

Minimum Competency Standards for an Orthoptist registered with the New Zealand Orthoptic society Inc.

New Zealand currently does not have the size or capacity to train Orthoptists and those from the United Kingdom (whom are working here) have to abide by the British and Irish Professional Practice and Competency standard developed in 2007. This document is the culmination of a review from the Australian, British and Canadian standards and provides the basis for the new New Zealand Standards for those coming to New Zealand to work whom have not previously had to comply with Competency standards.

The UK Health Act of 1999 bestowed the status of profession on orthoptics and requirement to protect patients accessing the service. There the title of 'orthoptist' is protected by law to those whom have completed a diploma (DBO) or degree in Orthoptics or BMedSci (orthoptics) Hons and is entitled to hold registration. A registered orthoptist holds the status of professional.

Here in New Zealand we do not yet have the support of statutory professional protection and so developed these competency standards to aid the society achieving this and provide protection for those patients in our care.

This set of standards has been developed to provide an optimal set of standards for Orthoptic Practice, education and professional development, consistent with good clinical outcomes. A standard approach is important to ensure delivery of quality care that must be in place in the Orthoptic Departments.

'It is hoped that each Orthoptic Department will benefit from applying these competency standards and guidelines for professional practice threefold; the department as a professional Orthoptic Service; the individual Orthoptist in his/her practice and professional development, and the patient on receipt of professional, competent and quality patient care.'

The Orthoptist has the responsibility to ensure that:

They abide by Professional conduct in an ethical, moral and legal manner.

In summary, the orthoptist has the responsibility to ensure that:

- The autonomy of each and every patient is recognised
- The consent and involvement of the patient in the treatment is obtained (or if not that of the patient a responsible authority) and recorded.
- The treatment and advice given is of a competent standard, evidence –based, clearly explained and intended to benefit the patient.

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Section 1 Patient Care

Aim:

Appropriate and accurate evaluation is necessary to provide quality patient care.

1.1 Patient interview

1.2 Patient assessment

1.3 Diagnosis

1.4 Management

1.5 Recording of clinical data

1.1 Patient Interview

Overview

The patient interview is an integral part of the Orthoptic practice whereby an Orthoptist gains essential information which will form the focus/basis of further assessment. The case history may be the first point of contact between the patient, carer and Orthoptist.

Essential standards;

- i. The intellectual needs of the patient are considered and communication techniques adjusted accordingly to best meet the patient's needs.
- ii. The language needs of the patient and/or carer are considered
- iii. Questions and statements are phrased so that adequate information can be elicited
- iv. Information gained in interview is recorded accurately and concisely and may include:
 - iv.1 Name, address, date of birth
 - iv.2 GP and address
 - iv.3 Relationship of carer to patient
 - iv.4 Occupation
 - iv.5 Source of referral
 - iv.6 Reason for attendance
 - iv.7 Family history
 - iv.8 General health
 - iv.9 Birth history
 - iv.10 Previous ophthalmic history
 - iv.11 Symptoms
 - iv.12 Signs
 - iv.13 Age
 - iv.14 Age at onset
 - iv.15 Mode of onset

- iv.16 Deviating eye
 - iv.17 Change in deviation
 - iv.18 Variation in angle
 - iv.19 Precipitating /attributed cause
- v. The orthoptist establishes a rapport with the patient /carer, introduces self and discusses the role of the orthoptist at first visit and introduces self at each subsequent visit
- vi. The orthoptist address the patient by name and make eye contact
- vii. The orthoptist shows an interest in the patient and respects the individual need of the patient.

Measures

Methods that may be used to determine compliance with the above may include;
 General statement of intent during investigation and communication
 Patient questionnaire
 Audit of documented information in case notes.

1.2 Patient Assessment

Overview

This involves the application of the attributes of knowledge, investigative and technical skills to the case. Through patient assessment all the information relevant to the case is efficiently and safely acquired.

Essential standards:

1.2.1 The assessment make observations of patient with are documented and may include;

- i. Strabismus
- ii. Ocular adnexa
- iii. Head postures
- iv. Nystagmus
- v. Asymmetry of facial feature
- vi. Pupil reactions
- vii. Glasses prescription and fitting
- viii. Mobility/gait/physical appearance
- ix. Disability

1.2.2 The Orthoptist uses knowledge of the visual system and its abnormalities to formulate strategies for assessing the patient

1.2.3 The orthoptist varies testing procedures according to the patient's responses and selects testing procedures applicable to the level of ability of the patient.

