

OPTOMETRY COUNCIL OF
AUSTRALIA AND NEW ZEALAND



ACCREDITATION MANUAL FOR OPTOMETRY PROGRAMS IN AUSTRALIA AND NEW ZEALAND

Part 2 – Standards
April 2006

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KEY TERMS

ACCREDITATION COMMITTEE	Appointed by the Optometry Council of Australia and New Zealand, this committee is responsible for implementing and administering accreditation in accordance with the procedures and Standards adopted by the Optometry Council of Australia and New Zealand.
ACCREDITATION SUBMISSION	Detailed information relating to the Standards provided by a school to the Optometry Council of Australia and New Zealand prior to the commencement of the accreditation process.
ASSESSMENT TEAM	A team whose primary function is the analysis and evaluation of the optometry program against the Optometry Council of Australia and New Zealand Standards.
ASSESSMENT TEAM REPORT	Report of the Assessment Team completed at the conclusion of the assessment process. This report is presented to the Accreditation Committee and provides recommendations on the accreditation and re-accreditation of an optometry program. This is an internal document and is marked 'not for circulation.'
COMPETENCY STANDARDS	A list of the skills, knowledge and attributes that a person needs to be able to practice optometry.
EFTS / EFTSU	Equivalent Full Time Student (Unit) – a means of quantifying student numbers for funding purposes.
EXTRAMURAL PLACEMENTS	Student clinical placements that occur outside the optometry school.
OPTOMETRY COUNCIL OF AUSTRALIA AND NEW ZEALAND (OCANZ)	The accrediting agency for the Australian and New Zealand Registration Boards, responsible for conducting examinations for overseas qualified optometrists seeking registration in Australia and New Zealand and for developing and administering the accreditation system for Australian and New Zealand optometry programs.
PROGRAM	A program of study provider by a school. Note: The term "course" is used in many universities.

SCHOOL	Specialist area within a university that delivers the optometry program. Note: The term 'school' has been used throughout this document however the word 'department' or 'discipline' is used in some universities. The term 'education provider' is used by National Law to describe universities or other institutions.
STANDARDS	Used to assess whether a program of study, and the university that provides the program of study, provide persons who complete the program with the knowledge, skills and professional attributes necessary to practise optometry.
SUBJECT	A component of an optometry program. Note: The term 'unit', 'course' or 'topic' is used in many university programs.
THERAPEUTIC PRACTICE	The practice of optometry that includes the prescribing and possession of certain controlled drugs and poisons.

1. INTRODUCTION

OCCANZ was established in 1996 with the support of and representation from the:

- Registration Boards in Australia and New Zealand
- Heads of the optometry schools
- Optometrists Association Australia
- New Zealand Association of Optometrists

The two key roles of OCCANZ are:

- to conduct examinations for overseas qualified optometrists.
- to accredit optometry programs in Australia and New Zealand.

Both roles aim to provide a system of quality assurance for the Registration Boards that all those entering the profession are competent to practise to contemporary standards.

OCCANZ published accreditation standards and procedures in 1998. These standards and procedures were subject to a major review in 2004 with the aim of streamlining the accreditation process for optometry schools in Australia and New Zealand and for Assessment Teams assessing optometry programs.

Changes to legislation in several jurisdictions formally extended the scope of optometric practice to include the prescribing of certain controlled drugs and poisons by suitably qualified optometrists (therapeutic practice). As a result it was also necessary to establish criteria relevant to a graduate's ability to undertake therapeutic practice.

It is a requirement of accreditation that all graduates be trained for therapeutic practice in the jurisdictions in Australia and New Zealand where optometrists are able to manage the widest range of ocular disease.

The revised accreditation standards and procedures, published in 2006, comprise two parts, namely:

- Part 1 – Process and Procedures.
- Part 2 – Standards.

The OCCANZ accreditation process requires optometry schools to provide evidence that demonstrates that the programs they offer meet the standards contained within the following Standards and produce graduates who are competent for therapeutic practice. These ten Standards are grouped into three general categories, namely:

Organisation and Management

1. Organisation, governance and funding

The Optometry Program

2. Educational goals and objectives
3. Program development and management
4. Program curriculum
5. Teaching and learning methods
6. Clinical training and settings
7. Student assessment

Resources

8. Teaching and support staff

9. Students

10. Physical resources

This document contains a description and interpretation of the Standards as well as suggested evidence to demonstrate achievement of the Standards.

The school is asked to prepare an accreditation submission in the form of a portfolio or information manual for the Assessment Team. The submission is to address each of the ten Standards as well as the requirement that all graduates be trained for therapeutic practice in the jurisdictions in Australia and New Zealand where optometrists are able to manage the widest range of ocular disease.

In assessing a program for accreditation, the Assessment Team must be satisfied that graduates have acquired the knowledge, skills and attributes needed to meet contemporary standards of practice and that they have the capacity to maintain competence. In addition to the Standards, the Competency Standards (including the Therapeutic Competencies) provides guidance to the Assessment Team as to the standards expected in Australia and New Zealand (refer Appendix 2).

Note June 2012: The Accreditation Manual for Optometry Programs in Australia and New Zealand Part 1 - Process and Procedures was reviewed and updated in 2012. Only the Key Terms and references to the National Law (Health Practitioner Regulation National Law Act 2009) have been updated in this manual.

2. ORGANISATION AND MANAGEMENT

This section provides contextual information regarding the institution and school delivering the optometry program. It covers the following Standard:

1. Organisation, governance and funding

Standard 1 — Organisation, governance and funding

The optometry school should have sufficient funds and administrative and academic organisational structures that allow control over the objectives and direction of the optometry program, and the resources available for its implementation.

Interpretation

This standard addresses the organisation, governance and funding of the optometry school within the university. Its focus is on the context in which the optometry program is delivered, specifically:

- the administrative and academic organisational structure of the university and the degree of control that the school has over the curriculum and allocation of resources
- the adequacy of and the source of funding for the school
- the networks and affiliations that enrich the clinical learning experience.

a) Administration and organisational structure

OCCANZ expects each optometry school to be part of a large multi-disciplinary university, as are the present schools in Australia and New Zealand, and acknowledges that universities:

- have different academic structures for organising disciplines
- have different administrative and funding structures for managing resources.

b) Strategic planning

The strategic plans developed within the school/faculty indicate future activity, developments and priorities. Strategic planning gives the school an opportunity to review the strengths and weaknesses of the optometry program and issues relating to its implementation.

c) Funding

The optometry school must be able to demonstrate sufficient resources to enable it to adequately deliver and maintain the basic optometry program to the standards expected by OCCANZ.

d) Relationships with other organisations

Health authorities

Optometry schools are encouraged to build constructive relationships with relevant health authorities, as publicly funded health service institutions play an important role in clinical teaching.

Affiliated institutions

OCCANZ expects optometry schools to have well established and beneficial relationships with health service agencies and research institutions affiliated with the university. These might include:

- access to affiliated health care service institutions by academic staff who teach clinical subjects to enable them to maintain and develop clinical skills.
- clinical teaching of undergraduate optometry students within affiliated health care service institutions.

- joint academic and clinical appointments in the school and affiliated health care service institutions.
- formal mechanisms for high level consultation between the school and the affiliated institutions to ensure appropriate communication and liaison on matters of mutual interest, particularly those relating to teaching and clinical service.

Formalised arrangements to protect these relationships should be developed to ensure that an appropriate environment for teaching is in place.

The profession and the broader health community

There should be effective mechanisms enabling the school to communicate with and receive feedback from:

- optometric practitioners,
- professional associations,
- the medical profession and other health professions.

Evidence

Suggested evidence requirements for submission

a) Administration and organisational structure

Overview of the university

- Brief summary/overview of the university, including information on its establishment, governance and management structures and the disciplines covered.
- Statistical overview of its size, including student and staff numbers.
- Information that shows the national and international standing of the university as a teaching and research university, including a list of senior university officers and researchers.
- List of website addresses displaying relevant information.

School and faculty structure in the university

- Organisational chart depicting the school's relationship with its faculty and university including the positions of senior officers.
- List of website addresses displaying relevant information.

School structure and administration

- Organisational chart depicting the structure and management of the school.
- List of other university departments that provide teaching in the basic optometry program – including the names of the subjects taught by each.
- List of website addresses displaying relevant information.

School committees

- Description of the school committee structure.
- Description of membership, functions, terms of reference and frequency of meetings of school committees, such as curriculum or planning committees.
- List of website addresses displaying relevant information.

1. INTRODUCTION

Suggested evidence that might be requested during the site visit

- Position descriptions / curriculum vitae for the Head of School and senior officers.
- University or school policy documents or other publications that provide information about the school's governance, structure and administration.
- Copies of the Terms of Reference for major school or faculty committees.
- Any other documents that will assist the Assessment Team to understand the relationship of the school to its university and the standing of the university.

Note: For new programs, this section of the submission will need to be more detailed than for existing programs.

b) Strategic planning

Suggested evidence requirements for submission

- Statement from the Head of School evaluating the strengths and weaknesses of the school, as they relate to the goals and objectives of the program – this should include a summary of the areas of concern identified in previous Optometry Council Accreditation Reports and the school's response to these.
- Statement outlining future priorities, new developments and possible program changes.

Suggested evidence that might be requested during the site visit

- Copy of the school's strategic plan and/or financial budget.
- Copy of any faculty review or planning documentation.

c) Funding

Suggested evidence requirements for submission

Funding policies

- Statement about the policies and formulae that determine the funding provided to the school by the university.

d) Relationships with other organisations

Suggested evidence requirements for submission

Relationships with relevant health authorities

- Statement listing the relevant health authorities the school has a relationship with and the nature of the relationship.

Suggested evidence that might be requested during the site visit

- Copies of any formalised arrangements, relating to the optometry program, between the school and other organisations.
- Documentary evidence of:
 - strategies used to communicate with the profession / health community
 - feedback received from the profession / health community.

3. THE OPTOMETRY PROGRAM

This section focuses on the optometry program curriculum and covers the following Standards:

2. *Educational goals and objectives*
3. *Program development and management*
4. *Program curriculum*
5. *Teaching and learning methods*
6. *Clinical training and settings*
7. *Student assessment.*

Standard 2— Educational goals and objectives

The goals and objectives of the program should be clearly stated and broadly consistent with those described by OCANZ as necessary to provide the knowledge, skills and attitudes for the effective and professional practice of optometry.

Interpretation

This standard focuses on the formally stated educational goals and objectives of the optometry program and their consistency with those of OCANZ. It considers whether the goals are generally known and understood by both staff and students and whether the program addresses and develops in students the required knowledge, optometric skills and appropriate attitudes for professional practice.

Schools are expected to define and document the educational goals and objectives of the optometry program. These should be broadly consistent with those specified by OCANZ (refer Appendix 1).

OCANZ considers that an optometry program leading to registration has two key goals:

- to ensure that graduates are competent to undertake independent practice of optometry, including therapeutic practice.
- to provide the educational foundation for career-long learning.

Objectives relating to knowledge and skills should be firmly based on scientific principles and graduates should develop appropriate professional attitudes.

The scope of knowledge relating to optometry and its foundation in biomedical science is growing fast, and many aspects of practice are changing rapidly. Emphasis in basic optometric education should be placed on the principles underlying ophthalmic science and practice although, as graduates must be capable of independent practice immediately on graduation, a firm grasp of current knowledge and highly proficient clinical skills must also be achieved.

The organisation of the curriculum will be enhanced by explicit statements about the knowledge, skills and attitudes expected of the students at each stage of the program. Goals and objectives should be made known to students at the outset and be referred to frequently throughout the program. OCANZ encourages schools to provide guides for each subject that clearly set out the objectives of the subject and what each student is expected to achieve.

