Sept. 2006)

6.3 Refractive Assessment and Prescribing

Description

Assessing the patient's refractive error and, where required, prescribing (OPR 5.2) an optical correction is an integral part of optometric care. Assessment methods include objective and subjective techniques.

Regulatory Standard

The Professional Misconduct Regulation (**Regulation 859/93 under the Optometry Act**) includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.
13. Failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination.
14. Failing to make available to a patient who requests one a written, signed and dated prescription for a subnormal vision device, contact lenses or eyeglasses.
16. Recommending or providing unnecessary diagnostic or treatment services.
17. Failing to maintain the standards of practice of the profession.

Professional Standard

The process of obtaining *required clinical information* (OPR 4.2) includes determination of the refractive status and best-corrected visual acuities. When possible, objective and subjective refraction techniques are used to assess the refractive status of the eye, at the initial visit and as clinically indicated thereafter. *Cycloplegic refraction* is employed when clinically necessary. (OPR 7.6)

Refractive assessment alone does not provide sufficient information to allow an optometrist to issue an appropriate prescription for vision correction. The effects of ocular and systemic health conditions, binocular vision status and the occupational and avocational visual environment and demands must also be considered.

The College standard on *delegation and assignment* (OPR 4.3) and *collaboration* (OPR 4.8) must be followed when refractive data is obtained from a person to whom the procedure has been assigned, including another regulated health professional (RHP). Specifically, there must be direct supervision of the subjective refractive assessment when this procedure is assigned.

Clinical Guideline

Refraction Techniques

Refraction techniques fall into two broad categories. Objective techniques generally require no decision-making by the patient and include:

- Retinoscopy
- Auto-refraction
- Wave-front assessment

Subjective techniques depend on responses from the patient and may include:

- Trial frame methods
- Phoropter methods
- Auto-refractor with subjective capability

New and advanced techniques for the assessment of the refractive status of the eye and vision system continue to be developed. It is recommended that optometrists maintain current knowledge of new technologies.

Prescribing for Vision Correction

Although the objective and subjective refractive results are important in formulating a prescription for vision correction, the optometrist should consider a number of other factors prior to issuing the prescription including:

- Ocular health: A number of ocular health conditions, such as *cataract formation* (OPR 7.3), may affect the refractive error. These may cause temporary or permanent refractive changes.
- Systemic health: Some systemic health conditions may influence the refractive error by circulatory changes and/or osmotic balance of the eye and other parts of the vision system. A common example of this is *diabetes* (OPR 7.4).
- Binocular vision: *Binocular vision anomalies*, such as accommodative, or convergence dysfunctions or anisometropia, may affect the final prescription. (OPR 6.7)
- Occupational and avocational visual environment and demands: Many occupations or avocations have specific visual demands that require patients to view certain working distances on a regular basis or assume certain postures posing specific optical requirements. For example, a computer operator requires specific optical correction for viewing the computer monitor.

Collaboration with another Regulated Health Professional (RHP):

The results of a refractive examination obtained from another RHP may also be considered when formulating an appropriate prescription for vision correction. All collaboration with another RHP must comply with policies outlined in the College documents on *delegation and assignment* (OPR 4.3) and *collaboration* (OPR 4.8). As the optometrist maintains the ultimate responsibility for supervised procedures and the final *prescription* (OPR 5.2) for vision correction, it is imperative that persons performing these tasks be appropriately trained. In all cases, the responsibility for the performance of the procedures and the efficacy of the prescription remains with the optometrist.

First Published: May 2009

6.4 Spectacle Therapy

Description

Optometrists are authorized to dispense spectacles for the treatment of disorders of refraction and/or sensory and oculomotor disorders and dysfunctions of the eye and vision system. The patient must present a valid prescription written by an optometrist or physician.

Regulatory Standard

The *Optometry Act* (1991) authorizes optometrists to perform the following controlled act:

- Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses (1991, c.35,s.4).

The Professional Misconduct Regulation (O.Reg 859/93 under the *Optometry Act, 1991*) includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which consent is required by law, without such a consent.
11. Making a misrepresentation with respect to a remedy, treatment or device.
12. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.
14. Failing to make available to a patient who requests one a written, signed and dated prescription for a subnormal vision device, contact lenses or eyeglasses.
16. Recommending or providing unnecessary diagnostic or treatment services.
17. Failing to maintain the standards of practice of the profession.
33. Charging fees that are excessive or unreasonable in relation to the services performed.
34. Charging a fee for a service that exceeds the fee set out in the schedule of fees published by the Ontario Association of Optometrists at the time the service was rendered without informing the patient, before the service is performed, of the excess amount that will be charged.
35. Failing to issue a statement or receipt to a patient or to a third party responsible for the payment of the account of a patient.
36. Issuing a statement or receipt which does not,
 - i. itemize the services provided and the fees charged,
 - ii. describe the ophthalmic appliances utilized by the member in the performance of the services, or

Effective Date: June 2009

- iii. set out the commercial laboratory cost incurred by the member in the provision of the services.
37. Charging or receiving payment for contact lenses, a subnormal vision device or eyeglasses in excess of the commercial laboratory cost incurred by the member in the provision of the service.
 40. Accepting payment before performing an optometric service that is not an insured service within the meaning of the Health Insurance Act, unless the patient is informed of his or her right to refuse to make payment before the service is performed, and the patient consents to make the payment in advance. This does not apply to the payment of a commercial laboratory fee to be incurred by a member in connection with the service.
 43. Displaying or permitting the display of ophthalmic appliances that may be seen from the exterior of the premises in which a member is engaged in the practice of optometry.