1.2.4. The orthoptist correctly uses quantitative and qualitative tests to investigate further the ocular status of the patient which determines:

- i. The sensory state of the eye
- ii. The motor function of the eyes
- iii. The presence and level of binocular vision

1.2.5 The testing sequence is modified according to the result gained.

1.2.6 Accurate observations about the patient's responses to the tests are made and patterns of normal and abnormal responses to the testing procedures recorded and evaluated for accuracy.

1.2.7 The test results are critically evaluated for differential diagnosis

1.2.8. The orthoptist uses interpersonal and communicative skills to indicate to the patient / carer the purpose of the tests and to obtain appropriate responses to the tests.

Desirable objectives:

1.2.2.1 The orthoptist may undertake specialised ophthalmic testing procedures in the ophthalmic setting in which the orthoptist has been deemed competent; the standards of practice and proficiency are found in the ('BIOS; Competency standards and Practice guidelines for the Extended role of the orthoptist)

- i. Glaucoma
- ii. Stroke assessment and rehabilitation
- iii. Retinoscopy and refraction
- iv. Visual field assessment
- v. Visual assessment of children with special needs
- vi. Cataract assessment
- vii. Specific learning difficulties
- viii. Neuro-ophthalmology /neuro-orthoptics
- ix. Low vision assessment and low vision aids

Additional procedures may include

- i. Ultrasonography
- ii. Auto-refraction
- iii. Contact lens fitting
- iv. Tonometry
- v. Oculo-coherence tomography

- vi. Corneal topography
- vii. Surgical assisting

Measures

Methods that may be used to determine compliance with the above may include;

- Review of case notes at random.
- Written department statements regarding additional specialised testing skills and policies and procedures applicable to these.
- Audits of practice.
- Evidence of clinical protocols.

1.3. Diagnosis

Overview:

A diagnosis is made following appropriate interview and assessment of the patient using the available Orthoptic techniques and equipment and ophthalmic assessment.

Essential Standards:

The Orthoptist...

1.3.1 Interprets information gained in patient assessment to suggest possible ocular diagnoses.

1.3.2 Selects or recognises additional tests to further investigate possible diagnoses

1.3.3 Is able to identify when clinical findings suggest a possible change in direction of patient management.

1.3.4 Establishes which area of intervention will be required i.e. sensory, motor, optical, rehabilitation or further monitoring of the condition.

1.3.5 Is able to determine if the tests provide evidence for the diagnosis of the ocular motor condition.

1.3.6 Where inconsistencies arise, is able to highlight the most important information gained in the assessment.

1.3.7 Considers the ocular and general history in conjunction with the test results in order to summarise the findings with regards the diagnosis and possible cause.

Measures:

Methods that may be used to determine compliance with the above include;

- Random review of case notes
- Audit of practice
- Peer review

Case presentations and discussions.

1.4 Management

Overview:

Each patient has a care programme developed specific to their ocular condition.

Essential Standards:

The Orthoptist...

1.4.1 Designs and implements Orthoptic treatment plans with the patient/carer's involvement and content /assent (which may be verbal for non-invasive treatment)

1.4.2 Demonstrates a knowledge of the practical and technical aspects of the the therapeutics for Orthoptic treatment including;

1.4.2.1 Occlusion methods

1.4.2.2. Pharmacological effects on vision function

1.4.2.3 Binocular vision exercises

1.4.2.4 Prismatic and optical influences on vision and binocular function

1.4.3.5.The implication of ocular surgery

1.4.3 Explains the diagnosis in appropriate terminology to the patient and carer

1.4.4. Considers all treatment options in liaison with the ophthalmic team and patient, where necessary /appropriate with respect to all prognostic indicator, available resources, any adverse side effects and level of patient involvement that will be required.

1.4.5 Structures specific treatment with respect to the general condition of the patient.

1.4.6 Provides details of verbal or written instructions /information regarding Orthoptic and ophthalmic procedures and care.

1.4.7 Reviews the progress of the treatment plan regularly and evaluates the need for modification or alternative treatment plans.

1.4.8 Assists in the management of pre and post-operative care

Measures

Methods that may be used to determine compliance with the above may include:

Polices and procedures relating to treatment and care plans.