3. THE OPTOMETRY PROGRAM

Evidence

This section should provide evidence of the formally stated goals and objectives of the program. The Assessment Team will consider this evidence and whether the goals are consistent with those of OCANZ. Refer to Standard 2 for further information.

Suggested evidence requirements for submission

- Published statement of the goals and objectives of the program relating to knowledge, skills and attitudes.
- Statement explaining how students are made aware of the goals and objectives of the program.
- Copies of official school/faculty publications, student guides, subject guides and lists of websites where the goals and objectives of the program and/or components of the program are published.
- List of website addresses displaying relevant information.

Standard 3 — Program development and management

Schools are responsible for developing, implementing and monitoring a curriculum that achieves their stated educational goals and objectives. Optometry schools will have mechanisms for developing, monitoring and evaluating the program content and assessment requirements to achieve the goals and objectives of the program.

Interpretation

This standard focuses on the organisational processes for the development and review of the program content. It considers the school's capacity to change the structure and content of the program to meet changing needs.

a) Curriculum design and implementation

Schools need to demonstrate that they are able to develop, implement and change the curriculum according to stated educational goals and objectives and the changing needs of the profession.

OCANZ expects schools to have a committee in place to develop and implement curriculum and assessment, policy and content. Membership of this committee should include individuals with expertise and interest in optometric education from both the pre-clinical and clinical sciences. The responsibilities of individuals should transcend specific discipline interests. It is also expected that mechanisms will exist for the ongoing monitoring and review of the curriculum.

b) Emergent topics requiring special emphasis

The school should demonstrate that it has mechanisms that recognise and initiate responses to emerging issues, especially those that cross disciplinary boundaries. Topics of emerging interest may include those arising from recent or imminent legislation changing the scope of practice of optometry or changes in methods of practice arising from new knowledge or technology.

c) Monitoring and evaluating the curriculum and teaching effectiveness

Each school must demonstrate that it has mechanisms for monitoring and evaluating its curriculum, quality of teaching and quality of graduates against stated educational goals and objectives. These mechanisms may include periodic reviews leading to major restructuring and change as well as more gradual changes to the curriculum and its components.

The major mechanism for monitoring the program will be a program committee. The monitoring of programs should also aim to incorporate:

- student feedback
- success rates
- tracking and monitoring graduates

Student feedback

Questionnaires/surveys

OCANZ recommends that student questionnaire responses be obtained and evaluated regularly for each component of the program, especially where the program has changed. Carefully designed and evaluated student questionnaires can provide valuable information where a suitably high rate of return of completed questionnaires is received.

Mechanisms for providing such feedback to those responsible for designing and teaching individual programs or program components must exist as part of a continuous improvement process. Negative feedback should also be identified and analysed and consideration given to possible program changes.

Student representation on committees

In addition to student questionnaires, other pathways for student feedback should exist including student representation on curriculum committees or input into formal consultative process. Students should also have ready access to conveners of components of the program and to administrative staff.

Success rates

Analysis of pass rates in individual components can provide an indication of issues relating to:

- program content
- the teaching of the subject/component
- examinations and assessment

The curriculum committee should oversee the pass rates in individual components and investigate situations where these are inappropriately low.

Tracking and monitoring graduates

Examining the quality and success of graduates is useful in evaluating the appropriateness and effectiveness of the program. Although tracking graduates can be difficult, schools should attempt to implement mechanisms for obtaining feedback from both employers and graduates. Schools in Australia can obtain some information from graduates who complete the Program Experience Questionnaire and/or the Graduate Destinations Survey conducted by the Graduate Careers Council of Australia four months post graduation.

3. THE OPTOMETRY PROGRAM

Evidence

This section should provide evidence of the mechanisms in place for the development and management of the program. Refer to Standard 3 for further information.

Suggested evidence requirements for submission

a) Program design and implementation

- Statement describing the policies and procedures used by the school to develop and implement the curriculum content and assessment strategies.
- Overview of the organisational structure of the program/curriculum committee and a description of its key responsibilities, membership and schedule of recent activity.
- Short summary of the significant changes that have been made to the program in the last five years, including significant changes to the rating and extent of clinical experience.

b) Emergent topics requiring special emphasis

- Description of the mechanisms used to recognise and initiate responses to emerging issues, including those relating to changing health and educational priorities and those crossing disciplinary boundaries.

c) Monitoring and evaluating the curriculum and teaching effectiveness

- List of the strategies used to monitor the quality and effectiveness of the program, its component subjects and teaching, both within the optometry school and in other departments.
- Statement describing the policies and procedures used by the school to evaluate the curriculum and the effectiveness of teaching, and to instigate change. This should cover:
 - staff feedback
 - student and staff surveys
 - analysis of student results and success rates
 - tracking and monitoring of graduates
- Summary of examples of recent changes to the curriculum and methods of teaching made in response to student/graduate surveys and staff views.

Suggested evidence that might be requested during the site visit

- Copies of any recent reviews of the program or component subjects that have been conducted by the university or the school.

Site visit / focus of Assessment Team

The Accreditation Committee may nominate some emerging issues that it wishes to have considered during the assessment. Issues may include those arising from recent or imminent legislation changing the scope of practice of optometry or changes in methods of practice arising from changes in knowledge or technology.

Standard 4 — Program curriculum

Each optometry school should establish a curriculum capable of achieving its stated educational goals and objectives. This curriculum must provide:

- strong foundations in the basic and biomedical sciences and a thorough understanding of the optical and vision sciences.
- a strong didactic program in the dysfunctions and diseases of the eye and the fundamental skills required for the practice of optometry.

Interpretation

This standard focuses on the adequacy of the optometry curriculum to achieve its stated educational goals and objectives.

OCANZ does not specify core curriculum or individual subjects and supports the belief that diversity between schools in the approach to the optometry program is desirable.

a) Entry requirements

Students selected for optometry programs need the necessary knowledge and skills to ensure success in the program. Certain standards of literacy, numeracy and scientific knowledge are required for successful completion of an optometry program. It is desirable that students entering an optometry program have knowledge of chemistry, physics and mathematics to year 12 or tertiary level. This is especially important for programs that embark on clinically related studies early. Students should also have a competent command of the English language. This may be demonstrated through results in English studies or by means of an assessment tool used in student selection.

b) Curriculum design and structure

The three essential components of an optometry program include:

- a foundation in the basic and biomedical sciences, either through the program or pre-requisite tertiary studies, that provide students with a thorough understanding of the optical and vision sciences.
- a program covering the dysfunctions and diseases of the eye and the fundamental skills required for the practice of optometry.
- a significant period, the equivalent of at least one year, spent primarily in direct contact with patients to experience and learn about:
 - the diversity of presentations and patient needs.
 - the complex interplay of causative factors, pathogenic processes, and psychological and physical factors in the patient.

The optometry program should be of a suitable duration and structured to meet these essential components.

Integration of pre-clinical and clinical sciences

While there is merit in having pre-clinical science programs designed specifically for optometry students to focus on optometry related issues, there are also distinct advantages to optometry students learning their basic sciences with science students and sharing classes in biomedical sciences with students of other health professions.

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In order to demonstrate the relevance of the pre-clinical subjects to optometry students, every effort should be made to ensure that the provider university department teaches in a way that demonstrates the clinical relevance of the material. Where possible, optometric educators should take some special lectures, tutorials or practical classes so that bridges can be constructed between the science and its clinical application.

c) Research

Optometric education is enhanced by a school environment in which research is actively pursued. An active research environment within a school provides students with opportunities to observe and participate in ongoing programs either as mandatory or elective components of their curriculum. All optometry students can benefit from some direct contact with active researchers.

Evidence

This section should provide details of the program curriculum. Refer to Standard 4 for further information.

Suggested evidence requirements for submission

a) Entry requirements

- Statement of admission requirements for entry to the program.
- List of publications and website addresses where this information is officially stated.
- Admission statistics if available.

b) Curriculum design, integration and organisation

- Table outlining the structure and duration of the program. This should include the number of teaching weeks in each year of the program and how teaching, study and examination periods are organised for each semester.
- Descriptive and explanatory statement of how the program:
 - balances and integrates the goals of providing rigorous education in:
 - the basic, biomedical and paramedical sciences as a foundation for understanding ocular function and dysfunction
 - the vision and optical sciences
 - ensures professional competence on graduation.
- Website addresses of relevant information.
- Documentation delineating responsibilities and standards required in shared programs/ programs.
- Table depicting the organisation and integration of subjects in the program that:
 - provides the contact hours for lectures, tutorials/seminars and practical/clinical classes for each subject, in each semester
 - provides total contact hours for each semester, year and the program as a whole
 - indicates the teaching department responsible for each subject and the name of the coordinator.

Concurrent degrees and double degree programs

- Description of any options for students to undertake the study of non-optometry subjects or a concurrent program.

Rural and remote area teaching

- Details about rural and remote area experience that are part of the program or available as an option.

Teaching of understanding of social and cultural diversity

- Details about the extent to which the program deals with the provision of health care to the indigenous community, the disadvantaged, the disabled and to community groups with differing cultural and social mores.

c) Research

Suggested evidence requirements for submission

Research program

- Brief description of the research programs of the school, funding sources, research fields and current projects for each academic staff member active in research.

Site visit / focus of Assessment Team

The Assessment Team will assess how the school ensures the appropriate level of teaching, and the effectiveness and comprehensiveness of the program for optometry students where other departments are involved in delivering the program.

The Assessment Team will also enquire into the research activities of the optometry school to establish that they are of sufficient substance to bring appropriate benefit to the teaching program. Specific attention will be given to the opportunities for all students to encounter research activities at some stage of their program and for some students to pursue particular research interests in depth. The accreditation process does not evaluate the specific research activities of the school.

Standard 5 — Teaching and learning methods

Teaching and learning methods used in the optometry program should be consistent with the optometry school's educational goals and objectives and the nature of pre-clinical and clinical subjects. A range of learning strategies, especially those that promote active, student-centred inquiry, problem-based learning and the fostering of life long learning skills, should be used.

Interpretation

This standard focuses on the teaching methods used in the program, including the clinical teaching methods and the adequacy of the clinical experience provided.

a) Requirement for varied and innovative teaching methods

OCCANZ encourages innovative methods of teaching that promote the educational principles of active student participation, problem solving and development of communication skills. Problem-based learning, computer assisted learning and other student-centred learning strategies are encouraged. Some of these strategies include:

3. THE OPTOMETRY PROGRAM

- essays / extended responses
- problem sheets / case studies / computer aided activities
- independent and group research assignments
- activities that promote additional reading

Evidence

This section should provide details of the teaching and learning methods used in the delivery of the program. Refer to Standard 5 for further information.

Suggested evidence requirements for submission

- statement about the teaching strategies for each program component/subject
- description of student-centred learning methods used for non-contact hours for each subject. (Note: this can include both academic subjects and clinical subjects or clinical subjects can be addressed separately in the next section.)

Suggested evidence that might be requested during the site visit

- Samples of student research / assignment / practical task instructions.

Standard 6 — Clinical training and settings

During the optometry program, students must be provided with extensive and varied clinical experience. This includes opportunities to have direct contact with patients over a significant period of time. It is also essential that students are taught in clinical environments where large numbers of patients of varying ages and social backgrounds are seen and where there is a wide diversity of presentations of ocular dysfunction and disease.

Interpretation

This standard focuses on the need for an extensive and varied clinical experience. Guidance is provided where clinical exposure is limited and for programs utilising extramural placements.

a) Requirement for an extensive and varied clinical experience

Students should be exposed to a range of settings in which health care and health promotion services are delivered to broaden their perspective of health care delivery and to increase the diversity of patients they see.