Professional Standard

The provision of spectacle therapy involves:

- reviewing with the patient any relevant environmental, occupational, avocational, and/or physical factors affecting spectacle wear;
- reviewing the details of the prescription;
- advising the patient regarding appropriate ophthalmic materials;
- taking appropriate measurements (including but not limited to interpupillary distance and segment height) to ensure proper function of the spectacles;
- arranging for the fabrication of the spectacles;
- verifying the accuracy of the completed spectacles to ensure that they meet required tolerances;
- fitting or adjusting the spectacles to the patient; and
- counselling the patient on aspects of spectacle wear including, but not limited to: the use, expectations, limitations, customary adaptation period and maintenance requirements of the spectacles.

The principle of informed consent applies to spectacle therapy with respect to ophthalmic materials, costs and fees.

Patients experiencing unexpected difficulty adapting to new spectacles should be counselled to seek re-examination by the prescriber to assess the appropriateness of the prescription. Optometrists dispensing appliances based on a prescription from another practitioner are expected to ensure that this has been filled appropriately, however they are not responsible for the efficacy or accuracy of that practitioner's prescription.

Clinical Guideline

In order to advise patients of products appropriate for their specific needs, optometrists are encouraged to maintain up-to-date knowledge with respect to advances in optical products including, but not limited to, lens designs, spectacle lens materials, coatings, tints and frames. Consideration of additional factors may be made in special circumstances:

1. High Refractive Error:

- a. Lens materials with higher refractive indices and/or aspheric designs may be recommended for prescriptions indicating higher refractive error.
- b. A specific size or shape of frame may be selected to better support higher power prescription lenses.
- c. Additional specific measurements may be taken to ensure the effectiveness of the prescription (including but not limited to monocular interpupillary distances, pantoscopic tilt, optical centre height and vertex distance).

2. Presbyopia:

- a. Determination of multifocal fitting height may require consideration of specific patient characteristics, such as stature, posture, vocation and avocation.
- b. A specific progressive-addition lens design may be recommended for an individual patient to reduce adaptation difficulties and/or maximize visual performance.
- c. Specialty multifocal lenses, including computer progressive-addition lenses, may be recommended for patients with extensive intermediate and near vision demands.
- d. Specialty vocational lenses may be considered where patients have unique or non-standard vision tasks.

3. Anisometropia:

- a. Special consideration should be given to the effect of base curve and thickness of lenses in affecting the patient's adaptation to and visual performance with spectacles. Manipulation of such parameters may be made to optimize the effectiveness of the prescription.
- b. Special consideration should be given to vertical prismatic imbalance. Alternative lens designs, such as bicentric grind, may be recommended to the patient.
- c. Special consideration should be given to cost and/or cosmetic appearance when choosing the power and optical parameters of a balance lens.

Effective Date: June 2009

4. Accommodative and Binocular Vision Disorders: (OPR 6.7)

- a. The multifocal style and height prescribed for young children may be altered from standard practices, to maximize the effectiveness of the prescription.
- b. The use of high index lens materials and/or Fresnel prisms may be considered for prism prescriptions.

5. Low Vision Aids: (OPR 6.6)

- a. Spectacle mounted low vision devices, including microscopes, telemicroscopes and telescopes may be provided.
- b. The use of Fresnel prisms and lenses may be considered for special prescriptions.
- c. A specific size or shape of frame may be selected to adequately support the low vision aid.
- d. Adequate counselling and training in the use of the spectacles should be provided to the low vision patient.

6. Safety Requirements:

- a. Occupational safety lenses and frames should meet Canadian Standards Association (CSA) Z94.3 standards.
- b. Sports spectacles and goggles should meet CSA Z94.3 standards.
- c. Impact resistant lenses should be utilized whenever possible. Special consideration should be given to the use of highly impact resistant materials (such as polycarbonate) for children and monocular patients.

7. Other:

- a. Custom frames may be obtained for patients with special needs and/or facial deformities.
- b. A ptosis crutch may be fitted to a spectacle frame to provide support for a ptotic eyelid.

First published: May 2009

6.5 Contact Lens Therapy

Description

Optometrists are authorized to prescribe and dispense contact lenses. The provision of this service to patients involves an initial assessment to determine suitability of the patient for contact lens therapy, a determination of the parameters of a contact lens appropriate for that patient, and ongoing monitoring of the efficacy of treatment.

Regulatory Standard

The Professional Misconduct Regulation (**Regulation 859/93 under the *Optometry Act***) includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.
12. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.
13. Failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination.
15. Dispensing to a patient a contact lens, other than for diagnostic or emergency purposes, that the member knows or should know is not new.
17. Failing to maintain the standards of practice of the profession.