Random review of case notes

Patient questionnaire

Review case presentation and discussion.

1.5 Recording of clinical data

Overview.

This involves the method of correct documentation of information gathered during the patient interview and assessment.

1.5.1 Essential Standards:

The Orthoptist...

1.5.1 Ensures that accurate patient records and ophthalmic assessments are organised in a legible, secure, accessible, and clear manner, including relevant test results filed in an appropriate manner. Patient record should be in permanent ink copy or be part of a computer based hospital /ophthalmic practice record system. All entries should be dated, signed and designated and follow local guidelines.

1.5.1.2 Ensures that amendments or updates to the records are clear and does not erase information previously documented. Nor should the previous information be made difficult to read. Errors may be amended by crossing through with a single line and the amendment should be signed.

1.5.1.3 Ensures permanent copies of file are kept for every consultation where possible.

1.5.1.4. Uses abbreviations and diagrams that are recognised by the Orthoptic and ophthalmic professions on all Orthoptic records as listed in the 'Dictionary of Common terms in Orthoptic Practice' (BIOS).

1.5.1.5. Ensures that care programmes developed by unqualified staff are countersigned by a registered member of staff.

1.5.1.6 Maintains confidentiality of patient records

1.5.1.7 Ensures department records and case notes being held in the department are kept in a secure place and access is available only to authorised personnel.

1.5.1.8 Ensures documentation of informed consent is gained before releasing Orthoptic files and personal histories to outside the hospital /ophthalmic practice (dependent upon local policy) such as educational providers and non-health care professionals.

1.5.2 Essential standard (dependent upon local referral policy):

The Orthoptist....

1.5.2.1 Refers the patient for appropriate additional assessment and treatment to other allied health professionals or agencies for special needs, as part of the knowledge of Orthoptic management in the context of overall patient care in consultation with the referring specialist .

1.5.2.2 When necessary refers the patient to an Ophthalmologist

1.5.2.3 Refers the patient back to the referring specialist if clinical judgment indicates possible additional pathology.

1.5.2.4 Refers the patient to the referring medical practitioners for medical assessment and management.

1.3.2.5 Refers the patient to appropriate agencies for specific needs such as vision impairment.

1.3.2.6 Documents follow-up arrangements and referral /attendance /discharge details.

Measures

Methods that may be used to determine compliance with the above may include:

Audit of clinical practice,

Policies and procedures for referrals and data handling (case notes)

Random review of case notes.

SECTION 2 Orthoptic Practice

Aim:

A standardised approach to the investigation of Orthoptic patients is important to the provision of quality patient care and the development of appropriate care plans for the management of patients.

2.1 Orthoptic investigative procedures

2.2 Assessment and management of amblyopia

2.3 Assessment and management of heterophoria

2.4 Assessment and management of constant concomitant strabismus

2.5 Assessment and management of intermittent concomitant strabismus

2.6 Assessment and management of microtropia

2.7 Assessment and management of incomitant strabismus

2.1 ORTHOPTIC INVESTIGATIVE PROCEDURES

2.1.1 Visual Acuity

Assessment of Visual acuity (VA) should be quantitative wherever possible using tests based on logMAR (gold standard), Snellen or Snellen equivalent, preferential looking and vanishing optotypes. Qualitative assessment will be required in individual circumstances.

Unocular VA is tested for distance and where feasible also for near. A pinhole may be used in appropriate patients, where VA is reduced and refractive error is suspected. Occlusion, for VA assessment, is usually with an occlusion patch, occlusion glasses or an opaque occluder.

In cases where nystagmus is present, the VA assessment test is performed with and without abnormal head posture (AHP) at near and distance and at near where indicated allowing the patient to hold the print at a preferred distance (to be recorded). VA is also assessed with both eyes open (BEO). A high plus lens of Speilmann occluder may be used for unocular VA assessment.

The existence of crowding should be evaluated as appropriate.

Where it is not possible to obtain acuities the reason should be recorded accurately in the clinical records.

2.1.2 Cover Test.

The cover test is performed:

-with /without corrective prescription

- with /without accommodative target
- with/without abnormal head posture
- for near and distance fixation, and other distances where appropriate

The presence or absence of manifest strabismus, its type and size, whether concomitant or inconcomitant and the presence, type, size and recovery of any latent deviation recorded.

The presence of nystagmus and a description of the waveform characteristics are recorded.