While core instruction may be provided within a university optometry clinic, students should also be provided with experience in other settings. The school should ensure that its university clinic has a large, diverse patient base and that it provides a well-patronised range of specialist optometric services. These patient encounters should provide students with experience across a wide range of presentations and should ensure that their procedural skills are highly practised. They should have extensive experience in the delivery of glasses, contact lenses, low vision aids, visual training and the primary treatment of a diverse range of ocular disease.

Experience in the provision of care must be supplemented by case demonstrations, case discussions and by observation of experienced practitioners in a variety of clinical settings.

b) Requirements when clinical exposure is limited

Where the school is unable to provide a sufficient number of student/patient contacts, it must be able to demonstrate that effective clinical teaching is provided during those encounters and that the clinical experience is extensively supplemented by:

- demonstrations of patients with common or important visual and ocular conditions
- case discussions
- computer aided case exercises
- observation in a diversity of clinical settings

The school must also be able to show that students have a high level of proficiency in core clinical techniques, despite limited experience in direct patient care.

c) Requirements for extramural placements

Mechanisms must be in place to ensure that all extramural clinical placements are well organised and provide services and teaching of a high standard. The objectives and the assessment of all clinical placements should be clearly defined and known to both students and practitioners. Practitioners who provide student instruction in extramural clinical settings should have an active relationship with the school, at least through regular meetings, and by visits to the extramural settings by academic staff. Special effort should be made to monitor the educational experiences in these clinical placements.

Evidence

This section should provide details of the clinical training arrangements for the program. Refer to Standard 6 for further information.

Suggested evidence requirements for submission

a) Instruction in clinical methods

- Statement describing how students are taught clinical procedures and clinical methods prior to entering clinics to see patients under supervision. Clearly indicate how students are encouraged to develop their skills with clinical procedures and the opportunities they have to practise these techniques outside formal class times.

b) Clinical experience and clinical teaching

- Statement describing the clinics within which students obtain their clinical instruction and experience, indicating for each clinic:
 - name of operator
 - scope of practice, size and diversity of patients
 - methods of clinical instruction used
 - ratio of clinical instructors to students at various stages of clinical years.

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Clinical experience

Table 1: Number of patients managed by final year students under supervision in the preceding year

Patients by clinic / type of contact	Lowest number	Median number
General Clinics		
First visits		
Subsequent visits		
Contact Lens Clinics		
Number of patients fitted with soft contact lenses		
Number of patients fitted with hard/ RGP contact lenses		
Total patients fitted with contact lenses		
Aftercare visits provided		
Children & Binocular Vision (BV) Clinic		
First visits		
Subsequent visits		
Low vision clinic		
First visits		
Subsequent visits		
Other clinics (give details)		
Total number of patients managed		
Number of patients observed by students under supervision in the preceding year		
Vision screening		
Number of days spent vision screening		
Number of patients screened		
Number of patients aged <8 years screened		
Delivery of glasses		
Number of patients to whom glasses delivered		
Number of patients observed by students		
General Clinics		
Contact Lens Clinics		
Children's & BV Clinics		
Low Vision Clinics		
Demonstration Clinics		
Grand Rounds		
Total patients observed		

Patients by clinic / type of contact	Lowest number	Median number
Overall total of patient contacts		
Number of days in extramural placements in the preceding year		
Number of days spent in the following:		
Hospitals (Australia or NZ)		
Hospitals (international)		
Other clinical settings		
Private practice		
Community health centres		
Externships		
Total number of days extramural		
Number of optical appliances prescribed by students in the preceding year		
Optical appliances dispensed and fitted to patients		
Number of single vision spectacles		
Number of bifocal/trifocal spectacles		
Number of progressive lens spectacles		
Number of low vision aids		
Other		
Total optical appliances prescribed		

Experience in dispensing

Statement describing the extent to which students have experience in:

- lens and frame manufacture
- fabrication of glasses
- repairs of glasses
- checking of glasses
- checking of contact lenses

c) Teaching in special clinical areas

- Descriptive and explanatory statement on the strategies used to teach in each of the following special clinical areas, and goals for the future:
 - paediatric optometry, orthoptics and visual training
 - contact lens prescribing and management
 - assessment and rehabilitation of the partially sighted
 - treatment of ocular disease, including treatment using pharmacological agents
 - ethics and professional responsibilities

3. THE OPTOMETRY PROGRAM

Suggested evidence that might be requested during the site visit

- Student publications regarding clinical placements.
- Sample student log books showing patient load (de-identified to protect confidentiality).
- Sample student evaluation forms (de-identified to protect confidentiality).
- Copies of clinical manuals provided to students.

Site visit / focus of Assessment Team

The Assessment Team will:

- tour the school clinic and/or affiliated clinics/facilities
- focus on whether the clinical teaching components of the program contribute to students achieving competence in the practice of optometry
- assess whether components of different subjects in various years of the program contribute in a planned way to competency in each area
- review the different methods of teaching used (lectures, practical classes, clinical experience, assignments, computer aided instruction etc).

Standard 7 — Student assessment

Student achievement of the educational goals and objectives for both the pre-clinical and clinical components of the program should be assessed using the most appropriate methods to ensure that the assessment is valid, sufficient, authentic and current. Assessment methods should be explicitly stated to students at the outset of the program and each program component/subject.

Interpretation

This standard focuses on the assessment methods used in the program, the reliability and validity of the methods used and whether or not the methods give assurance that every student who passes the program is competent to practise optometry safely to the minimum standards expected by the profession. The Competency Standards (including the Therapeutic Competencies) provide clear guidance as to the standards expected in Australia and New Zealand (refer Appendix 2).

a) Assessment methods

Schools are expected to use both summative and formative assessment methods. Formative assessment should be regarded as integral to the education of optometry students. Methods of assessment should be varied and are likely to include assessment of:

- essays / extended responses
- case studies / commentaries
- project reports
- oral assessments / interviews / presentations
- documentation of the completion of required tasks (such as clinical log books)
- clinical case examinations

b) Clinical assessments/examinations

OCCANZ considers it important that clinical examinations, whether with real or simulated patients, should form a significant component of the overall process of assessment of the clinical disciplines. Clinical examinations assess clinical competence and communication skills, and provide an incentive to students to practise and improve these skills.

A number of strategies may be used, including:

- use of simulated and standardised patients to test specific skills in a structured, multiple-station assessment process (sometimes known as the 'objective-structured clinical examination').
- long case examinations that allow an assessment of the student's ability to take a complete history, conduct a full clinical examination, interpret the findings and develop a management plan.
- observation of the student performing a number of complete clinical evaluations, both during clinical training and towards the end of clinical training.

c) Assessment instruments

OCCANZ encourages optometry schools to develop valid and reliable instruments to assess all of their specific educational objectives, including attitudinal objectives such as independent learning, communication with patients, working as part of a health team and problem solving skills.

d) Progression and remediation

Students should be provided with information on:

- the rules of progression and progression rates
- options for students to transfer to another program
- the systems of feedback to students
- support systems for students

Evidence

This section should provide details of student assessment in the program. Refer to Standard 7 for further information.

Suggested evidence requirements for submission

a) Assessment methods

- Brief statement of the philosophy that underpins the choice of assessment methods used by the school.

Pre-clinical assessment and examinations

- List each pre-clinical subject and state the assessment methods for each including:
 - format of the assessments
 - an indication of the weighting given to each component of assessment

3. THE OPTOMETRY PROGRAM

Clinical assessment and examinations

- List each clinical subject and state the assessment methods for each, including:
 - a description of how clinical knowledge and clinical proficiency are assessed
- the weighting given to each component of assessment
- Describe the requirements for student proficiency in core clinical techniques, both prior to undertaking examinations of patients under supervision and prior to completion of the program.

b) Progression and remediation

Description of the requirements for program progression, including:

- satisfactory completion enabling the student to progress in the program
- exceptional circumstances, such as when a student may:
 - be admitted to supplementary examinations
 - progress in the program without a clear pass in every subject
- Statement describing the rules under which a student may be suspended from the program.
- Statistical information on:
 - success/failure rates in each subject
 - progression rates from one year to the next and the proportion of students who complete the program in minimum time
- the number of students suspended from the program in the last five years

Statement describing:

- the options open to students to transfer to another program, with or without credit
- the systems of feedback to students who fail components of assessment
- support systems for students who experience difficulty with the program

Suggested evidence that might be requested during the site visit

- Sample examinations or assessment instruments, e.g. student instructions for research/ assignments, essay topics, practical tasks.
- Copy of examination/assessment schedule and standards issued to students.
- Published set of clinical outcomes for students.
- Copies of any reports to the faculty or university on success/failure rates.
- Copies of external examiners' reports for the last three years (if used).

4. RESOURCES

This section focuses on resources to support the delivery of the optometry program and covers the following Standards:

8. *Teaching and support staff*

9. *Students*

10. *Physical resources.*

Standard 8 — Teaching and support staff

An optometry school should be adequately staffed by academic, administrative and technical staff who have the appropriate qualifications and expertise to provide and support the educational goals and objectives of the optometry program.

Staff should be provided with professional development opportunities and be involved in performance review processes under the leadership of the Head of School.

Interpretation

OCANZ believes that the following staffing requirements are necessary to deliver a basic optometry program:

- sufficient academic staff with the qualifications and expertise to provide effective teaching and academic leadership in each of the main divisions/specialties of optometry.
- affiliate and associate appointments of clinicians in addition to academic staff requirements.
- administrative and technical staff to support the academic staff.

a) Teaching staff

Optics and vision science

The optometry school will have qualified staff members responsible for teaching the different aspects of visual performance and visual physiology.

Clinical optometry

Adequate numbers of full-time staff, responsible for the teaching of clinical optometry, are required to cover:

- functional disorders of vision
- diseases of the eye
- paediatric optometry and binocular vision
- contact lens practice
- geriatric optometry
- rehabilitation of the partially sighted

Full-time academic staff members in each of these areas is not required as some academic staff will have more than one field of expertise.

b) Visiting staff

An optometry program needs to draw on the experience and insights of clinicians who are engaged in full-time clinical practice.

4. RESOURCES

c) Support staff

The academic staff must be adequately supported by administrative and technical staff. The number of support staff will depend on the extent to which support is provided through faculty or central university services and the extent to which responsibilities are devolved to the school.

d) Staff development and review

OCCANZ encourages professional development and performance review opportunities for staff involved in the delivery of optometry programs leading to registration.

Evidence

This section should provide details of teaching and support staffing for the program. Refer to Standard 8 for further information.

Suggested evidence requirements for submission

a) Qualifications and expertise of staff

Academic staff

- List of all full-time academic staff in order of seniority, giving their academic rank, qualifications, particular expertise and present teaching duties. Include any position that is currently vacant but which is expected to be filled in the next year.
- Organisational chart for the school and, if relevant, the university faculty.
- Description of the qualifications and expertise of academic staff from the school or faculty handbook.

Visiting academic staff

- List of all visiting staff who work in the school for an average of a half day a week or more during the academic year or who give more than five lectures. List final year clinical instructors and provide for each their position/title, qualifications, primary occupation outside the school and the nature and extent of teaching duties.

Support staff

- List the number of support staff (0.5–1.0 EFT) by position title (e.g. research assistant, receptionist, administrative officer).

b) Staff development and review

- Statement describing the staff development and performance review policies.

Standard 9 — Students

The optometry program should have clearly documented entry requirements and student selection methods for entry into the program, regardless of whether the selection is administered centrally by the university or by the schools. Transparent mechanisms for exiting to alternative programs should also be provided to students.

Support services and facilities that provide assistance with both the academic and personal development of students should be accessible and promoted to students, including specialised services for international students.