Professional Standard

Initial Contact Lens Fitting

Prior to contact lens fitting, the optometrist obtains *required clinical information (OPR 4.2)* to determine the suitability of the patient for contact lens wear. Special emphasis is given to the analysis of:

- the health of the cornea, conjunctiva, lids, tarsal and bulbar conjunctiva, and the integrity of the tear layer;
- corneal curvature;
- refractive status and visual acuity;
- the effects that contact lens wear may have on the function of the accommodative, oculo-motor and sensory systems; and

- relevant environmental, occupational, avocational, emotional and systemic health factors affecting contact lens wear.

To allow the patient to make an informed decision about proceeding with treatment, patients are counselled on the advantages, risks, limitations, and costs of contact lens wear and on the prognosis for successful treatment.

In fitting contact lenses a practitioner will determine, by diagnostic fitting or calculation, lenses that are appropriate for the patient. The initial lenses are evaluated on the patient's eyes and subsequent modifications of the lens parameters are made as required.

Instructions are provided to the patient with respect to:

- hygiene;
- lens insertion and removal;
- use of specific lens care products;
- recommended wearing times;
- normal and abnormal adaptive symptoms;
- contraindications to lens use;
- progress evaluations; and
- emergency care.

The patient is examined during the adaptation period to assess lens performance, adaptation and compliance.

Continuing Care

The optometrist provides continuing care to the established contact lens patient. In providing continuing care, the optometrist:

- Maintains a history concerning:
 - the specifications, age and wearing schedule of current contact lenses;
 - the current lens care regime;
 - any adverse reactions associated with contact lens wear; and
 - any health or medication changes.
- Assesses the patient to determine if the patient is achieving:
 - acceptable lens appearance and fit;
 - satisfactory wearing time;
 - acceptable comfort with lenses in place;
 - acceptable corneal clarity and integrity;
 - stable corneal curvature;
 - acceptable conjunctival and lid appearance;

- acceptable tear characteristics;
 - acceptable over-refraction for best visual acuity;
 - acceptable spectacle acuity; and
 - compliance with recommendations on lens handling, lens care, lens replacement and wearing times.
- Identifies any problems and counsels the patient as necessary.
 - Provides and implements a management plan for any problems identified, making recommendations for further care.

Replacement Contact Lens Services

When providing replacement contact lens services, the optometrist:

- determines the currency of clinical information and provides diagnostic services as required;
- determines the need for alteration of previous lens specifications and makes adjustments accordingly;
- advises the patient as to the need for and extent of continuing care; and
- provides follow-up services as needed.

Clinical Guideline

Frequency

Patients using contact lenses generally require an annual examination. This is particularly important for patients on a continuous wear schedule.

Consent

The optometrist should obtain informed consent from all patients electing to wear contact lenses. In particular, the optometrist should obtain written consent from patients electing to use extended or continuous wear lenses.

Instrumentation

In addition to the normal complement of *required clinical equipment* (OPR 4.1), the following may be helpful in contact lens practice:

- instrumentation for the verification of contact lens parameters; and/or
- instrumentation to assess corneal topography and thickness.

Special considerations for Continuous Wear

Patients using contact lenses on a continuous wear schedule require:

- more frequent follow-up examinations;
- counselling regarding the increased risk of complications and precautionary measures for avoiding them, particularly microbial infection; and
- access to emergency care.

Management of Adverse Outcomes

Although infrequent, adverse ocular complications may occur with contact lens wear. Treatment options may include:

- discontinuation of lens wear or modification of wearing schedule;
- modification of lens design, material or care system;
- appropriate topical ocular therapy; and/or
- *referral* (OPR 4.5) to another regulated health professional.

Optometrists should maintain current knowledge of contact lens therapy and are encouraged to consult peer-reviewed literature and professionally developed guidelines (professionally developed guidelines would include clinical guidelines published by the American Optometric Association).

(Jan. 2007)

6.8 Visual Field Assessment

Description

Optometrists may perform an assessment of the field of vision as part of an evaluation of the oculo-sensory system. Assessment strategies used may be either screening or detailed in nature, utilizing manual or computer controlled equipment and can be done to assess the patient's central and/or peripheral field of vision. Visual field assessment is used in the diagnosis and monitoring of conditions of the eye and vision system including glaucoma, neurological disease and retinal disease, and to quantify visual function in patients with visual disabilities.

Regulatory Standard

The Professional Misconduct Regulation (**Regulation 859/93 under the *Optometry Act***) includes the following acts of professional misconduct.

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or health-related purpose in a situation in which a consent is required by law, without such consent
12. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.
13. Failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination.
16. Recommending or providing unnecessary diagnostic or treatment services.
17. Failing to maintain the standards of practice for the profession.

Professional Standard

The *required clinical information* (**OPR 4.2**) includes the results and analysis of visual field assessment when indicated by patient signs, symptoms or history. The nature of the signs, symptoms or history will determine the test strategy used and the frequency of re-assessment.

Indications for visual field assessment may include:

- glaucoma or risk factors for glaucoma;
- use of medications with potential neuro-retinal toxicity;
- some retinal diseases and abnormalities;
- unexplained photopsia or other visual disturbances;
- unexplained headaches;
- optic nerve disease and abnormalities;

- lesions of the optic chiasm;
- post-chiasmal lesions;
- cerebrovascular accident;
- eyelid anomalies affecting the visual field; and/or
- assessment of visual disability.