2.1.3 Binocular Single Vision (BSV)

The presence or absence of BSV should be assessed at the initial visit if possible.

Free space tests are recommended for evaluation of retinal correspondence and BSV.

The synoptophore is recommended for further evaluation of binocular status in patients with heterotropia.

The prism adaption test may be used in the investigation of binocular potential.

Where suppression is demonstrated, the area of suppression and density of suppression should be investigated if appropriate

Where BSV or potential for BSV is demonstrated, it is recommended that motor fusion and fusional vergences should be assessed (positive and negative relative convergence) are investigated where possible.

Vertical motor fusion and fusional vergences should be assessed with vertical deviation.

2.1.4 Ocular Motility

Ocular Motility is assessed by version and duction assessment in nine positions of gaze and may be documented in a diagrammatic or written form.

Ocular motility may include assessment of smooth pursuit, saccadic, vergences, vestibular and optokinetic systems.

2.1.5 Measurement of Ocular Deviation

The angle of deviation is measured in the primary position and in the eight other positions of gaze and fixing either eye where appropriate.

It may also be measured with additional lenses in order to calculate the AC/A ratio.

Measurement of torsion, Hess Chart, field of binocular vision and fields of unocular fixation may be assessed as indicated in incomitant strabismus.

The convergence and accommodative near points, accommodative amplitude and accommodative facility are measured where indicated.

2.2 ASSESSMENT AND MANAGEMENT OF AMBLYOPIA

For assessment of visual acuity /function, see section 2.1.

Management

The aim is to achieve equal visual acuity or the optimum visual acuity in the affected eye. A refraction, fundus and media examination should be requested on all patients and fixation status (fixation ophthalmoscope) documented where appropriate.

Where visual acuity does not improve following appropriate spectacle correction (if required) and adaptation period, occlusion is undertaken which may be full time / part-time, total / partial form or pharmacological penalisation. Optical penalisation or admission to hospital for occlusion may be also be appropriate in some cases.

When VA does not improve following occlusion, or pharmacological penalisation it is important to reassess and change management if required. Failure to improve may reflect poor compliance, inadequate occlusion prescribed, or fundus abnormality, and future management would reflect this.

Older patients with no/poor fusion are evaluated for depth of suppression/strength of BSV prior to occlusion and monitored carefully during treatment.

Where optimum VA is achieved with appropriate occlusion, occlusion is reduced and the outcome is monitored carefully during treatment.

Patients with eccentric fixation are often treated initially with conventional occlusion. However, inverse occlusion of the amblyopic eye may be employed in an attempt to disrupt fixation (with or without associated use of red filters), followed by a return to use of conventional occlusion.

Patients with nystagmus and amblyopia are most often treated with conventional occlusion. Where there are concerns regarding reduced levels of visual acuity due to an increase in the amplitude of nystagmus on occlusion /dissociation, optical and pharmacological penalisation may be appropriate.

2.3 ASSESSMENT AND MANAGEMENT OF HETEROPHORIA

All patients have a relevant Orthoptic Investigation from which diagnosis and prognosis are formed and an appropriate care plan implemented. The investigation is made in accordance with the patients' age and ability.

The aim is to achieve optimum visual acuity, good control, stable ocular status, asymptomatic BSV, patient/carer satisfaction.

Assessment.

Ensure refraction, fundus, media examination are carried out.

All patients require a thorough assessment at their initial visit, and assessment as indicated by their diagnosis and care plan at subsequent visits. Where tests are not possible due ,for example, to young age or poor ability, this is documented in the Orthoptic report.

Assessment may include:

Case history

Visual Acuity testing

Cover test

Assessment of ocular motility

Assessment of convergence/accommodation range

Assessment of Binocular Single Vision

Measurement of angle of deviation

Assessment of fixation

Measurement of AC/A ratio

Monocular occlusion to differentiate between ocular and non-ocular symptoms

The care plan and prognosis are dependent on the presence or absence of symptoms/amblyopia, signs of decompensation, age, previous treatment and refraction.

Management

Ensure appropriate refraction correction where indicated

Amblyopia and or anti/suppression treatment

Orthoptic exercises to increase fusional vergences (positive for exophoria, negative for esophoria)

Prism therapy

Refer for surgery and /or botulinum toxin where there is a large angle of deviation and reassess postoperatively for further conservative treatment to consolidate the result.