Interpretation

This standard focuses on:

- student selection methods for entry into the program.
- student support services and facilities, including those for international students.

a) Methods of student selection

O CANZ recognises that universities use different processes for selecting the most appropriate students into professional programs. Whichever method is used, the process should be clearly defined and documented and applied consistently. A description of the selection process should be published and made available to potential students.

Where student interview is used, steps should be taken to develop and trial the interview process to make it as objective and fair as possible.

Follow-up of the outcome and feedback on the selection process is encouraged so that the process can be improved as necessary.

b) Support services and facilities

Adequate student support services and physical facilities for student study and recreation should be provided. Support services should include access to counselling services with trained staff, student health and financial services, student academic advisers and more informal and readily accessible advice from individual academic staff.

Physical facilities should include adequate lounge, locker and food service areas.

c) Personal development of students

The curriculum should encourage personal development of breadth and perspective in the student, rather than being focused narrowly on vocational training. Electives, self-directed learning, advanced study units in optional areas and research or work experience locally or abroad can help to develop this breadth.

d) International students

Appropriate language and counselling support for international students should be provided if required.

Evidence

This section should provide evidence relating to students undertaking the program and of arrangements to support them. Refer to Standard 9 for further information.

Suggested evidence requirements for submission

a) Student numbers

- Table listing student intake figures for the current or previous year to the assessment visit. The figures should clearly indicate both quota and actual numbers for national residents and international students.

b) Student selection

Modes of entry

- Description of the different modes of entry into the program, such as:
 - from year 12 of secondary school into first year

4. RESOURCES

- admission with advanced standing for those with completed tertiary studies
- special admission scheme for disadvantaged students
- admission for international students

Prerequisites for entry

- Statement describing the qualifications/requirements for:
 - admission (e.g. completion of year 12 school examinations, university entrance examination, part or all of a degree program) and, where relevant, subjects that applicants are required to have studied and passed.
 - admission with advanced standing into a later year of the program (e.g. completion of a degree, completion of particular tertiary subjects).
 - Admission statistics and if available, profile of successful applicants for the past five years
 - include information on gender, academic ranking and international/local student ratio.

Selection methods for standard entry into the program

- Statement describing the methods used for selection for standard (first year) and advanced standing entry.
- Copy of the school's statement of policy and procedures for student selection.

Academic performance standard required for entry

- Data on the intellectual quality of students selected over the past four years. This can be in the form of:
 - percentile of academic ability (e.g. as shown by year 12 or university entrance examinations)
 - cut off score of any scale used to rank the academic ability of students – provide an explanation of the calculation and interpretation of any local scale used.

Special admissions

- Details on the selection methods used for the school's special admission programs. Include any publications or addresses of websites available to applicants for special admission.

International students

- Details on the methods used for selecting international students and information made available to applicants.

c) Student support services

- Statement outlining any school or university student support services including orientation of new students, mentor programs, student counselling service, student health service, student financial support schemes and remedial programs for students making unsatisfactory progress. Include any publications or addresses of websites available to students regarding support services.

d) Student/staff ratios

- Statement about staff/student ratios for the school.

Suggested evidence to be available during the site visit

- Copies of any publications available to applicants for special admission.
- Copies of any publications that explain the selection process to potential students.
- Sample recruitment materials e.g. entries included in program selection/careers handbooks.
- Copies of publications relating to international student selection.
- Copies of publications relating to student support services.
- Examples of orientation programs for new students.

Standard — 10 Physical resources

Appropriate facilities must be provided to meet the educational objectives of the optometry program. This includes facilities suitable for:

- teaching
- clinical training and experience
- researching and referencing current materials relating to the program.

Interpretation

This standard focuses on the physical resources required to meet the educational goals and objectives of the optometry program.

a) Teaching facilities

Suitable teaching facilities must be available for lectures, tutorials and practical classes. This includes:

- auditoriums / lecture rooms
- tutorial rooms / classrooms
- practical laboratories / pre-clinical laboratories

The following equipment, used to support teaching activities, should also be provided:

- audiovisual and multimedia equipment
- laboratory equipment for optics and vision science practical classes.

b) Clinical facilities

It is expected that the school will have its own clinical facility, the size of which will depend on the number of students and the extent to which the school makes use of the clinical facilities of affiliated or associated institutions.

School clinic

If the school clinic is the primary venue for clinical teaching, it must:

- have a sufficient number of well-equipped consulting rooms to provide adequate experience for students in the direct care of patients.
- be well provided with specialist ophthalmic equipment.
- include rooms for patient demonstrations and case discussions.

The clinic should not simply be a clinic for teaching optometry students but should meet real needs for optometric care in the community.

4. RESOURCES

Associated or affiliated clinics

If the clinics of associated or affiliated institutions are used extensively to provide clinical experience and training, the Assessment Team will need to evaluate their adequacy by a site visit. Clinical facilities must be available for initial clinical training to prepare students for entry into the clinic.

c) Library

Libraries containing current books and journals in the biomedical, vision and optical sciences, and in optometry, must be provided and reasonably accessible for use by students and staff. Library staff and access to computer-based reference systems and the Internet should also be available to help students and staff.

Evidence

This section should provide details of the physical resources required to deliver the program. Refer to Standard 10 for further information.

Suggested evidence requirements for submission

a) Facilities

Teaching facilities

- List or map depicting the principal pre-clinical teaching spaces, indicating the area of each space.

Clinical facilities

- List or map depicting:
 - the consulting rooms available for student use during the academic year.
 - other clinical spaces used for teaching (e.g. patient demonstration rooms or theatres, special clinics, rooms for specialised equipment, rooms for spectacle frame display and selection, dispensary, rooms for clinical discussions during clinical supervision etc).

Teaching facilities provided in hospitals and other health centres

- Description of teaching facilities located in hospitals or other health care institutions that are regularly used for student teaching. Include a comment on the adequacy of these facilities.

Facilities for students

- Description of the facilities available to students for private study, relaxation and storage of personal belongings. Include a comment on the adequacy of these facilities.

Optometry library and other information systems

- Description of:
 - library facilities available for optometry students and staff.
 - computer facilities, including Internet and email access.
 - any computer-based reference systems and learning packages.
- Copy of school/university policies relating to Internet and email access.
- Statement on the proportion of students who have Internet and email access through the school or the university.

b) Resources

Clinical equipment

- List or register containing details of:
 - standard equipment in each student consulting room.
 - specialised equipment (including the number of items available for teaching and student use).
- List of the clinical equipment students are required or expected to possess.

References

- Copy of a reference list provided to students for each major subject including books, journals and websites.

Site visit / focus Assessment Team

The Assessment Team may request a tour of teaching facilities, the library and/or clinical facilities.

Objectives relating to knowledge and understanding

Graduates completing an optometry program must have knowledge and understanding of:

- i. the physical, mathematical, optical, biological, biomedical and behavioural sciences at a level adequate to provide a rational basis for both present optometric practice and the assimilation of the advances in knowledge that will occur over their working life
- ii. the principles and methodology of scientific investigation and inference to provide the basis for evaluating the effectiveness of current practice and the value of propositions for changes and innovations
- iii. the normal structure, function and development of the human eye and visual system at all stages of life
- iv. ocular and visual dysfunctions and diseases across the lifespan; a more detailed knowledge is required of those conditions that present commonly and require urgent assessment and treatment
- v. common diagnostic and therapeutic procedures, their uses and limitations
- vi. management of ocular and visual dysfunctions and diseases, including optical therapies, visual training, workplace environmental factors and pharmacological therapies
- vii. the principles of public health, including health service delivery, health education, prevention of disease and morbidity, and rehabilitation
- viii. factors affecting human relationships, the psychological wellbeing of patients and their families, and the interactions between humans and their social and physical environment
- ix. the principles of ethics related to health care and the legal responsibilities of optometrists.

Objectives relating to skills

Graduates completing an optometry program should have developed the following skills to an appropriate level for their stage of training:

- i. the ability to take a tactful, accurate, organised and problem-focused history
- ii. the ability to choose from the repertoire of clinical skills, those which it is appropriate and practical to apply in a given situation
- iii. the ability to select the most appropriate and cost-effective diagnostic and therapeutic procedures
- iv. the ability to apply the common optometric clinical skills proficiently
- v. the ability to interpret and integrate the history and physical examination findings to arrive at an appropriate diagnosis or differential diagnosis
- vi. the ability to formulate a management plan, and to plan management in concert with the patient
- vii. the ability to communicate clearly, considerately and sensitively with patients, relatives, medical practitioners, other health professionals and the general public
- viii. the ability to counsel sensitively and effectively, and to provide information in a manner that ensures patients and families can be truly informed

- ix. the ability to identify and treat those ocular and visual dysfunctions and diseases that can be treated within the scope of optometric therapeutic practice and to recognise ocular disease and ocular signs of systemic disease that require ophthalmological opinion or treatment
- x. the ability to perform common emergency and life-saving procedures such as caring for the unconscious patient and cardiopulmonary resuscitation
- xi. the ability to interpret biomedical evidence in a critical and scientific manner, and to use libraries and other information resources to pursue independent inquiry relating to optometric problems.

Objectives relating to attitudes affecting professional behaviour

During basic optometric education, students should acquire the following professional attitudes, which are regarded as fundamental to optometric practice:

- i. respect for every human being, with an appreciation of the diversity of human background and cultural values
- ii. full understanding of the ethical issues relating to the delivery of health care
- iii. a desire to improve the human condition and to ease discomfort and suffering
- iv. an awareness of the need to communicate with patients and to involve them fully in decisions on management
- v. a desire to achieve optimal patient care for the least cost, with an awareness of the need for cost-effectiveness to allow maximum benefit from the available resources
- vi. recognition that the health and wellbeing of the patient and the community are paramount
- vii. a willingness to work effectively in a team with other health care professionals
- viii. an appreciation of the responsibility to maintain standards of optometric practice at the highest possible level throughout a professional career
- ix. an appreciation of the need to recognise when a clinical problem exceeds their capacity to deal with it safely and appropriately and of the need to refer the patient for help from others when this occurs.

CLINICAL AND EXPERIMENTAL
OPTOMETRY

COMPETENCIES

Optometrists Association Australia Universal
(entry-level) and Therapeutic Competency
Standards for Optometry 2008

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Background: Competency standards for entry-level to the profession of optometry in Australia were first developed in 1993, revised in 1997 and expanded in 2000 to include therapeutic competency standards. The entry-level standards cover the competencies required by a person entering the profession without therapeutic endorsement of their registration. The therapeutic competency standards address the additional competencies required for therapeutic endorsement of registration. This paper presents a revised version of the universal (entry-level) and therapeutic competency standards for the profession of optometry in Australia in 2008.

Methods: Expert members of the profession and representatives from schools of optometry, registration boards in Australia, state divisions of Optometrists Association Australia and the New Zealand Association of Optometrists were consulted in the process of updating the standards.

Results: Three new elements of competency have been added to the standards. Twenty-three new performance criteria with associated indicators have been added. Some performance criteria from the earlier document have been combined. Substantial alterations were made to the presentation of indicators throughout the document. The updated entry-level (universal) and therapeutic competency standards were adopted on behalf of the profession by the National Council of Optometrists Association Australia in November 2008.

Discussion: Competency standards are used by Australian and New Zealand registration authorities for the purposes of registration and therapeutic endorsement of registration via the Optometry Council of Australia and New Zealand accreditation and assessment processes. They have also been used as the basis of the World Council of Optometry Global Competency-Based Model.

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at a more specialised level.¹ In the 1990s, optometry was among a number of professions that developed entry-level competency standards (for example, nurses,³ dietitians,⁴ speech therapists⁵).