Visual field screening provides a rapid assessment of the sensitivity and/or extent of the visual field to determine if a more detailed evaluation of the visual field is required. Screening strategies include:

- confrontation methods;
- Amsler grid;
- tangent screen and arc perimeter methods; or
- automated techniques specifically designed for screening.

When a more detailed evaluation is required, it is appropriate to utilize advanced techniques, including:

- Goldmann perimetry (kinetic and/or static); or
- automated threshold perimetry.

If an optometrist does not have the required instrumentation, arrangements must be in place whereby the appropriate testing will be performed elsewhere in a timely fashion. Visual field assessment results and analysis comprise part of the *patient health record* (OPR 5.1) and must be retained. Appropriate communication of these results to the patient is expected when indicated.

Guideline

Frequency

The visual fields of some patients need to be re-assessed frequently, whereas others may require only periodic assessment. Generally, glaucoma patients are assessed at least once a year. Patients with macular pathology may be advised to self-monitor at home on a frequent basis using an Amsler grid.

Macular conditions

Testing of the central visual field is useful in assessing the status and progression of macular pathologies. Self-monitoring using an Amsler grid is often advisable. Threshold testing can also be performed if quantification of abnormalities is desired.

Glaucoma

Threshold perimetry of the central 24 to 30 degrees is usually indicated for the diagnosis and ongoing management of glaucoma. Serial testing to monitor for changes is an integral part of glaucoma diagnosis and management.

Peripheral Field Assessment

Peripheral field assessment may be indicated:

- to assess neurological conditions;
- to assess some peripheral retinal pathologies;
- to evaluate unexplained visual symptoms; and/or
- to fulfill reporting requirements.

Kinetic perimetry

Kinetic perimetry (e.g., Goldmann) can be used to quantify loss of peripheral fields or scotomas within the field. This technique is often useful for patients who have difficulty with the static methods of testing.

Computerized perimeters will typically archive results; however, optometrists should ensure that effective back-up methods are being utilized and/or hard copies are retained in the *patient health record* (OPR 5.1).

The optometrist should maintain current knowledge of the introduction of new techniques and equipment.

(Jun. 2007)

7. Specific Diseases, Disorders and Procedures

7.1 Age-related Macular Degeneration

Description

Age-related Macular Degeneration (AMD) is an acquired retinal disorder that affects central visual function. Nonexudative AMD, also known as “dry” AMD, results in a gradual, progressive loss of central visual functioning, whereas patients with exudative AMD, also known as “wet” AMD, notice a more profound and rapid decrease in central visual functioning.

Regulatory Standard

The Professional Misconduct Regulation ([Regulation 859/93 under the *Optometry Act*](#)) includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.
12. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.
13. Failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination.
16. Recommending or providing unnecessary diagnostic or treatment services.
17. Failing to maintain the standards of practice of the profession.

Professional Standard

In addition to required clinical information, the evaluation of patients with retinal changes suggestive of AMD, or patients suspected of having AMD, includes:

- patient history of any symptoms associated with AMD; and
- ocular examination including the following:
 - measurement of best corrected monocular visual acuity, distance and near;
 - Amsler grid testing; and
 - *ocular fundus examination* ([OPR 6.2](#)), stereoscopic where possible, with pupillary dilation unless contraindicated.

The management of a patient with AMD includes:

- continued assessment for differential diagnosis;
- monitoring the patient at a frequency that is dependent on the risk of progression of the disease;
- educating patients to be aware of symptoms such as decreased vision, scotoma and dysmorphopsia by monocular assessment;
- instructing patients that an onset of new symptoms warrants a prompt return for assessment; and
- making a timely *referral* (OPR 4.5) for treatment assessment for patients suspected of having choroidal neovascularization (CNV).

In developing a treatment plan, consideration should be given to the patient's visual demands and abilities.

Clinical Guideline

The role of antioxidants in preventing or slowing the effects of AMD is currently being investigated. Nutritional considerations that may reduce the risk of development or progression of macular degeneration may be discussed with those at increased risk.

For patients with macular degeneration, examination with a fundus contact lens is useful in assessing risk of macular edema. Use of advanced imaging technologies may also be helpful in monitoring disease progression.

Some patients may be candidates for low vision rehabilitation including the use of specialized optical devices and training. These patients may benefit from a consultation with a practitioner who has advanced training or clinical experience in low vision. When extensive visual loss occurs, the optometrist should also consider referral for rehabilitation, occupational, vocational and independent living counselling services.

Management of patients with AMD may also include:

- home Amsler grid testing;
- education regarding current and emerging treatment options;
- nutritional supplementation; and/or
- risk counselling for relatives.

Research in the area of macular degeneration is advancing quickly and it is recommended that optometrists stay current with new treatments as they become available.

(Sept. 2006)

7.4 Patients with Diabetes

Description

Diabetes mellitus (DM) is a very common systemic condition that can have numerous ocular manifestations. While diabetic retinopathy poses the greatest long-term threat to vision for most patients, the practitioner should also be alert to the development of many other possible complications ranging from transient fluctuations in refractive error and dysfunctions of accommodation and colour vision, to abnormalities in the cornea, iris, lens, vitreous, and optic nerve. Also, oculomotor anomalies may arise from neuropathies affecting the third, fourth or sixth cranial nerves.

Regulatory Standard

The Professional Misconduct Regulation (**Regulation 859/93 under the *Optometry Act***) includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.
12. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.
13. Failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination.
17. Failing to maintain the standards of practice of the profession.

