Optometry Board of Australia

GUIDELINES FOR USE OF SCHEDULED MEDICINES

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Authority

The Optometry Board of Australia (the Board) has developed these *Guidelines for use of scheduled medicines* under section 39 of the Health Practitioner Regulation National Law, as in force in each state and territory (the National Law).

National Board guidelines describe the professional standards the Board expects of registered practitioners. They may be used to indicate appropriate professional conduct or practice in proceedings involving health practitioners under the National Law.

Purpose

These guidelines outline the Board's expectations in relation to the use of scheduled medicines by endorsed and non-endorsed optometrists.

Scope

The guidelines apply to:

- optometrists with general registration who use scheduled medicines for diagnostic purposes, and
- optometrists whose registration is endorsed for scheduled medicines, who use scheduled medicines therapeutically to manage eye conditions independently and collaboratively with other healthcare practitioners.

Under the Board's *Code of conduct for optometrists*, optometrists have a responsibility to recognise and work within the limits of their competence and scope of practice. This includes ensuring they have the equipment, expertise and skills necessary to practise safely and effectively.

1 Endorsement for scheduled medicines

Under section 94 of the National Law, the Board may endorse the registration of suitably qualified optometrists to prescribe scheduled medicines[1].

Table 1 of the Board's *Endorsement for scheduled medicines registration standard* lists the Schedule 4 medicines that optometrists with this endorsement are qualified to obtain, possess, administer, prescribe or supply for topical use. (Refer to table C1 of **Appendix C** of these guidelines.)

The Board considers optometrists whose registration is endorsed for scheduled medicines to be qualified and competent to:

- obtain, possess, administer, prescribe or supply specified scheduled medicines, and
- use those medicines appropriately for the treatment of conditions of the eye.

Optometrists who hold this endorsement may only possess, prescribe or supply Schedule 4 medicines to the extent authorised under the legislation that applies in the state or territory in which they practise. Information will be published on the Board's website about the authorities that apply in each state and territory of Australia.

1.1 Eligibility for endorsement

To be eligible for an endorsement for scheduled medicines, an applicant must, in accordance with the *Endorsement for scheduled medicines registration standard,* have successfully completed:

- an approved program of study in ocular therapeutics, or
- a program of study determined by the Board to be substantially equivalent to an approved program of study, or
- a Board-approved examination or assessment in ocular therapeutics.

1.2 Approved programs of study and assessments

Information about currently approved programs of study and assessments is contained in **Appendix A Approved programs of study and assessments for the purpose of endorsement for scheduled medicines**.

2 Use of scheduled medicines by optometrists

In all Australian states and territories, optometrists with general registration are permitted to obtain, have in their

1 The term 'scheduled medicine' is a substance included in a schedule to the current Poisons Standard within the meaning of the *Therapeutic Goods Act 1989* (Cth).

possession and use scheduled medicines in the course of their practice for diagnostic purposes (for example anaesthetic and mydriatic eye drops).

Appendix B of these guidelines lists the scheduled medicines approved by the Board for administration for diagnostic purposes by optometrists holding general registration. An endorsement is not required for an optometrist to use diagnostic medicines in the course of their practice.

2.1 Quality use of medicines

Optometrists who prescribe scheduled medicines should observe the Quality Use of Medicines (QUM)[2] principles.

Quality use of medicine means:

a) selecting management options wisely by:

- considering the place of medicines in treating illness and maintaining health, and
- recognising there may be better ways than medicine to manage many disorders.

b) choosing suitable medicines (if a medicine is considered necessary) so that the best available option is selected by taking into account:

- the individual
- the clinical condition
- risks and benefits
- dosage and length of treatment
- any coexisting conditions
- other therapies
- monitoring considerations, and
- costs for the individual, the community and the health system as a whole.

c) using medicines safely and effectively to get the best possible results by:

- monitoring outcomes
- minimising misuse, over-use and under-use
- improving people's ability to solve problems related to medication, such as negative effects, and
- managing multiple medications.

2.2 Maintaining competence

All optometrists are expected to maintain their competence through continuing professional development, and need to meet the requirements set out in the Board's *Continuing professional development registration standard*[3].

This standard also outlines the specific requirements to be met by optometrists whose registration is endorsed for scheduled medicines.

2.3 Prescriptions

Optometrists whose registration is endorsed for scheduled medicines must ensure that, when authorising the supply of a Schedule 4 medicine to a patient, the prescription is handwritten or computer generated.

When prescribing a Schedule 2 or 3 medicine, the Board encourages endorsed optometrists to issue a prescription, to help ensure effective communication with the pharmacist.