The competency standards were to list the skills, knowledge and attributes that a person needed to be able to perform the activities associated with a particular trade or occupation to a standard appropriate for the workplace.¹ The term 'attributes' is used to indicate the personal qualities that underpin performance and, hence, competence. Attributes include capacities, skills, abilities and traits. Inevitably, to some extent such listings are open-ended as identifying and describing human attributes is not an exact science.

A 'competent' professional has the capacity to perform the range of professional roles and activities at the required standard of practice. The term 'competence' is a blanket term used to describe overall professional ability and links (or integrates) three key ideas: a practitioner's 'capacity', 'performance' and the 'standard' of the performance. These three notions are represented centrally in professional competency standards, where the term 'standards' is a convenient name for the overall structure that taken together comprises a detailed description of professional practice: units, elements, performance criteria and indicators.

1. Units are groupings of major professional practice tasks/activities used to describe practice. Units are the categories under which competency standards are listed.⁶
2. Elements are sub-divisions of units and are significant actions that are important contributions to performance within a unit. They are the lowest identifiable logical and discrete sub-grouping of actions and knowledge contributing to a unit of practice. Elements taken singly are sometimes referred to as 'competencies'.
3. Performance criteria, which accompany elements, are evaluative statements specifying the required level or standard of performance.⁶ Performance criteria can be used by an assessor to determine whether a person

performs to the level required for the profession.

4. Indicators assist in the interpretation of the performance criteria by pointing to the range of capacities, knowledge, skills, abilities et cetera that the practitioner needs to be competent. Indicators include measurable and/or observable features that are useful for determining whether aspects of competence have been achieved.⁶ Because competent performance is often significantly context-sensitive, the indicators can never be exhaustive or complete and assessors are expected to supplement them as needed. Assessors will always need to exercise informed professional judgement in choosing the indicators that suit the particular context.

Optometrists in Australia are the major providers of primary eye care and also provide eye care secondary to referrals from vision screening programs, other optometrists, general medical practitioners and other health and educational providers. In Australia, optometrists' clinical skills include case history taking, determination of refractive error, assessment of binocular vision and accommodation, assessment of the health of the ocular structures through the use of techniques such as ophthalmoscopy, slitlamp biomicroscopy and tonometry; visual field assessment; colour vision assessment; assessment of the basic neurology of the eyes and visual pathways, prescription and supply of spectacles, contact lenses and low vision aids; use of ophthalmic drugs to facilitate diagnostic procedures (anaesthetics in performing tonometry, mydriatics for internal examinations and cycloplegics for refractive and physiological investigations). Optometrists' skills include problem solving and case management; they advise patients with ocular conditions, recommend suitability for work activities and may refer patients for general medical, specialist optometric, specialist educational, ophthalmologic or other professional care. In recent years, legislation has been passed in all but one of the states and territories of Australia, allowing optometrists to use and prescribe

topical ophthalmic medications to treat a range of eye diseases.

In optometry, entry-level is the point at which a person is able to be registered to practise optometry. Entry-level competency standards describing the skills and knowledge a person needed to be regarded as sufficiently qualified to be registered to practise optometry in Australia were first developed in 1993⁷ and revised in 1997 to reflect the growing scope of the profession and to incorporate modifications prompted by experience in the application of the competencies.⁸

Specialised competencies were not developed until 2000,⁹ when it was recognised that with the prospect of legislation to allow therapeutic endorsement to optometric registration, there needed to be a mechanism in place to specify the skills and knowledge required for an optometrist to be able to prescribe therapeutic medications. Therapeutic competencies could not be regarded as entry-level competencies in Australia but would be regarded as skills possessed by optometrists who had undertaken additional study or gained the necessary knowledge and experience outside their undergraduate training sufficient to gain therapeutic licensing. It is expected that the therapeutic competencies will become entry-level competencies as optometric training in all states now includes training in the use of therapeutic drugs.

The entry-level (or universal) and therapeutic competency standards for optometry in Australia have been used by the Optometry Council of Australia and New Zealand in its processes to accredit the undergraduate optometry¹⁰ and postgraduate therapeutic courses in optometry in Australia and New Zealand and in the assessment of overseas trained optometrists seeking to practise optometry in Australia.¹¹ The standards have also been used as the basis of the World Council of Optometry Global Competency-Based Model for the Scope of Practice in Optometry.¹²

To commence the process to review the competency standards, a literature survey was conducted to see which standards similar to competency standards were in

place for optometry elsewhere in the world and for other health professions in Australia and to determine whether there were any areas addressed in these standards that were not contained in the 2000 Australian entry-level and therapeutic competencies.

The 2000 document was circulated to over 80 optometrists in the different states of Australia and members of optometrists registration boards for suggestions about how the standards needed to be altered to reflect current expectations for entry-level to the profession of optometry and the requirements for therapeutic endorsement. Responses were received from optometrists in academia, the state divisions, the registration boards, the New Zealand Association of Optometrists, members of the National Council of Optometrists Association Australia and individual optometrists. The resulting comments were incorporated into a master document that was then analysed and refined at a workshop comprising 12 optometrists and facilitated by Dr Paul Hager from the University of Technology Sydney.

Recommendations from the workshop were incorporated into a second master document and returned to workshop participants for further comment. Following this refinement, the standards were sent to state divisions of Optometrists Association Australia for further comment and refinement prior to presentation to the National Council of Optometrists Association Australia for adoption as association policy. It is estimated that the total number of optometrists who were given the opportunity to comment on the draft competencies exceeded 100, although the precise number is unknown.

A major issue that had been raised during the initial circulation of the standards for comment was the format in which the indicators had been presented in the 2000 competencies. In some instances indicators comprised structured sentences; in other places they comprised lists of equipment and techniques. One respondent suggested that *'brevity is the way to go with these competencies, particularly the indicators, as any attempt to make them com-*

prehensive will tend to highlight omissions and be more confusing to candidates if they start to treat these as a very specific syllabus'.

To address this issue a different format was adopted in the indicators where a phrase was used commencing with a noun, for example, 'knowledge of . . .' or 'ability to . . .' or 'understanding of . . .' or 'recognition of . . .'

There were also comments on recategorising some therapeutic indicators to entry-level and reduction of the detail in the therapeutic standards so that there was consistency across the document in the degree of detail.

These modifications to the format of the indicators and other refinements detailed below were incorporated in the final document that is shown in Appendix 1. To differentiate Universal (entry-level) competencies from those specific to therapeutic competency standards, the Universal competencies are shown in black and the performance criteria and indicators specific to Therapeutic competencies are presented in blue.

In the revised standards, there are no new units of competency but three new elements of competency have been added. The first of the new elements addresses prognosis of disease (4.2). The contents of the element regarding treatment of ocular disease and injury (5.8) were distributed to other sections and replaced by a new element on the provision of legal certification. The third new element was on requirements for retention and destruction of patient records and other practice documentation (6.3).

Twenty-three new performance criteria with associated indicators have been added. In some instances performance criteria from the earlier document were combined, for example, 1.7.2 and 1.7.3 were combined into the new 1.7.2. Performance criteria 3.3.5 and 3.3.6 from the earlier version have been deleted and distributed to other competencies. The subsections of 5.5.1 in the previous version of the standards have been deleted and modified to act as indicators in 5.5.1. The modifications to the entry-level and therapeutic competency standards were not contentious.

The Universal (entry-level) and Therapeutic standards for optometry analyse professional practice into units, which are subdivided into elements for purposes of assessment, teaching et cetera. The order in which Units, Elements, Performance Criteria and Indicators are presented does not imply any degree of priority. The standards must be read holistically. This means several things.

1. Instances of actual practice often involve two or more elements simultaneously, for example, taking a case history, communicating with the patient, acting ethically et cetera. In practice, the individual elements are not discrete and independent. For assessment purposes this means that performance on several elements can be assessed simultaneously.
2. In the case of new, unusual or changing contexts, the standards may need to be interpreted or adapted to the situation. Such contextually-sensitive situational understanding requires informed professional judgement to comply with the spirit of the competency standards.
3. They are also holistic in the sense that competence is not directly observable. Rather, what is observable is performance on a series of relatively complex and demanding professional tasks. Competence is a global construct that is inferred from observed performance on a sufficiently representative range of tasks and activities.

At present, therapeutic competencies are still considered a second-tier competency as not all graduates from Australian schools of optometry have these competencies and therefore, they are not eligible for therapeutic licensing. By 2013, all optometry courses in Australia will produce graduates who will be entitled to automatic therapeutic licensing. Therapeutic competencies would then be regarded as entry-level requirements of the profession rather than a second-tier expertise.

The updated version of the entry-level and therapeutic competency standards was adopted in November 2008 by the National Council of Optometrists Association Australia for the profession as it exists

in 2008. It is expected that both sets of standards will continue to be modified as the profession develops.

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UNIT 1. PROFESSIONAL RESPONSIBILITIES

Elements	Performance criteria	Some suggested indicators (this is not an exhaustive list)
1.1 Maintains and develops optometric knowledge, clinical expertise and skills.	<p>1.1.1 Optometric knowledge, equipment and clinical skills are maintained and developed.</p> <p>1.1.2 Developments in clinical theory, optometric techniques and technology are critically appraised and evaluated for their efficacy and relevance to clinical practice.</p> <p>1.1.3 Newly developed and existing clinical procedures and techniques are applied and adapted to improve patient care.</p> <p>1.1.4 Clinical experiences and discussions with professional colleagues are used to improve patient care.</p>	<p>Ability to continue to develop skills and knowledge.</p> <p>Ability to access material such as recent publications, journal articles, library materials (including textbooks and electronic media, seminar and conference proceedings, internet and computer materials, online databases).</p> <p>Understanding of continuing professional development requirements of Optometrists Association Australia and boards of optometric registration.</p> <p>Understanding of the need to have access to appropriate equipment.</p> <p>Understanding of current developments in optometry.</p> <p>Understanding of statistical methods and scientific requirements necessary for sound research.</p> <p>Ability to incorporate relevant research findings into practice.</p> <p>Understanding of the advantages, disadvantages and limitations of clinical procedures and techniques.</p> <p>Ability to discuss and appraise clinical experiences.</p>
1.2 Practises independently.	<p>1.2.1 Professional independence in optometric decision-making and conduct is maintained.</p> <p>1.2.2 Possible consequences of actions and advice are recognised and responsibility for actions accepted.</p> <p>1.2.3 Advice is sought from other optometrists, health and other professionals when it is deemed that a further opinion is required.</p>	<p>Recognition of the need for products and services provided to the patient to be appropriate and in the best interests of the patient.</p> <p>Recognition of limitations in clinical skills and ability to care for and manage a patient.</p> <p>Recognition of the need to maintain appropriate independence when working with other health professionals.</p> <p>Ability to arrange timely referral of a patient.</p> <p>Understanding that patient complaints should be dealt with in a professional and co-operative manner.</p> <p>Recognition of the need to accept responsibility for decisions.</p> <p>Awareness of the need to inform the professional indemnity insurer of cases that are potentially litigious.</p> <p>Recognition of patients for whom referral to another practitioner is necessary.</p> <p>Understanding of the scope of practice and services offered by other health professionals and when there is a need to seek information from them.</p> <p>Ability to access contact details of other health professionals.</p> <p>Recognition of situations where there is a need for liaison with other health professionals.</p>