Professional Standard

Due to the high prevalence of ocular manifestations of diabetes and the increasing incidence of retinopathy as the duration of the disease increases, all patients with diabetes require periodic assessment of the eye and vision system. The patient is advised as to the appropriate frequency of such assessments which depends on factors such as the duration of the disease, the nature of the condition (e.g. Type I versus Type II), the quality of blood glucose control and the clinical findings. The normal complement of required clinical information is updated regularly with particular emphasis on a detailed case history and a thorough *ocular fundus examination* (**OPR 6.2**) with dilated pupils. Any abnormalities found are carefully documented in the patient's record.

Referral (**OPR 4.5**) to an appropriate healthcare professional is required when indicated.

Clinical Guideline

Quality care of a patient with diabetes starts with a meticulous and comprehensive case history. The patient history should elicit any visual symptoms such as blurred, distorted or fluctuating vision, diplopia, flashes/floaters, etc., particularly if they are of recent onset. (Note that a recent onset of such symptoms in a patient who denies a previous diagnosis of diabetes may arouse a suspicion of undiagnosed DM and trigger a *referral* (OPR 4.5) to a physician for appropriate medical testing).

The patient's medical history should be explored to determine the type and duration of the DM, and the patient's management regime should be reviewed, noting:

- any oral medications taken;
- insulin type and usual dosage, where applicable;
- frequency and usual results of blood glucose self-monitoring; and/or
- recent laboratory values for HbA1c (if available).

This information provides valuable insight into patient compliance with therapeutic regimens and control of the DM, which may affect the development of ocular complications. It is also useful to determine if any history of non-ocular complications of DM such as neuropathy or nephropathy exists. The name of the patient's primary care physician should be noted in the record to facilitate communication and coordination of the patient's care.

In addition to the normal complement of *required clinical information* (OPR 4.2) to be obtained on each patient, certain supplementary procedures may be useful in some cases, depending on clinical findings. Such procedures may include:

- blood pressure measurement;
- colour vision assessment;
- contrast sensitivity testing;
- fundus photography (or other ocular imaging procedures);
- gonioscopy; and/or
- macular function assessment (e.g. Amsler grid testing).

Integral to the ocular examination of every patient with diabetes is the detection and assessment of retinopathy by means of a thorough *ocular fundus examination* (OPR 6.2) with dilated pupils, preferably employing stereoscopic techniques wherever possible. The practitioner should be familiar with the classification and current management standards for the various stages of diabetic retinopathy. Studies¹ have demonstrated that optimal control of blood glucose combined with timely intervention for treatments such as focal or panretinal laser photocoagulation or vitrectomy (if necessary) can significantly reduce the risk of visual loss or delay its onset. The practitioner may refer to the American Optometric Association Clinical Practice Guideline, Care of the Patient with Diabetes Mellitus, for a detailed outline of these studies and their implications².

As a general guideline, the presence of any of the following findings should lead the optometrist to refer the patient to an ophthalmologist skilled in treating diseases of the retina:

- moderate to severe non-proliferative diabetic retinopathy (NPDR);
- any proliferative diabetic retinopathy (PDR);
- clinically significant macular edema;
- neovascularization of the iris; or
- any unexplained vision loss.

Loss of Vision

In spite of the treatment interventions available, some patients with diabetes will inevitably experience a permanent loss of visual acuity or functional vision. These patients may benefit from a specialized low vision consultation in which various optical or non-optical aids or other devices may be considered to assist with the independent performance of routine daily tasks. In addition, referral for orientation and mobility training, occupational/vocational consultation, or psychosocial counselling may help some patients to achieve more fulfilling, self-sustaining lifestyles.

Coordination of Care

In view of the multidisciplinary nature of diabetes management, appropriate communication with the patient's primary care physician and any other referral consultants is critical for the proper coordination of the patient's care. It is always beneficial to send written letters or reports to the patient's diabetes management team and to keep copies of such documentation in the patient's record, even in cases where ocular complications have not yet developed. Also, patients should be reminded of the importance of maintaining optimal glycemic control at all times, and should be encouraged to maintain contact with their physician on a regular basis to ensure that vital systemic health indicators such as blood pressure, kidney function, etc., are monitored at appropriate intervals.

(Jan. 2007)

¹ The Diabetic Retinopathy Study (DRS), the Early Treatment Diabetic Retinopathy Study (ETDRS), the Diabetic Retinopathy Vitrectomy Study (DRVS), the Diabetes Control and Complications Trial (DCCT), and the United Kingdom Prospective Diabetes Study (UKPDS)

² American Optometric Association Clinical Practice Guidelines: <http://www.aoa.org/documents/CPG-3.pdf> Care of the Patient with Diabetes Mellitus (CPG 3)

7.5 Patients with Hypertension

Description

Hypertension is a common and insidious systemic condition that frequently affects the ocular fundus, particularly the retinal vasculature. While the most common ocular manifestations of hypertension are usually asymptomatic and do not pose an immediate threat to vision, these findings may indicate a need for systemic medical assessment and intervention in the interest of maintaining the patient's general health. The need for such intervention may be urgent in some circumstances¹. The optometrist should also recognize that poorly controlled hypertension may contribute to the development of potentially sight-threatening complications within the visual system. These include vascular occlusions and obstructions, hemorrhages, retinal edema and neovascularization, optic neuropathies, and oculomotor anomalies arising from neuropathies affecting the third, fourth or sixth cranial nerves².