Prescriptions must be handwritten or computer generated and include the:

- date of issue
- details of the prescriber, patient, medicine (including name, strength and quantity)
- precise directions (except when directions are too complex and are provided separately, or when administration is to be carried out by a nurse or other person instructed in and authorised to administer), and
- the prescriber's signature.

The Board advises against endorsed optometrists self-diagnosing and then self-prescribing Schedule 4 medicines.

2 The complete strategy can be found at www.health.gov.au.

3 Refer to the *Registration Standards* tab on the Board's website.

2.4 Practice procedures

Optometrists should ensure that:

- scheduled medicines are stored securely and in accordance with the manufacturer's recommendations and as required under the legislation of the relevant jurisdiction
- details of in-practice administration of scheduled medicines are recorded on the patient's clinical record, and
- if required under the legislation of the jurisdiction, relevant authorities are notified of the loss or theft of a scheduled medicine.

2.5 Adverse event reporting

The Therapeutic Goods Administration (TGA) is part of the Australian Government Department of Health and Ageing, and is responsible for regulating therapeutic goods including medicines, medical devices, blood and blood products.

The TGA also collects reports of adverse events associated with medicines and medical devices. Monitoring of adverse events allows the TGA to investigate and take action on medicines safety issues.

Optometrists can assist the TGA in safeguarding public health by reporting all suspected adverse events associated with medicines, particularly those associated with new products. This information forms an important part of the TGA's monitoring activities and plays a key role in helping identify potential relationships between a therapeutic good and a series of adverse events. When a link can be established, the TGA takes action to ensure that medicines available in Australia continue to meet appropriate standards of safety, efficacy and quality.

Further information can be found on the TGA website www.tga.gov.au.

3 Supply of scheduled medicines

The Board supports the view that the division of responsibility between an optometrist with scheduled medicines endorsement who prescribes (authorises the supply of a scheduled medicine), and a pharmacist who dispenses the scheduled medicine to the patient, provides an important check designed to safeguard patients.

The expertise of the pharmacist in counselling patients is important in the follow-up care of the patient. This includes checking adherence to the prescriber's instructions, confirming administration times and techniques, screening for adverse reactions, and referring back to the prescriber for further investigations or advice when required.

Circumstances when it is permissible for an optometrist to prescribe and supply a scheduled medicine to a patient include an emergency, in remote areas or after hours, when access to a pharmacy is impractical, or when the particular drug or agent is not normally stocked by the pharmacy.

Optometrists who choose to supply a scheduled medicine directly to a patient must meet the labelling and record-keeping requirements of the jurisdiction in which they are practising, provide counselling about the use of the medicine, its side effects and potential interactions and, if available, provide a Consumer Medicines information leaflet[4].

4 Guidelines for the use of topical antimicrobials

All optometrists treating anterior eye infections with scheduled medicines must have a clear understanding of:

- microbiological and pathological processes relevant to anterior eye infection and their natural histories
- typical presentations of ocular surface infections and the differential diagnoses of these from other anterior eye conditions
- ocular infections that constitute true ocular emergencies and require immediate treatment
- identification of risk factors for ocular surface infections
- indications and mechanisms of referral for microbiological investigation, and
- interpretation of the results of microbiological investigation and appropriate management stratagems arising from these results.

4 Consumer Medicines information sheets are available at www.medicines.org.au.

4.1 Microbial resistance

Optometrists using antimicrobial preparations should understand all issues relating to the emergence of resistance by pathogenic organisms and mechanisms for limiting this. Selection of an antimicrobial should always involve consideration of the risk that microbial resistance could develop. In particular, treatment regimens should be avoided that could result in:

- inappropriate drug selection
- insufficient therapeusis (i.e. drug regimen inadequate to control infection, either in duration or therapeutic effect)
- overuse, or
- inappropriate dosage.

At present, fluoroquinolones have broad-spectrum activity with relatively little microbial resistance. To maintain maximal efficacy of these preparations, fluoroquinolones should not be used when alternative, equally effective agents could be used instead.

Optometrists should consider a specialist opinion for patients who may require long-term antimicrobial use.

5 Guidelines for the use of topical steroidal preparations

Optometrists seeking to treat ocular inflammation with scheduled medicines must have a clear understanding of the:

- immunological processes relevant to inflammatory conditions of the eye and their natural histories
- typical presentations of inflammatory conditions of the eye and the differential diagnoses of these from other anterior eye conditions
- inflammatory conditions of the eye that constitute true ocular emergencies and require immediate treatment
- identification of risk factors for developing ocular inflammation
- potential side effects of topical steroid preparations, including a propensity for raising intraocular pressure in susceptible individuals and the potential development of cataract, and
- management strategies for steroid-related intraocular pressure rises.