<p>1.3 Acts in accordance with the standards of ethical behaviour of the profession.</p>	<p>1.3.1 Optometric services are provided as necessary for the management of the patient.</p> <p>1.3.2 Patient eye care interests and comfort are held paramount.</p> <p>1.3.3 Advantage (in a physical, emotional or other way) is not taken of the relationship with the patient.</p> <p>1.3.4 The services of optometric assistants are used appropriately.</p> <p>1.3.5 The ethical standards of the profession are maintained.</p>	<p>Understanding of the role of the optometrist in society.</p> <p>Ability to identify ocular and visual conditions that require additional assessment by the optometrist.</p> <p>Ability to assess patient requests.</p> <p>Understanding of the obligation to recommend only clinically necessary follow-up visits and to recommend or administer only appropriate optical and other appliances, medications, procedures and treatments.</p> <p>Ability to put patient interests ahead of self-interest.</p> <p>Understanding that practitioners to whom patients are referred should be selected on the basis of the most suitable practitioner for the needs of the patient.</p> <p>Recognition of the obligation of optometrists to respect the dignity and rights of the patient.</p>
<p>1.4 Communicates appropriate advice and information to patients and others.</p>	<p>1.4.1 Information is clearly communicated to patients, patient carers, staff, colleagues and other professionals.</p> <p>1.4.2 Liaison with other professionals is maintained.</p>	<p>Ability to determine whether it is suitable to delegate specific tasks to optometric assistants.</p> <p>Recognition of the need to provide training and supervision for optometric assistants to whom tasks are delegated.</p> <p>Recognition of the need to conform to standards of practice of the Optometrists Association of Australia and standards of other relevant organisations.</p> <p>Provision of sufficient information in a suitable form to assist patients to give informed consent regarding their management.</p> <p>Understanding that information should be provided to the patient in a manner suitable to the abilities of the patient, e.g. written/oral instructions/information; CDs or electronic records of ocular photographs.</p> <p>Recognition of the need for patients to be provided with an opportunity to ask questions regarding their care.</p> <p>Understanding of when the services of interpreters should be utilised.</p> <p>Ability to obtain information about accessing the services of an interpreter.</p> <p>Ability to use the services of an interpreter.</p> <p>Understanding of the different formats in which information is provided to patients in optometric practice, e.g. itemised accounts, letters, optical or therapeutic prescriptions, information regarding referral and recalls, reports and shared-care arrangements.</p> <p>Understanding of patient privacy issues.</p> <p>Understanding of the need to verify accuracy/success of communication.</p>
<p>1.5 Uses resources from optometric and other organisations to enhance patient care.</p>	<p>1.4.3 Significant or unusual clinical presentations can be recognised and findings communicated to other practitioners involved in the patient's care or to government bodies.</p> <p>1.5.1 The various functions of, and resources available from, optometric and other organisations are understood and used.</p>	<p>Understanding of what information should be included in referral/report letters.</p> <p>Understanding of the need to investigate and report findings to the necessary authority where ramifications may extend beyond the patient to the community (following patient consent if applicable). Examples of findings that may need to be reported include side-effects of drugs that are reported to the Adverse Drug Reactions Advisory Committee (ADRAC); communicable diseases; abuse of children, the elderly or the disabled; and driving suitability.</p> <p>Understanding of the role of organisations and government bodies such as State and Territory registration boards, educational/research institutions in optometry, state and federal divisions of Optometrists Association Australia, the Australasian College of Behavioural Optometrists, the Contact Lens Society of Australia, societies for the blind and vision impaired (e.g. Macular Degeneration Foundation, Glaucoma Australia, Diabetes Australia).</p> <p>Ability to access information from the different organisations described above.</p>

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<p>1.5.2 Community and other resources are recommended to patients.</p>	<p>Ability to identify patients who could benefit from services from societies and support agencies. Understanding of the optometrist's role in advising patients of the services that different organisations provide and how these organisations can be contacted. An example is referral to specialist low vision support organisations.</p>
<p>1.6.1 The roles of practice staff and the need for staff training are understood.</p>	<p>Understanding of the need for staff to be trained for their role in the practice and to recognise patients requiring immediate attention. Knowledge that staff should be asked to perform only duties that are within their competence. Understanding of the need to monitor performance of staff and assistants.</p>
<p>1.6.2 Equipment is maintained in a safe, accurate, working state.</p>	<p>Knowledge of the frequency with which items such as tonometers should be calibrated and the need to record when calibration is performed. Understanding of the need for a staff member to be assigned to arrange or perform regular cleaning and maintenance of equipment (including calibration in accordance with the manufacturer's recommendations) and to organise repairs promptly.</p>
<p>1.6.3 Personal and general safety, comfort, tidiness and hygiene are maintained in the practice.</p>	<p>Understanding of the need for a staff member to be assigned to ensure that spare parts such as new globes and batteries are available. Ability to describe the measures to be applied to ensure safety, comfort, cleanliness and tidiness of the reception area, consulting rooms, waiting area (including toys and reading materials), frame displays, toilets etc. Knowledge of the infection control measures to be implemented in optometric practice, e.g.:</p> <ul style="list-style-type: none"> • cleaning of the consulting room; disinfection of equipment and materials between patients (e.g. tonometers, contact lenses, refractor heads, slitlamp and keratometer chin and head rests etc) • provision and use of handwashing facilities, use of gloves and masks when necessary; attention to nail length and hair • sterility of pharmaceuticals and other solutions, refrigeration of pharmaceuticals where recommended by the manufacturer, monitoring of refrigerator temperatures, regular cleaning and defrosting of refrigerator; disposal of solutions at the recommended time after opening or if contaminated or past their expiry date • management of practice waste and absence of unpleasant odours.
<p>1.6.4 Patient appointments are scheduled according to the time required for procedures.</p>	<p>Understanding of which furnishings, ventilation, lighting and noise levels are suitable for optometric practice. Recognition of the need to provide safe access to the practice for children, the elderly and disabled. Recognition of the need to allocate adequate appointment times for patients, with attention to changes to scheduling when pupil dilation is to be performed.</p>
<p>1.6.5 Financial obligations associated with optometric practice are recognised.</p>	<p>Recognition of when follow-up appointments need to be organised. Recognition of the need to accommodate emergency appointments in the appointment schedule. Understanding of the need for the practice to organise timely payments to staff and creditors. Understanding of a practice's obligations for taxation and superannuation payments for staff. Understanding that timely accounts and receipts must be provided to patients. Recognition of the need for a practice procedure for banking and for the issuing of invoices, statements and receipts.</p>
<p>1.7 Understands the legal obligations involved in optometric practice.</p>	<p>Recognition of the need for the practice to have a business plan. Recognition of the need for a staff member or members or accountant to assist with finances in the practice. Ability to access and interpret information about provisions and requirements for optometrists under Medicare, private health insurance schemes, Department of Veterans' Affairs, low cost spectacle schemes, Pharmaceutical Benefits Scheme etc. Ability to interpret and apply information about fee schedules.</p>

<p>1.7.2 Relevant legislation, common law obligations relevant to practice and Australian Standards are understood and implemented.</p>	<p>Universal: Recognition of the optometrist's obligation to register as an optometrist in any jurisdiction where he/she will practise. Recognition of the optometrist's obligation to adhere to requirements under State, Territory or Federal Acts such as the Health Insurance Act, Privacy Acts, Health Records Acts, Poisons Acts and Regulations, Child Protection Acts. Recognition of the optometrist's obligation to ensure that products provided conform to any relevant Australian Standard. Recognition of the optometrist's obligation to act in accordance with requirements concerning businesses, e.g. occupational health responsibilities to provide a safe practice environment, financial reporting in accordance with Australian Taxation Office requirements (e.g. BAS, PAYG). Recognition of the optometrist's obligations in the issuing of certificates for sick leave, the provision of prescriptions and the reporting of patient fitness to drive and to undertake other activities. Recognition of the optometrist's obligations regarding the Pharmaceutical Benefits Schedule, Veterans' Affairs Entitlement Scheme. Understanding of the 'duty of care' of an optometrist in dealings with patients and staff and that decisions should be made in the best interests of the patient. Recognition of the situations in which it is necessary to obtain informed consent from patients. Recognition of matters that may constitute negligence. Recognition of the need for optometrists to have indemnity insurance. Understanding of the need to follow recommendations for the 'Quality use of medicines'. Recognition of when the best interests of the patient necessitate the arrangement of patient referral. Understanding of the optometrist's responsibilities in comanagement arrangements. Recognition of situations where there may be a conflict of interest.</p>
<p>1.8 Provides for the care of patients with special needs.</p>	<p>Therapeutic level Recognition of the optometrist's obligation to have therapeutic endorsement of their registration in any jurisdiction where they will prescribe or supply controlled therapeutic medications. Knowledge of available subsidised eye-care schemes. Ability to access information on eligibility of patients and benefits and requirements under arrangements with Department of Veterans' Affairs, Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), state subsidised eye-care programs etc. Ability to identify people who qualify for subsidised eye-care schemes and to advise them of their eligibility. Ability to advise eligible patients if the optometrist does not participate in the subsidised eye-care scheme and offer the option of referral to a practitioner who does. Ability to describe/select the equipment that is necessary for a domiciliary visit. Recognition of the need to provide patients unable to attend the practice for their consultation with a domiciliary visit or to direct them to a practice that provides domiciliary visits. Ability to deliver optometric care that considers cultural, language and socio-economic diversity, e.g. Aboriginal and Torres Strait Islander communities, socio-economically disadvantaged or otherwise marginalised people (e.g. homeless); people with intellectual disabilities; residents in aged care facilities or supported accommodation, ethnic minority groups. Ability to identify patient presentations that require immediate attention. Understanding of the need to train staff to recognise patient presentations that require immediate attention by the optometrist.</p>
<p>1.8.1 Subsidised eye care schemes are understood and explained, recommended or made available to patients who are entitled to them.</p>	<p>1.8.2 Domiciliary optometric care can be provided.</p>
<p>1.8.2 Domiciliary optometric care can be provided.</p>	<p>1.8.3 Culturally inclusive optometric services are delivered.</p>
<p>1.9 Provides or directs patients to emergency care.</p>	<p>1.9.1 Situations requiring emergency optometric care and general first aid are identified.</p>

<p>1.9.2 Emergency ocular treatment and general first aid can be provided.</p> <p>1.9.3 Emergency care is organised for times when the optometrist is unavailable.</p> <p>1.10 Promotes issues of eye and vision care to the community.</p> <p>1.10.1 Information on matters of visual health and welfare (including the need for regular eye examinations) and product and treatment developments is provided.</p> <p>1.10.2 Advice is provided on eye protection for occupational and home-based activities and for recreational pursuits.</p> <p>1.11 Understands factors affecting the community's need for eye care services.</p> <p>1.11.1 The demography, social determinants of health and epidemiology of the community and the patient population are understood.</p> <p>1.11.2 Current trends and topical issues regarding eyes, vision and health care are evaluated.</p>	<p>Understanding of what form of emergency ocular treatment/management should be provided to patients with urgent clinical presentations.</p> <p>Ability to provide general first-aid and cardiopulmonary resuscitation or evidence of the ability through first aid and cardiopulmonary resuscitation qualifications.</p> <p>Understanding the need for at least one staff member to have an up-to-date first aid and cardiopulmonary resuscitation qualification.</p> <p>Understanding of the need to direct patients to where they can access emergency care after hours through an after-hours telephone number, an answering machine or redirection of the practice telephone number to the optometrist.</p> <p>Ability to access and interpret information on eye and vision care.</p> <p>Ability to integrate information on eye and vision care into advice provided to patients.</p> <p>Understanding of the different methods by which information on issues of eye and vision care can be provided, e.g. verbally or in writing through practitioner newsletters, practice information sheet, brochures and notices at reception or in the waiting room.</p> <p>Knowledge of the types of eye protection that meet the requirements in Australian and New Zealand Standards, e.g. safety lenses, radiation protection, sunglasses.</p> <p>Ability to provide advice on tints, occupational lens designs, contact lenses, lighting, ergonomic design and visual hygiene for a range of activities such as home renovations, gardening, woodwork etc.</p> <p>General knowledge of epidemiology (prevalence, incidence and causes) of ocular and visual disorders and other relevant issues and of the demographics of the patient population.</p> <p>Ability to research information about demography and epidemiology through suitable methods such as database analysis, questionnaires and other means.</p> <p>Understanding of how social determinants of health affect presentations to optometrists.</p> <p>Ability to provide a balanced viewpoint of current trends and topical issues to patients.</p>
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Universal competencies are shown in black.
Therapeutic competencies are shown in blue.