Regulatory Standard

The Professional Misconduct Regulation (**Regulation 859/93 under the *Optometry Act***) includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.
12. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.
13. Failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination.
17. Failing to maintain the standards of practice of the profession.

Professional Standard

Due to the high prevalence of ocular manifestations of hypertension, all patients with hypertension require periodic assessment of the eye and vision system. The frequency of such assessments depends on factors such as the history and status of the condition, the clinical findings and the presence of other cardiovascular risk factors such as diabetes^{2,3}. The normal complement of *required clinical information* (**OPR 4.2**) is updated regularly with particular emphasis on a detailed case history and a thorough *ocular fundus examination* (**OPR 6.2**). Any abnormalities found are carefully documented and the patient's primary healthcare practitioner is advised of any findings that may pose a threat to the patient's ocular or systemic health. This is particularly urgent if swelling of the optic nerve head (suggestive of malignant hypertension) is discovered^{1,2}.

Clinical Guideline

Since hypertension tends to be an insidious and asymptomatic condition, even when poorly controlled, the presence or absence of specific symptoms in the case history rarely provides much insight regarding the patient's risk profile. However, the patient's medical history should be explored to determine if a history of hypertension exists and, if so, the duration of the condition and the presence of any complications or other cardiovascular disease³. The patient's management regime should be reviewed, noting:

- any medications taken, with dosages where applicable;
- frequency and usual results of blood pressure monitoring; and/or
- any history of other medical interventions, diagnostic procedures or ongoing monitoring related to cardiovascular disease.

The name of the patient's primary healthcare practitioner should be noted in the record to facilitate communication and coordination of the patient's care.

In addition to the normal complement of required clinical information to be obtained for each patient, certain supplementary procedures may be useful in some cases, depending on clinical findings. Such procedures may include:

- blood pressure measurement;
- visual field assessment; and/or
- fundus photography (or other ocular imaging procedures).

The most critical issue in the ocular examination of a patient with hypertension is the detection and assessment of retinopathy by means of a thorough ocular fundus examination, preferably employing stereoscopic techniques through dilated pupils wherever possible. The practitioner should be familiar with the fundus signs that are characteristic of hypertensive and arteriolar sclerotic retinopathy, which may include:

- i. anomalies in retinal vessel calibre;
- ii. changes in the appearance of arteriovenous crossings;
- iii. hemorrhages, exudates or cotton-wool spots;
- iv. retinal edema; and/or
- v. edema of the optic nerve head¹.

Similarly, the practitioner should be aware of other signs and symptoms that may arise from vascular complications affecting the eye and vision system secondary to hypertension. To this end, any anomalies in best-corrected visual acuity, visual fields, ocular motility, pupil reflexes, colour vision and/or contrast sensitivity that could be caused by hypertensive vascular changes should be carefully assessed and documented. The practitioner should make appropriate *referrals* (OPR 4.5) as required^{1,3}.

Coordination of Care

It is always beneficial, when positive signs exist, to send written letters or reports to relevant members of the patient's healthcare team and to keep copies of such documentation in the patient's record³. Also, patients should be reminded of the importance of continued compliance with their primary healthcare practitioner's recommendations regarding optimal blood pressure control and lifestyle modifications, and should be encouraged to maintain contact with this practitioner on a regular basis to ensure that vital systemic health indicators such as blood pressure, lipid profile, kidney function, etc., are monitored at appropriate intervals.

(Apr. 2007)

¹ Rhee, DJ, Pyfer, MF, eds. *The Wills Eye Manual*. 3rd ed., pp 340-341. Philadelphia: Lippincott, 1999.

² Kanski, JJ. *Clinical Ophthalmology*. 5th ed., pp 468-470. Philadelphia: Butterworth-Heinemann, 1999.

³ American Optometric Association Clinical Practice Guidelines: www.aoa.org/x4813.xml
Comprehensive Adult Eye and Vision Examination (CPG 1)

7.6 Cycloplegic Refraction

Description

Objective and subjective refraction done under cycloplegia can provide useful information in situations where sustained accommodative effort is suspected to be contributing to symptoms or obscuring a full diagnosis of the clinical problem.

Regulatory Standard

The Professional Misconduct Regulation ([Regulation 859/93 under the *Optometry Act*](#)) includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.
13. Failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination.
16. Recommending or providing unnecessary diagnostic or treatment services.
17. Failing to maintain the standards of practice of the profession.

Professional Standard

A member's decision to perform a cycloplegic refraction will be influenced by the patient's:

- age;
- signs;
- symptoms; and
- risk factors.

Cycloplegic refraction is indicated in children and young adults with suspected amblyopia, unexplained reduced visual acuity, or those who are at risk of developing amblyopia secondary to accommodative esotropia or asymmetric refractive error. Cycloplegic refraction is repeated when clinically indicated.