Optometrists should consider referral for a specialist opinion for those patients who may require long-term steroid use.

6 Collaborative care guidelines

For the purpose of these guidelines, 'collaborative care' is when the care of a patient is provided by two or more health practitioners, each practising within their sphere of expertise in consultation with the patient.

Various collaborative care relationships between health care practitioners exist, ranging from ad hoc to formal documented shared-care agreements. For eye conditions, shared care is likely to vary according to the location of the patient and the skill-base of the local health care practitioners.

The Board's *Code of conduct for optometrists* provides further guidance on communication with patients and other health practitioners.

6.1 Role, responsibilities and communication in collaborative care of patients

Within any collaborative care arrangement, it is essential that the roles and responsibilities of the optometrist and the other health practitioner(s) are defined clearly and continue to be redefined as required over time.

Communication is the linchpin of effective collaborative care. Participating practitioners and their patients must understand which practitioner is responsible for providing the various aspects of care.

To avoid repetition and confusion, each party must have a clear understanding of:

- the diagnoses, treatment(s) and ongoing recommendations to the patient of the other treating practitioners
- the information to provide to other parties involved in the care of the patient
- timeframes in which this information should be provided
- the preferred format for this information
- who is responsible for ongoing patient care and the follow up of patients who miss scheduled appointments, and
- the roles and responsibilities of each person participating in the shared care.

The Board recommends the use of protocols and forms to clarify responsibilities and facilitate the transfer of information and communication between practitioners. Such systems may involve standardised forms used by all parties participating in the arrangement or may be a less regimented agreement that each party should provide or forward a report to others after each consultation with the patient[5].

Ongoing discussion between the optometrist and the other treating practitioner(s) should involve reviewing these protocols and making changes necessary over time to ensure optimal care of the patient.

6.2 Patient involvement

In any collaborative care arrangement, patients must consent to the arrangement and be clearly informed about who is responsible for their primary eye care and when they are required to attend reviews with each practitioner.

Written information for patients about collaborative care may prove a useful addition to verbal discussions with treating practitioners.

7 Guidelines for care of patients with, or at high risk of developing, chronic glaucoma

The following guidelines for care of patients with, or at high risk of developing, chronic glaucoma should be read in conjunction with:

- section 6 of these guidelines 'Collaborative care guidelines'
- National Health and Medical Research Council of Australia's NHMRC *Guidelines for the screening, prognosis, diagnosis, management and prevention of glaucoma 2010* (the NHMRC guidelines)[6], and
- *A guide to glaucoma for primary health care providers – a companion document to NHMRC Guidelines for the screening, prognosis, diagnosis, management and prevention of glaucoma*[7].

The NHMRC guidelines and the companion document outline a series of recommendations and supporting evidence for all practitioners involved in the screening, prognosis, diagnosis, management and prevention of glaucoma.

In terms of collaborative care of patients with glaucoma, the Board endorses the recommendation from the NHMRC guidelines 'that the professional roles, responsibilities and referral pathways are best determined in individual cases based on location, resources, skill-base of local health care practitioners and patient choice'.[8]

When an initial diagnosis of chronic glaucoma is made, or a patient is at high risk of developing the disease, optometrists whose registration is endorsed for scheduled medicines must:

- refer the patient for specialist assessment and advice about confirmation of diagnosis and ongoing management, or
- develop a management plan that includes initiation of treatment and monitoring of the patient's response.

Instillation of anti-glaucoma eye drops is the preferred primary intervention in chronic glaucoma management[9]. However, in certain cases patients will need assessment by an ophthalmologist for possible surgical intervention or laser treatment. Optometrists must be able to identify those cases and refer where appropriate.

Optometrists should refer to the NHMRC guidelines when setting target intra-ocular pressures and when making decisions about glaucoma management plans, including the frequency of review appointments. The patient's risk factors for progression, their disease state and capacity to self-manage will dictate the frequency of review[10].

7.1 Referral

The optometrist must provide a referral for ophthalmological assessment and advice after making an initial diagnosis and initiating treatment for chronic glaucoma[11]:

- if the anti-glaucoma treatment does not stabilise the patient's condition

5 Optometrists Association Australia has published a position statement on shared care. This may inform the development of such protocols and or forms.