UNIT 2. PATIENT HISTORY

Elements	Performance criteria	Some suggested indicators (this is not an exhaustive list)
<p>2.1 Communicates with the patient.</p>	<p>2.1.1 Modes and methods of communication are employed which take into account the physical, emotional, intellectual and cultural background of the patient.</p>	<p>Proficiency in spoken and written English.</p> <p>Understanding of how communication can be facilitated through the use of interpreters, Auslan interpreters, questionnaires, written means etc.</p> <p>Understanding of the need to use appropriate language, vocabulary and terminology when communicating with the patient/carer/guardian.</p> <p>Understanding of the need to phrase/rephrase questions to enhance understanding.</p> <p>Recognition of the need to verify understanding (optometrist/patient/carer/guardian).</p>

<p>2.1.2 A structured, efficient, rational and comfortable exchange of information between the optometrist and the patient occurs.</p>	<p>Recognition of the need for optometrists to greet the patient, to introduce themselves and to establish the patient's identity.</p> <p>Understanding of the need for the optometrist to direct the discussion during the consultation.</p> <p>Recognition of the need to develop a rapport with the patient through attending to their statements, making tactful comments/questions, being empathetic.</p> <p>Understanding of how auditory and visual privacy can be maintained throughout the consultation and other communications in the practice and when using the telephone/email/fax.</p> <p>Understanding of the need to obtain patient permission for the presence of a third party during the consultation.</p> <p>Understanding of privacy legislation.</p>
<p>2.1.3 Privacy of patient communications and consultations is ensured.</p>	<p>Ability to recognise significant aspects regarding patient appearance, gait and general movements, balance, posture, behaviour, speech and verbal responses, as part of the patient assessment.</p> <p>Ability to investigate issues relating to patient well-being, health and comfort.</p>
<p>2.2 Makes general observations of patient.</p>	<p>Understanding of the different strategies that can be applied to investigate the reason for the patient's visit and elicit other relevant information, e.g. active listening to the patient, noting body language and anxieties, clarifying understanding and ambiguities, noting and understanding referral letters/notes.</p> <p>Understanding of the need to determine patient and/or parent (guardian) expectations.</p> <p>Understanding of the need to investigate the patient history throughout the examination and to explore and record information in relevant areas such as:</p> <ul style="list-style-type: none"> ● symptom/s and complaint/s ● personal and family medical and ocular history ● ocular and systemic medications ● visual needs and current/recent visual devices and care regimens ● allergies ● previous assessments and treatment by other professionals ● risk factors for certain eye and/or systemic conditions ● type and time of injury ● assessment of likely future/past compliance with treatment.
<p>2.3 Obtains the case history.</p>	<p>Understanding of the need to gather information about the patient through reading previous record cards and associated paperwork.</p> <p>Ability to recognise situations when further information needs to be obtained from other health professionals whom the patient has consulted.</p> <p>Recognition of when patient/parent/guardian permission needs to be obtained in order to seek information from other health professionals.</p> <p>Ability to interpret outcomes/implications of clinical tests performed by other optometrists or other health professionals.</p> <p>Ability to interpret and integrate information from different sources to assist in determining the management of the patient.</p>
<p>2.4 Obtains and interprets patient information from sources other than the patient.</p>	<p>2.2.1 Physical and behavioural characteristics of the patient are noted and taken into account.</p> <p>2.3.1 The reasons for the patient's visit are elicited in a structured way.</p> <p>2.3.2 Information required for diagnosis and management is elicited from the patient and/or others.</p> <p>2.4.1 Subject to the patient's permission, pertinent information from previous assessments by other professionals or information from other people is sought and interpreted for relevance to the patient's management.</p>

UNIT 3. PATIENT EXAMINATION

Elements	Performance criteria	Some suggested indicators (this is not an exhaustive list)
3.1 Formulates an examination plan.	<p>3.1.1 An examination plan based on the patient history is designed to obtain the information necessary for diagnosis and management.</p> <p>3.1.2 Tests and procedures appropriate to the patient's condition and abilities are selected.</p> <p>3.1.3 Relevant investigations not necessarily associated with the patient's history are considered.</p>	<p>Ability to consider the patient history to determine which tests are suitable/unsuitable for the examination and for the abilities of the patient, e.g. consideration of the patient's age, cognitive ability, developmental status, attention span, condition, physical comfort.</p> <p>Ability to select and justify inclusion or exclusion of tests for the examination after consideration of the age, cognitive and physical ability, and health of the patient.</p> <p>Ability to select tests that will investigate the problems described by the patient.</p> <p>Ability to consider tests targeting conditions that are associated with a patient's known conditions.</p> <p>Ability to select tests to investigate other conditions relevant to the patient's age that are not necessarily indicated through the patient history, e.g. tonometry, pupil reactions etc.</p>
3.2 Implements examination plan.	<p>3.2.1 Tests and procedures which efficiently provide the information required for diagnosis are performed.</p> <p>3.2.2 The examination plan and procedures are progressively modified on the basis of findings.</p> <p>3.3.1 The components of the ocular adnexae are assessed for their structure, health and functional ability.</p>	<p>Ability to be proficient, safe and accurate with equipment and in the performance of techniques.</p> <p>Ability to provide clear explanations about the purpose of different tests, what is involved in the tests and the effects of any diagnostic drugs used.</p> <p>Ability to recognise that the patient has fully understood explanations.</p> <p>Understanding of when and how patient informed consent is to be obtained.</p> <p>Ability to recognise what tests should be included or excluded for different patient presentations and the order in which tests should be performed.</p> <p>Ability to recognise situations in which it is necessary to perform additional tests or to organise additional or alternative tests through referral to another practitioner.</p>
3.3 Assesses the ocular adnexae and the eye.		<p>Universal:</p> <p>Ability to assess and evaluate the conjunctiva, lids, lashes, puncta, meibomian glands, lacrimal glands, skin lesions near the eye etc for the purposes of screening for health/diseases and vision.</p> <p>Ability to use tests/equipment such as:</p> <ul style="list-style-type: none"> ● macro-observation, slitlamp biomicroscopy, loupe ● palpation of (non-open) lesions ● measurement of interpupillary distance and the palpebral aperture ● lid eversion ● photography ● use of diagnostic pharmaceuticals ● assessment of tear formation, tear break-up time and tear dynamics. <p>Ability to describe and follow infection control measures relevant to optometric practice, e.g. instrument disinfection, use of disposable gloves, management of waste etc.</p> <p>Ability to perform punctal dilation and lacrimal lavage using appropriate equipment.</p>

3.3.1 continued

Therapeutic level

Ability to collect and store samples appropriately, select and order microbiological tests or refer the patient to their general medical practitioner to arrange microbiological tests.

Ability to recognise the significance of the following in the management of the patient:

- indications for microbiological investigations
- cost-effectiveness of additional testing and treatments
- urgency and diagnostic needs
- drug sensitivity testing
- collection, storage and delivery of samples
- collection and disposal of sharps and biohazards

Ability to complete necessary paperwork to initiate microbiological investigations.

Ability to assess and evaluate the cornea, conjunctiva, anterior chamber and aqueous humour, anterior chamber angle, anterior chamber depth, episclera, sclera, iris, pupil and ciliary body for the purposes of screening for health/disease and for visual function.

Ability to use, and interpret results/images from, tests/equipment such as:

- vital dyes and diagnostic pharmaceuticals
- slitlamp biomicroscopy
- keratometry; keratometry, corneal topography
- gonioscopy
- pachymetry
- tonometry
- photography
- pupil reactions and pharmacological evaluation of pupil abnormalities
- exophthalmometry

Ability to interpret results/images from tests/equipment such as:

- anterior segment imaging (e.g. optical coherence tomography [OCT])
- ultrasonography
- confocal microscopy

Ability to assess and evaluate the ocular lens, lens implants, the lens capsule and vitreous for the purpose of screening for health/disease and for visual function.

Ability to use, and interpret results/images from, tests/equipment such as:

- direct and indirect ophthalmoscopy
- retinoscopy
- photography
- diagnostic pharmaceuticals
- slitlamp biomicroscopy
- ultrasound

3.3.2 The components of the anterior segment are assessed for their structure, health and functional ability.

3.3.3 The components of the ocular media are assessed for their structure, health and functional ability.

<p>3.3.4 The components of the posterior segment are assessed for their structure, health and functional ability.</p>	<p>Ability to assess and evaluate the retina, choroid, vitreous, blood vessels, optic disc and neuro-retinal rim, macula and fovea for the purpose of screening for health/disease and for visual function.</p> <p>Ability to use, and interpret results/images from, tests/equipment such as:</p> <ul style="list-style-type: none"> ● direct and indirect ophthalmoscopy ● slitlamp biomicroscopy and slitlamp funduscopy ● retinoscopy ● photography ● diagnostic pharmaceuticals ● visual acuity and colour vision tests ● Amsler test ● visual field assessment ● photostress test ● pupil reactions <p>Ability to interpret results/images from, tests/equipment such as:</p> <ul style="list-style-type: none"> ● diagnostic imaging (e.g. OCT, HRT) ● ultrasound <p>Ability to use auxiliary lenses for fundus viewing and optic nerve head (ONH) assessment.</p> <p>Ability to interpret/use optical coherence tomography and techniques for nerve fibre layer analysis.</p>
<p>3.4 Assesses central and peripheral sensory visual function and the integrity of the visual pathways.</p>	<p>3.4.1 Vision and visual acuity are measured.</p> <ul style="list-style-type: none"> ● Ability to investigate vision and visual acuity using tests/equipment/assessment such as: <ul style="list-style-type: none"> ● measurement of the contrast sensitivity function ● neutral density filter test ● photo-stress test ● glare testing ● optokinetic nystagmus ● pinhole ● line and single letter tests and preferential looking tests ● logMAR charts ● letter/number/shape charts ● monocular/binocular measurements ● corrected/uncorrected (vision) measurements ● Interferometry. <p>Ability to select appropriate lighting and distances for the performance of tests.</p> <p>Ability to interpret the results of vision and visual acuity tests.</p>

3.4.2	Visual fields are measured.	<p>Ability to select appropriate tests to investigate visual fields using tests/equipment/assessment such as:</p> <ul style="list-style-type: none"> ● Amstler grid ● confrontation ● kinetic and static screening and threshold ● tests for functional visual loss, visual conversion disorder, malingering ● monocular/binocular measurements ● short wavelength automated perimetry (SWAP) and frequency doubling technology (FDT) ● assessment of appropriate fields for driving/occupation <p>Ability to interpret the results of visual field testing.</p>
3.4.3	Colour vision is assessed.	<p>Ability to select the appropriate tests to assess colour vision using tests and testing conditions such as:</p> <ul style="list-style-type: none"> ● pseudo-isochromatic tests ● hue ordering tests ● monocular/binocular measurements ● flicker ● colour matching. <p>Ability to interpret the results of colour vision testing and discriminate between the different types of acquired and congenital colour vision defects.</p>
3.4.4	Pupil function is assessed.	<p>Ability to assess pupils and pupil reactions for symmetry, response rate and cycle times using tests and testing conditions such as:</p> <ul style="list-style-type: none"> ● varied lighting conditions ● swinging flashlight tests ● pharmacological testing <p>Ability to interpret the results of a pupil assessment.</p>
3.5	Assesses refractive status.	<p>Demonstration of a working knowledge of refractive testing methodologies.</p> <p>Ability to select and apply appropriate tests to determine the spherical, astigmatic and presbyopic components of the refractive status for a range of presentations.</p> <p>Understanding of when cycloplegia is indicated.</p> <p>Ability to use cycloplegia.</p>
3.5.1	The spherical, astigmatic and presbyopic components of the correction are measured.	
3.6	Assesses oculomotor and binocular function.	<p>Ability to assess ocular alignment and binocular function in terms of:</p> <ul style="list-style-type: none"> ● manifest deviation (strabismus detection, direction, magnitude, laterality, constancy, comitancy) ● latent deviation (heterophoria direction and magnitude) ● fixation (quality and eccentricity) <p>Ability to assess nystagmus (particularly to determine if nystagmus is an ocular emergency)</p> <p>Ability to use tests/equipment which enable assessment of binocular status, such as:</p> <ul style="list-style-type: none"> ● prisms ● cover test (near/distance) in primary and other direction(s) of gaze ● head tilt test
3.6.1	Eye alignment and the state of fixation are assessed.	