The following patient review treatment may be adapted according to clinical findings and patient compliance.

2.4 ASSESSMENT AND MANAGEMENT OF CONSTANT CONCOMITANT STRABISMUS

All patients have a relevant Orthoptic Investigation from which diagnosis and prognosis are formed and an appropriate care plan implemented. The investigation is made in accordance with the patients' age and ability.

The aim is to achieve optimum visual acuity, an absence of symptoms, and acceptable alignment.

Assessment.

Ensure refraction, fundus, media examination are carried out.

All patients require a thorough assessment at their initial visit, and assessment as indicated by their diagnosis and care plan at subsequent visits. Where tests are not possible due, for example, to young age or poor ability, this is documented in the Orthoptic report.

Assessment may include:

Case history

Visual Acuity testing

Cover test

Assessment of ocular motility and convergence

Assessment of Binocular Single Vision (BSV)/investigation of suppression –area and density if appropriate

Measurement of the angle of deviation

Assessment of fixation

Post-operative diplopia test

The care plan and prognosis are dependent on the presence or absence of symptoms/amblyopia, signs of decompensation, age, previous treatment and refraction.

Management

Ensure appropriate refraction correction where indicated

Amblyopia therapy where indicated

Referral for surgery and /or botulinum toxin where indicated to achieve improved alignment or functional result dependent upon state of binocular function.

Reassess binocular function potential postoperatively as may require further Orthoptic or optical treatment to consolidate the result.

The following patient review treatment may be adapted according to clinical findings and patient compliance.

2.5 ASSESSMENT AND MANAGEMENT OF INTERMITTENT CONCOMMITANT STRABISMUS

All patients have a relevant Orthoptic Investigation from which diagnosis and prognosis are formed and an appropriate care plan implemented. The investigation is made in accordance with the patients' age and ability.

The aim is to achieve optimum visual acuity, good control using the optimum refractive correction to achieve asymptomatic BSV.

Assessment.

Ensure refraction, fundus, media examination are carried out.

All patients require a thorough assessment at their initial visit, and assessment as indicated by their diagnosis and care plan at subsequent visits. Where tests are not possible due, for example, to young age or poor ability, this is documented in the Orthoptic report.

Assessment may include:

- Case history
- Visual Acuity testing
- Cover test
- Assessment of ocular motility and convergence
- Assessment of Binocular Single Vision (BSV) /suppression
- Measurement of angle of deviation
- Assessment of fixation
- Measurement of AC/A ratio and diagnostic occlusion
- Prism adaption test

The care plan and prognosis are dependent on the presence or absence of symptoms/amblyopia, signs of decompensation, age, previous treatment and refraction.

Management

- Ensure appropriate refraction correction where indicated
- Amblyopia and/ or suppression treatment where indicated
- Optical lenses or prisms
- Miotics
- Occlusion to improve sensory binocular function in divergent deviations
- Orthoptic treatment to improve positive fusional vergences for exophoria (divergent deviations), and negative fusional vergences for esophoria (convergent deviations)
- Refer for surgery and /or botulinum toxin where indicated for the angle of deviation and reassess postoperatively to assess binocular potential and for further conservative treatment to consolidate the result.

The following patient review treatment may be adapted according to clinical findings and patient compliance.

2.6 ASSESSMENT AND MANAGEMENT OF MICROTROPIA

All patients have a relevant Orthoptic Investigation from which diagnosis and prognosis are formed and an appropriate care plan implemented. The investigation is made in accordance with the patients' age and ability.

The aim is to achieve optimum visual acuity, maximum control, use of optimum refractive correction, asymptomatic BSV where previously decompensated, acceptable alignment to restore BSV and patient /carer satisfaction, an absence of symptoms, and acceptable alignment.

Assessment.

Ensure refraction, fundus, media examination are carried out.

All patients require a thorough assessment at their initial visit, and assessment as indicated by their diagnosis and care plan at subsequent visits. Where tests are not possible due, for example, to young age or poor ability, this is documented in the Orthoptic report.

Assessment may include:

Case history

Visual Acuity testing

Cover test

Assessment of ocular motility and convergence

Assessment of Binocular Single Vision (BSV) normal and abnormal

4 dioptre test –BOP or BI for central suppression

Measurement of angle of deviation –may require simultaneous prism & cover test

Assessment of fixation

Measurement of AC/A ratio and diagnostic occlusion

The care plan and prognosis are dependent on the presence or absence of symptoms/amblyopia, signs of decompensation, age, previous treatment and refraction.