When *using cycloplegic agents* ([OPR 4.4](#)), optometrists will:

- be familiar with the properties of any cycloplegic agents they use;
- counsel the patient appropriately regarding the expected effects and anticipated duration of action of the agent; and
- consider the presence of any significant contraindications to the use of a cycloplegic agent prior to instillation (e.g., narrow anterior chamber angle, past

history of angle closure attacks or other adverse reactions or hypersensitivities to similar agents, etc.).

Clinical Guidelines

Situations in which the optometrist would consider performing a cycloplegic refraction include the following:

- hyperopic children and young adults on their first visit, particularly if associated with an eso deviation;
- children and young adults presenting with a strabismus on their first visit, particularly if the direction of the deviation is esotropia;
- patients whose symptoms are suspected to be arising from accommodative spasm (i.e., latent hyperopia, pseudomyopia);
- patients who appear to have a subnormal amplitude of accommodation for their age, or who have other signs or symptoms suggestive of accommodative dysfunction;
- patients in whom standard non-cycloplegic refractive techniques are not possible or who appear to give unreliable or inconsistent results due to inaccurate fixation, poor co-operation, misunderstanding of test procedure, etc.; and
- patients who are planning to undergo a surgical procedure that is intended to permanently alter their refractive error.

The specific cycloplegic agent to use in each case should be selected with the goal of providing adequately deep suppression of accommodation while at the same time minimizing the length of time that the patient will be inconvenienced by blur or excessive photophobia.

The agent selected and specific dosage will be influenced primarily by the age of the patient and secondarily by the degree of iris pigmentation. Patients with darker irides often require a more potent cycloplegic agent or a higher dosage than patients with lighter irides (e.g., two drops separated by a five minute time interval rather than a single drop in each eye).

Cyclopentolate hydrochloride (0.5% and 1% drops) is the most widely used cycloplegic agent available at this time. It provides the best compromise between efficacy and duration of action¹, with one to two drops of 1% solution producing adequate cycloplegia within 25-30 minutes of instillation and lasting 3-24 hours in the majority of cases².

Atropine (0.5% and 1% concentrations in ointment and drop form, respectively) is advocated by some authorities for the purpose of producing maximal cycloplegia in very young children, but it usually requires administration of the drug up to 3 days before the refraction and its effects are excessively long-lasting¹.

Tropicamide (0.5% and 1% drops) may also be effective for use in adult patients, offering a rapid onset of action (20-30 minutes) and a short duration (30 minutes to 4 hours)¹; however it may not provide a reliable degree and consistency of cycloplegia, especially in patients with dark irides and significant hyperopia¹.

The practitioner needs to exercise considerable clinical judgment in interpreting the refractive findings obtained under cycloplegia and prescribing an appropriate refractive correction. The final prescription decision will depend on:

- a comparison of the cycloplegic versus non-cycloplegic refractive findings;
- the patient's age;
- the patient's symptoms;
- the degree of hyperopia and/or esophoria; and
- the presence or absence of strabismus.

Properties of common cycloplegic agents that may be used are summarized in the *Guideline for the Use of Drugs by Optometrists (OPR 4.4)*.

(Apr. 2007)

¹ American Optometric Association Clinical Practice Guidelines: CPG 16 Care of the Patient with Hyperopia

² Bartlett et al. Ophthalmic Drug Facts. St. Louis: Lippincott, 1989:22-27

7.7 Dilation and Irrigation of the Naso-Lacrimal Ducts

Description

Dilation and irrigation of the naso-lacrimal ducts may be used as diagnostic or treatment procedures. These procedures temporarily enlarge the punctal opening to the canaliculi for insertion of occlusion devices and/or the irrigation of material from the canaliculi and the naso-lacrimal ducts and/or to maintain complete patency of the system.

Regulatory Standard

The Professional Misconduct Regulation ([Regulation 859/93 under the *Optometry Act*](#)) includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.
13. Failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination.
16. Recommending or providing unnecessary diagnostic or treatment services.
17. Failing to maintain the standards of practice of the profession.

Professional Standard

Members providing this service must be competent in performing this technique and have a thorough understanding of the anatomical features and fluid dynamics of the lacrimal system to determine the location of an obstruction.

- Dilation and irrigation of the naso-lacrimal ducts will follow a diagnostic process to determine if the procedure is warranted.
- Appropriate infection controls must be used.

Clinical Guideline

Signs and symptoms consistent with hyperlacrimation are determined by the patient history and slit lamp examination. Tests such as the fluorescein dye disappearance test for lacrimal outflow deficiency can be helpful in confirming the diagnosis of epiphora.

In dry eye conditions, knowing the patency of the drainage system is essential if hyperlacrimation is present.

(Sep. 2006)

7.8 Refractive Surgery

Description

The term Refractive Surgery (RS) is a general term for the various forms of surgery used to correct refractive errors of the eye. This includes techniques that use lasers and other forms of electromagnetic energy, implantable lenses and devices and conventional incision techniques. Optometrists provide preoperative and postoperative care to RS patients both in the optometrist's office and within surgical centres.

Refractive surgery is one of the situations in which optometrists often participate in a shared care relationship with another healthcare practitioner. Shared care arrangements are intended to assist in the delivery of effective, high quality patient care. This standard and guideline addresses the sharing of responsibilities, the communication of patient information and the financial arrangements within shared care situations.