6 Published at www.nhmrc.gov.au/guidelines/publications/cp113-cp113b.

7 Ibid.

8 National Health and Medical Research Council of Australia's (NHMRC) *Guidelines for the screening, prognosis, diagnosis, management and prevention of glaucoma* 2010, p 83 www.nhmrc.gov.au/guidelines/publications/cp113.

9 NHMRC guidelines, p. 108.

10 NHMRC guidelines, p. 91.

11 Note: Referral means providing a referral letter to the patient and sending a copy to the ophthalmologist or ophthalmology service.

- if a patient needs assessment by an ophthalmologist or ophthalmology service for possible surgical intervention or laser treatment, or
- if a patient experiences side effects of initial treatment.

In any event, the optometrist must provide the patient with a referral to an ophthalmologist or ophthalmology service within four months of commencing treatment for chronic glaucoma.

7.2 Communication

The Board expects that optometrists managing patients with glaucoma will maintain regular communication with the patient's general practitioner, ophthalmologist, physician or other health care practitioner. Clear communication between practitioners is crucial to ensure each practitioner understands who is responsible for providing each aspect of the patient's care.

7.3 Equipment

To comply with these guidelines, optometrists must have the equipment to measure and/or assess a patient's intraocular pressure, central corneal thickness, threshold visual fields, anterior chamber angle, optic nerve head and retinal nerve fibre layer. Optometrists should refer specifically to the sections on 'Diagnosis of glaucoma' and 'Monitoring: long-term care' in the NHMRC guidelines.

7.4 Emergency management of acute primary angle closure

Individuals suffering from an acute angle-closure event may present to an optometrist or, rarely, an angle-closure event may be induced through routine pupil dilation.

The standard management of such a patient is emergency referral to an ophthalmologist or hospital. However, both the nature of the condition and endorsement for scheduled medicines enable the optometrist to, in collaboration with a medical practitioner, provide first-aid for such patients to stabilise their ocular state (refer to **Appendix D** of this document for suggested first aid for an angle closure event).

As the definitive intervention in acute angle-closure is procedural intervention (laser therapy), the optometrist should seek ophthalmological input, if possible, before administering first aid to lower intraocular pressure and reduce pain. Exceptions to this include when an ophthalmologist cannot be contacted and the best interests of the patient are served by initiating treatment before emergency referral to the most convenient ophthalmologist or hospital.

Review

The Board will monitor this guideline for effectiveness and review it at least every three years. This guideline replaces any previously published National Board guidelines on use of scheduled medicines.

Date of issue: 8 December 2014

Date of review: 8 December 2017

Appendix A

Approved programs of study and assessments for the purpose of endorsement for scheduled medicines

The Board accepts the following qualifications and assessments for endorsement for scheduled medicines.

Approved programs of study

A list of approved programs of study accredited by the Optometry Council of Australia and New Zealand (OCANZ) is at www.optometryboard.gov.au/Accreditation.

Approved programs include:

- those that lead to qualification for general registration and endorsement for scheduled medicines, and
- postgraduate courses in ocular therapeutics that qualify for endorsement for scheduled medicines.

Overseas-trained optometrists

Optometrists currently registered in Australia who trained outside Australia and New Zealand and who have or have had therapeutic prescribing rights in their country of training, may have their registration endorsed to prescribe medicines by successfully completing the Assessment of Competence in Ocular Therapeutics (ACOT) examination. This is conducted by the Optometry Council of Australia and New Zealand (OCANZ). Information about ACOT can be found on the OCANZ website at www.ocanz.org.

Inactive programs of study

Ocular therapeutics courses conducted between 2001 and 2005 and granted accreditation by the Optometrists Registration Board of Victoria are also approved by the Optometry Board of Australia.

Appendix B

List of scheduled medicines approved by the Optometry Board of Australia for administration by optometrists holding general registration

The Optometry Board of Australia has approved the following diagnostic drugs for optometrists to administer in the course of their practice:

- anaesthetics, local (synthetic cocaine substitutes) — when prepared and packed in the form of eye drops
- tropicamide — when prepared and packed in the form of eye drops containing one (1) per cent or less of tropicamide
- cyclopentolate hydrochloride — when prepared and packed in the form of eye drops containing one (1) per cent or less of cyclopentolate hydrochloride
- atropine — when prepared and packed in the form of eye drops containing one (1) per cent or less of atropine sulphate
- homatropine — when prepared and packed in the form of eye drops containing two (2) per cent or less of homatropine hydrobromide
- pilocarpine nitrate — when prepared and packed in the form of eye drops containing two (2) per cent or less of pilocarpine nitrate
- physostigmine salicylate — when prepared and packed in the form of eye drops containing 0.5 per cent or less of physostigmine salicylate.