Management

Ensure appropriate refraction correction where indicated

Amblyopia treatment where indicated

Orthoptic exercises to improve binocular function where there is an associated decompensating heterophoria

Optical lenses (appropriate refractive correction should be ordered where indicated)

Prisms to Alleviate symptoms of decompensation

Surgery where indicated for decompensation into a larger angle of deviation or where control of the deviation is poor.

Postoperative evaluation to reassess the binocular potential and for further conservative treatment to consolidate the result.

The following patient review treatment may be adapted according to clinical findings and patient compliance.

2.7 ASSESSMENT AND MANGEMENT OF INCOMMITANT STRABISMUS

All patients have a relevant Orthoptic Investigation from which diagnosis and prognosis are formed and an appropriate care plan implemented. The investigation is made in accordance with the patients' age and ability.

Classification and associated findings of incomitant strabismus:

Neurogenic

Mechanical

Myogenic

Nuclear

Internuclear

Supranuclear

Ptosis /pupil anomaly
A/V pattern
Accommodative /convergence anomaly
Nystagmus

Assessment.

All patients require a thorough assessment at their initial visit, and assessment as indicated by their diagnosis and care plan at subsequent visits. Where tests are not possible due, for example, to young age or poor ability, this is documented in the Orthoptic report.

Orthoptic investigation should aim to clarify whether ocular motility disorders are long-standing, congenital or recently acquired, and type of defect.

Assessment may include:

Case history
Visual Acuity testing
Cover test
Assessment of ocular motility –smooth pursuit, saccades, vestibulo-ocular reflex, OKN as appropriate
Assessment of convergence /accommodation range
Assessment of Binocular Single Vision (BSV)
The angle of deviation is measured in relevant positions of gaze and fixing either eye
Measurement of torsion
Field of BSV
Field of uniocular fixation
Lees/Hess screen
Assessment of pupils and lid function
Beilshowsky Head tilt test (BH TT) /Park's 3-step test
Contrast sensitivity
Assessment of nystagmus

Management

The management of this complex and varied group of patients is determined by numerous factors including aetiology, previous ocular history, and signs and symptoms. The Orthoptic assessment explores the relief of symptoms using abnormal/compensatory head postures, prisms and occlusion. The assessment aids the differential diagnosis of neurological and mechanical disorders, congenital, long-standing disorders and acquired defects. The assessment must be sufficiently detailed to inform the medical decision making process, particularly with subsequent assessments, to determine change in alignment or stability when considering surgical intervention. The Orthoptist should ensure referral for further investigation and liaison with other specialties where deemed necessary.

Section 3: Staff development, and Professional Responsibilities

Aim

Continuing professional development is essential for qualified Orthoptists in order to maintain registration with the governing body and quality of care in the profession

2.1 Professional Development

2.2 Education of the patient /public and health professionals

3.1 PROFESSIONAL DEVELOPMENT

Overview

There is a development and educational programme in place that facilitates the professional development of each individual and is related to the objectives of the service and those of the hospital/ DHB.

3.1.1 *Essential standards;*

3.1.1.1 Orthoptists are responsible for maintaining their professional Orthoptic Standards and working within the ethical code of practice (Declaration of Helsinki and for members practicing in New Zealand either the HCPC standards of proficiency or the AOB standards until New Zealand has it's own registration of Orthoptists)

3.1.1.2 Orthoptists ensure Orthoptic Knowledge and clinical experience remain at a professional level.

3.1.1.3 Orthoptists maintain a record of professional development evidence. Orthoptists practicing in New Zealand must adhere to the HCPC or AOB standards for Continuing Professional Development.

3.1.1.4 Orthoptists identify continuing educational requirements and set personal objectives to locate resources to meet learning needs. Resources may include textbooks, journals, funding to attend conferences etc.

3.1.1.5 Orthoptists to review and critically evaluate new information published in the area of practice.

3.1.1.6 Orthoptists are aware of technical advances and new clinical techniques relevant to area of practice.

3.1.1.7 Orthoptists maintain contact with colleagues for purposes of discussion of clinical development. Contact may be in the form of staff meetings, specific feedback meetings, mentoring, email or phone calls between single handed orthoptists.