Regulatory Standard

The Professional Misconduct Regulation ([Regulation 859/93 under the *Optometry Act*](#)) includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.
8. Practicing the profession while the member is in a conflict of interest.
13. Failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination.
16. Recommending or providing unnecessary diagnostic or treatment services.
17. Failing to maintain the standards of practice of the profession.
25. Causing or permitting, directly or indirectly, a publication through any medium of communications that has a relation to or a bearing on a member's practice that,
 - iii. refers to any services that the member does not provide,
 - vi. refers to a particular drug or particular brand of product or equipment used to provide optometric service, or
 - ix. is part of any communication, advertisement, listing, promotion or offering of any product or service by a non-member.

The *Drug and Pharmacies Regulation Act* includes the following conflict of interest provisions:

- A member shall not engage in the practice of optometry where the member has a conflict of interest. (R.R.O. 1990, Reg. 550, s. 26 (2))
- It is a conflict of interest for a member to,
 - (a) share fees with any person who has referred a patient or receive fees from a person to whom the member has referred a patient or to engage in any form of fee sharing, rebates or other indirect remuneration. (R.R.O. 1990, Reg. 550, s. 26 (4))

Professional Standard

Optometrists providing care to RS patients will:

- maintain current knowledge of surgical procedures and competence in delivering the various types of preoperative and postoperative procedures in which they participate;
- inform patients of the various risks and benefits of the procedure, their options for care providers and all associated fees; and
- disclose to patients any financial interest in a surgical centre to which the optometrist refers the patient and with which the optometrist shares care.

Clinical Guideline

All optometrists should possess a reasonable degree of knowledge about RS in order to discuss treatment options with patients in general terms.

The following guidelines apply to members providing preoperative and postoperative RS care.

Counselling

The purpose of counselling is to enable the patient to make informed decisions about treatment options. Counselling is based upon an appropriate case history and clinical examination. In the case of RS, the optometrist shares this responsibility with the surgeon. The optometrist should ensure that appropriate informed consent is documented.

Pre-RS counselling should include:

- general information including a description of the procedure, expected outcomes, normal healing course and expected postoperative care schedule and procedures;
- potential benefits including potential reduction or elimination of refractive error and need for corrective lenses;

- potential risks and complications including potential surgical complications, healing complications, optical problems associated with over or under correction, and potential adaptation problems associated with post-surgical status;
- provider options such as available surgical facilities and qualified surgeons, as well as those qualified to provide preoperative and/or postoperative care;
- practitioner responsibilities so the patient is aware of which practitioner is providing which aspects of the RS care; and
- *referral (OPR 4.5)*, which usually includes one referral to a qualified and experienced ophthalmic surgeon by the optometrist for consultation and surgery, and a second referral to the optometrist by the ophthalmic surgeon for postoperative care. Optometrists are expected to provide the surgeon with relevant history and clinical findings.

Postoperative Care Considerations

The postoperative care regimen depends upon the surgical procedure and any complications involved.

- In a shared care environment, the results of postoperative assessments are communicated to the surgeon.
- Any urgent or emergent complications that arise require the optometrist to contact the surgeon immediately.
- Optometrists are to ensure that the RS patient has continuous access to emergency care.
- The surgeon will generally provide required pharmaceuticals as well as a schedule for medication use for an uneventful postoperative course. When changes in the drug regimen appear necessary, these should only be made upon the order of the prescriber.

Conflicts of Interest Related to RS

The optometrist must collect the fees for the provision of his or her services in preoperative and postoperative care. The optometrist should ensure that the patient is fully informed of the details of the services.

A member who accepts reimbursement from a surgical centre is at risk of allegations of professional misconduct, in particular for fee sharing, accepting rebates or receiving other indirect remuneration.

(Sept 2006)

7.9 Visual Perception/Learning Disabilities

Description

The assessment and management of disorders of visual perception and learning disabilities is complex and frequently requires the involvement of a number of professional disciplines. The optometrist acts as a member of a multidisciplinary team that may include one or more of the following professionals:

- educator;
- psychologist;
- physician;
- occupational therapist;
- audiologist; and/or
- speech pathologist.

Regulatory Standard

The Professional Misconduct Regulation (**Regulation 859/93 under the *Optometry Act***) includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.
3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation which a consent is required by law, without such a consent.
11. Making a misrepresentation with respect to a remedy, treatment or device.
12. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.
13. Failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination.
16. Recommending or providing unnecessary diagnostic or treatment services.
17. Failing to maintain the standards of practice of the profession.

Professional Standard

As part of the team dealing with the patient with a learning difficulty, the optometrist accepts the responsibility for providing consultation and advice regarding further investigation, as appropriate under the circumstances.

Clinical Guideline

Optometrists are often the first professionals to see children with reading or learning problems. An optometric examination to detect, diagnose and treat visual disorders and ocular disease is an appropriate step in the management of individuals with learning difficulties. Although vision problems may be associated with learning difficulties, they are rarely the sole factor.

The clinical practices in this field are ever changing and the optometrist should stay current with these changes. Optometrists may use current techniques to offer a “conventional” diagnosis and treatment plan, and be aware of any limitations with “alternative” plans less accepted in the field.

Additional information on this topic is available on the American Optometric Association website (www.aoa.org) and includes the following clinical practice guideline: Care of the Patient with Learning Related Vision Problems (CPG 20).

(Sept. 2006)