Registered optometrists should be familiar and comply with the current requirements of state and territory drugs and poisons legislation in the jurisdictions in which they practise. The Board will publish on its website a list of authorities that apply in each state and territory.

Appendix C

Board approved list of Schedule 4 medicines

Under section 94 of the National Law, the Board may endorse the registration of eligible optometrists as qualified to obtain, possess, administer, prescribe or supply the scheduled medicines used in the treatment of conditions of the eye, included in the list below[12].

Table C1 lists the Schedule 4 medicines that have been approved for use by optometrists whose registration has been endorsed by the Board. This is a duplicate of the list published in the Board's *Endorsement for scheduled medicines registration standard*.

For an optometrist to possess, prescribe, supply or use these Schedule 4 medicines in a particular jurisdiction, the authorisation must be provided for by enactment of legislation in that jurisdiction. Registered optometrists should be familiar and comply with the current requirements in the jurisdictions in which they practise. The Board will publish on its website a list of authorities that apply in each state and territory.

Table C1 Board-approved list of Schedule 4 poisons that optometrists with a scheduled medicines endorsement are qualified to obtain, possess, administer, prescribe or supply for topical use

Anti-infectives

Aciclovir
Azithromycin
Bacitracin
Cephazolin
Chloramphenicol[13]
Ciprofloxacin
Framycetin
Gentamicin
Gramicidin
Neomycin
Ofloxacin
Polymyxin
Tetracycline
Tobramycin
Vidarabine

Anti-inflammatories

Cyclosporin
Dexamethasone
Diclofenac
Fluorometholone
Flurbiprofen
Hydrocortisone
Ketorolac
Prednisolone

Decongestants/ anti-allergics

Olopatadine

Anti-glaucomas

Apraclonidine
Betaxolol
Bimatoprost
Brimonidine
Brinzolamide
Carbachol
Diprivefrin
Dorzolamide
Latanoprost
Levobunolol
Pilocarpine
Timolol
Travoprost

Miotics, mydriatics and cycloplegics

Atropine
Cyclopentolate
Homatropine
Pilocarpine
Phenylephrine
Tropicamide

Local anaesthetics

Amethocaine
Lignocaine
Oxybuprocaine
Proxymetacaine

12 Refer to the Board's *Endorsement for scheduled medicines registration standard* published under the *Registration Standards* tab of the Board's website.

13 Now a Schedule 3 medicine.

Appendix D

First aid for acute angle-closure event

The following immediate interventions are suggested, unless otherwise contraindicated in a given patient, for the emergency management of acute primary angle closure.

Optometrists whose registration is endorsed for scheduled medicines are not currently authorised under state and territory drugs and poisons legislation to prescribe, possess or supply acetazolamide (Diamox). In urgent cases, and when permitted by legislation in the relevant jurisdiction, a pharmacist can supply Diamox to the patient when requested to do so via a telephone order from a medical practitioner. Optometrists are advised to liaise with a medical practitioner to arrange the supply of Diamox for the patient.

a) An oral dose of acetazolamide 500mg (Diamox) can be administered provided there are no contraindications. If Diamox cannot be tolerated orally, the patient is likely to require intramuscular or intravenous administration of Diamox and/or treatment with other therapeutic agents.
In this situation, referral and transfer to an ophthalmologist or hospital emergency department should occur without delay.

b) Instil the following topical medications (allowing about two minutes between each drop):

- One (1) drop beta-blocking agent (e.g. timolol, 0.5 per cent).
- One (1) drop alpha agonist (e.g. apraclonidine, 0.5 per cent).
- One (1) drop carbonic anhydrase inhibitor (e.g. brinzolamide, 1.0 per cent).
- If the eye is red and inflamed, one (1) drop high-penetrance topical steroid — with the optometrist or patient to instil a further three (3) drops at regular intervals in the first hour, then hourly thereafter.

It is preferable to withhold instillation of pilocarpine until the IOP has been reduced (except in the rare instance of an angle-closure event being caused through routine pupil dilation, in which case instillation of pilocarpine should commence immediately).

c) Just before the patient is transferred, and after discussion with the ophthalmologist confirming that instillation of pilocarpine is indicated, instil:

- One (1) drop pilocarpine, 2 per cent (with the optometrist or patient to instil a further drop in 15 minutes).

Note: Pilocarpine should only be used for mechanisms involving phakic pupillary block or angle crowding. Use of pilocarpine is contraindicated for retrolenticular causes of angle closure as well as those involving aphakic or pseudophakic closure events.