Measures

Measures should be reviewed annually and staff required to sign evidence they have read and are aware of them. Methods that may be used to determine compliance with the above may include;

The onus is on the individual to record professional development evidence. The lead orthoptist (service Manager, in cases of single handed orthoptists) is responsible for the Personal development review (PDR) process in line with the requirements of the DGH service. Allocation of courses and places at conferences is largely dictated by the financial constraints of the service and will vary locally.

3.2 EDUCATION OF THE PATIENT/ PUBLIC AND HEALTH PROFESSIONALS

Overview

This section involves the dissemination of information and may relate to giving advice and instruction to the individual patient, opinions and education to other health professionals, and promoting the awareness of Orthoptic practice to the wider community.

3.3.1 *Essential standards for education of patient/public;*

The Orthoptist...

2.3.1.1 Provides advice to the patient or carer to a level appropriate to their level of understanding

2.3.1.2 Advises the patient or carer on diagnosis implications and discusses treatment options and prognoses.

2.3.1.3 Ensures that the patient and /or carer is communicated in the language of his/her choice, making use of an appropriate interpreter if necessary.

3.3.2 *Desirable objectives for education of health professionals;*

The Orthoptist...

3.3.2.1 Provides relevant information to other health professionals about the visual system and its disorders in simple jargon-free language.

3.3.2.2. Is aware of the role of other health professionals in the health care system.

3.3.2.3 Uses methods of information dissemination such as in-service talk and lectures.

Measures

Measures should be reviewed annually and staff required to sign as evidence they have read and are aware of these. Methods that may be used to determine compliance with the above may include;

A written report in case notes of information given verbally or in written format to the patient.

Examples of patient leaflets or posters

Patient questionnaire

Evidence of programmes of lectures /training provided by the Orthoptic service / Orthoptist.

2.0 Professional Development

Essential standards:

- i. Orthoptists are responsible for maintaining their professional Orthoptic Standards and working within an ethical code of practice. (Declaration of Helsinki)
- ii. Orthoptists ensure Orthoptic knowledge and clinical experience remain at a professional level.
- iii. Orthoptists maintain a record of professional development evidence. Orthoptists registered with their respective national body must adhere to their standards for continuing professional development.
- iv. Orthoptists review and critically evaluate new information published in the area of practice.
- v. Orthoptist are aware of new technical advances and new clinical techniques relevant to area of practice.
- vi. Orthoptists to maintain contact with colleagues for the purposes of discussion of clinical development. Contact may be in the form of staff meeting, specific feedback meetings, mentoring, email or phone calls between single handed orthoptists.
- vii. Orthoptists identify continuing educational requirements and set personal objectives to locate resources to meet learning needs. Resources may include journals, textbooks, funding to attend conferences etc.

Measures.

The onus is on the individual to record professional development evidence.

The allocation of courses and places at conferences is largely dictated by the financial constrains of the DHB service and will vary locally.

2.1 Education of the patient /public health professionals

Overview.

This involves dissemination of information and may relate to giving advice and instruction to the individual patient, opinions and education to other health professionals and promoting awareness of Orthoptic practice to the wider community.

2.1.1 *Essential standards for education of patient /public*

The Orthoptist...

- i. Provides advice to the patient or carer to a level appropriate to their level of understanding
- ii. Advises the patient or carer on diagnosis and discusses treatment options and prognoses
- iii. Ensures that the patient or carer is communicated to in the language of his/her choice, making use of an appropriate interpreter if necessary.

2.1.2 *Desirable objectives for education of patient/public;*

The Orthoptist...

- i. Provides information about further assessment procedures to be performed.
- ii. Educates the patient or carer about his/her condition and its effects on the individual
- iii. Provides information on the range of eye care services and agencies available to the patient and the community in line with local/national policy
- iv. Provides information to the community about the practice of Orthoptics and its place in the allied health system.

2.1.3 *Desirable objectives for the education of health professionals;*

The Orthoptist...

- i. Provided relevant information to other health professionals about the visual system and its disorders in simple jargon free language.
- ii. Is aware of the role of other health professional in the health care system.

- iii. Uses methods of information dissemination such as in-service talk and lectures

Measures.

Methods may be used to determine compliance with the above and may include:

Written report in case notes of information given verbally or in written format to the patient.

Examples of patient posters or leaflet.

Patient questionnaire

Evidence of programmes or lectures /training provided by the Orthoptic service.

Section 3