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3.6.2 The quality and range of the patient's eye movements are determined.	Ability to assess versions, vergences and near point of convergence. Ability to make gross assessments of ocular pursuit movements, saccades and ocular motility, giving consideration to the nine positions of gaze and any limitations of gaze. Ability to detect adaptive head postures.
3.6.3 The status of binocularity is determined.	Ability to evaluate the state of binocularity through assessment of parameters such as: <ul style="list-style-type: none"> ● sensory and motor fusion ● suppression ● diplopia ● stereopsis ● amblyopia ● normal and anomalous correspondence.
3.6.4 The adaptability of the vergence system is determined.	Ability to analyse the adaptability of the vergence system through assessment of parameters such as: <ul style="list-style-type: none"> ● fusional vergence ranges ● vergence facility ● near point of convergence ● accommodative convergence to accommodation (AC/A ratio) ● fixation disparity (including curve analysis)
3.6.5 Placement and adaptability of accommodation are assessed.	Ability to analyse the placement and adaptability of accommodation through assessment of parameters such as: <ul style="list-style-type: none"> ● posture of accommodation ● relative accommodation ● accommodative facility ● monocular and binocular amplitudes of accommodation ● AC/A ratio
3.7 Assesses visual information processing.	<p>3.7.1 Visual information processing abilities are investigated and compared to normal values for age.</p> <p>Understanding of methods used to investigate visual information processing abilities and an ability to interpret the results of these tests. Recognition of the need to consider normal developmental milestones and any history of learning problems in a child or his/her family. Recognition of the need to consider any history of suspected or known brain injury or neurological disease in a patient.</p>
3.8 Assesses the significance of signs and symptoms found during the ocular examination in relation to the patient's eye and/or general health.	<p>3.8.1 Pertinent ocular signs and/or visual symptoms found during the ocular examination are identified and their relevance determined.</p> <p>Ability to determine when it is necessary to analyse or refer for analysis of areas such as: <ul style="list-style-type: none"> ● visual spatial skills (laterality, directionality) ● visual analysis skills ● visual motor integration </p> <p>Ability to identify ocular signs and/or visual symptoms and recognise their significance in terms of: <ul style="list-style-type: none"> ● the general welfare of the patient: e.g. social and emotional factors, whether there has been assault/abuse of the patient etc. ● the medical condition of the patient: e.g. possibility or presence of acquired neurological disorders; implications of disorders of spatial confusion, communication and articulation and of short-term memory loss and reduced cognition, etc. ● the management of the patient: e.g. pharmacological interventions that are required or that have contributed to the condition; the need for referral, etc. </p>

- 3.8.2 Significant ocular signs and/or visual symptoms are investigated or referred for further investigation.
- Ability to identify ocular signs and/or visual symptoms that require further investigation and recognise when and to whom to refer for assessment such as:
- carotid auscultation
 - blood sugar level measurement
 - sphygmomanometry
 - thyroid function tests
- 3.8.3 Pertinent non-ocular signs and symptoms found incidentally during the ocular examination are identified and considered.
- Ability to identify non-ocular signs and symptoms and recognise their significance in terms of:
- the general welfare of the patient: e.g. social and emotional factors; whether there has been assault/abuse of the patient, etc.
 - the medical condition of the patient: e.g. the possibility or presence of acquired neurological disorders; the implications of disorders of spatial confusion, communication and articulation and of short-term memory loss and reduced cognition
 - the management of the patient: e.g. pharmacological interventions that are required or that have contributed to the condition; the need for referral etc.
- 3.8.4 Ensures that significant non-ocular signs and symptoms are investigated.
- Ability to recognise when it is necessary to initiate further investigation through referral of significant non-ocular signs and symptoms such as those that require:
- carotid auscultation
 - blood sugar level measurement
 - sphygmomanometry
 - thyroid function tests
 - erythrocyte sedimentation rate (ESR)
 - magnetic resonance imaging (MRI)
 - computed axial tomography (CAT or CT Scan)
 - complete blood count (CBC)

Universal competencies are shown in black.
Therapeutic competencies are shown in blue.

UNIT 4. DIAGNOSIS

Elements	Performance criteria	Some suggested indicators (this is not an exhaustive list)
4.1 Establishes a diagnosis or diagnoses.	4.1.1 Accuracy and validity of test results and information from the case history and other sources are critically appraised.	<p>Universal</p> <ul style="list-style-type: none"> Ability to interpret test data appropriately. Ability to analyse data and equipment for consistency and reliability. Ability to use reference material to assist in diagnosis. Ability to differentiate between refractive, inflammatory, infective, immunologic, metaplastic, neoplastic, dystrophic, degenerative, congenital, neurological, iatrogenic, irritative and traumatic conditions. <p>Therapeutic level</p> <ul style="list-style-type: none"> Ability to interpret results of laboratory tests. Ability to assess how the patient's condition has responded to previous interventions.

- 4.1.2 Test results and other information are analysed, interpreted and integrated to determine the nature and aetiology of conditions or diseases and to establish the diagnosis or differential diagnoses.
- 4.2 Evaluates the expected prognosis of the condition or disease.
- 4.2.1 Information from a number of sources is integrated to determine the expected prognosis of the disease or condition.
- Ability to integrate information from test results, the patient history and reference material.
- Ability to differentiate congenital, developmental, hereditary, and active and resolved pathological changes.
- Ability to differentiate chronic and acute conditions.
- Ability to establish a differential diagnosis.
- Ability to determine when there is a need for additional testing.
- Ability to refer to optometric and other literature to determine the natural progression of diseases and conditions with and without interventions.
- Ability to determine how the patient's condition has altered over time.
- Ability to assess how the patient's condition has responded to previous interventions.

Universal competencies are shown in black.
Therapeutic competencies are shown in blue.

UNIT 5. PATIENT MANAGEMENT

Elements	Performance criteria	Some suggested indicators (this is not an exhaustive list)
5.1 Designs a management plan for each patient and implements the plan agreed to with the patient/carer.	5.1.1 The diagnosis and prognosis are presented and explained to the patient in a manner that the patient can understand.	Use of language understood by patients to advise them of the nature of their condition and its implications and of strategies to assess understanding of key points.
	5.1.2 The relative importance or urgency of the presenting problems and examination findings is determined and addressed in the management plan.	Ability to assess patient understanding of their condition and its management and to provide responses regarding diagnosis and prognosis.
	5.1.3 Management options to address the patient's needs are discussed.	Ability to provide written information about the patient's condition/disease.
		Understanding of the urgency with which treatment/management of the patient's condition should be introduced and how this should be discussed with the patient.
		Understanding of the urgency associated with referral or review of the patient's condition and how this should be discussed with the patient.
		Ability to assess the likelihood of systemic sequelae of the patient's condition.
		Ability to investigate different management options available and suitable for the patient's condition.
		Ability to discuss the aims and objectives of management and the patient's expectations of the different management options.
		Ability to discuss the impact of the patient's condition and its management on the patient's lifestyle and activities, including possible side effects, consequences, complications and outcomes.
		Understanding of the review schedule associated with different management plans and how this should be discussed with the patient.
5.1.4 A course of management is agreed to with the patient, following counselling and explanation of the likely course of the condition, case management and prognosis.		Ability to consider and select from a range of management options such as optical correction (spectacles, contact lenses, low vision aids), vision therapy, pharmacological therapy, task modification, environmental adaptations, referral etc.
		Understanding of the need to make clear recommendations to the patient about management options, to discuss the likely prognosis of the disease with and without treatment/management, and the consequences of non-adherence.
		Ability to provide advice about ongoing care, review, referral, discharge.
		Understanding of the need to discuss repercussions of management options (e.g. the patient's ability to drive or to operate machinery).

<p>5.1.1.5 The informed consent of the patient/carer is sought and obtained for the initiation and continuation of management.</p> <p>5.1.6 Patients requiring ongoing care and review are recalled as their clinical condition indicates and management is modified as indicated.</p> <p>5.1.7 Patients with life- or sight-threatening conditions who do not attend a scheduled review or referral are followed up promptly.</p>	<p>Understanding of the need to provide sufficient information to allow patients to make informed decisions about their management, addressing matters such as presenting complaints, alternative management options, diagnoses, expected duration of treatment, costs, outcomes and limitations of treatment and possible complications and risks.</p> <p>Understanding of the need to answer patient queries and clarify ambiguities and misinterpretations.</p> <p>Ability to recognise situations in which specific informed consent must be obtained from patients and the manner in which this should be documented.</p> <p>Ability to organise and schedule review visits.</p> <p>Ability to modify the management plan based on results obtained.</p> <p>Understanding of how and when recalls are conveyed.</p> <p>Ability to recognise situations in which it is necessary to make contact with the patient to assess progress.</p> <p>Understanding of the need to provide patients with information regarding emergency after-hours numbers or where emergency after-hours care can be accessed.</p> <p>Understanding of the need for the optometrist to check whether patients with life- or sight-threatening conditions have attended a scheduled review or referral and of Optometrists Association Australia guidelines for processes to be followed in this follow-up.</p> <p>Understanding of the need for the optometrist to contact patients with life- or sight-threatening conditions who have not attended a scheduled review or referral to reinforce the need for review/referral.</p> <p>Understanding of the need to consider the physical characteristics (e.g. bridge of nose, ear height) and the visual, recreational and occupational requirements of the patient when determining the suitability of spectacles.</p>
<p>5.2 Prescribes spectacles</p> <p>5.2.1 The suitability of spectacles as a form of correction for the patient is assessed.</p> <p>5.2.2 The patient's refraction, visual requirements and other findings are applied to determine the spectacle prescription and lens form.</p>	<p>Ability to determine the final spectacle prescription through consideration of factors such as:</p> <ul style="list-style-type: none"> ● refraction, near addition and interpupillary distance ● working distances, use, vocational needs ● magnification requirements ● prism requirements ● dispensing requirements and limitations (vertex distances) ● anisometropia ● aniseikonia and incidental optical effects ● vergence accommodation status ● safety spectacle/lens hardening ● special lenses and treatments ● sports requirements ● lens design (single vision, bifocal, multifocal) ● lens materials, tints and coatings ● lens form and specifications ● care regime ● need for Fresnel lenses <p>Ability to describe the modifications necessary to the spectacle prescription as a result of the status of oculomotor and binocular function, perceptual testing and disease status.</p>

APPENDIX 2: COMPETENCY STANDARDS

5.2.3 A spectacle prescription is written in a manner that can be interpreted for correct fabrication of the appliance.	Ability to write a spectacle prescription using appropriate terminology with all the information necessary for correct dispensing (e.g. sphere, cylindrical correction, axes, additions, prism, lens type, interpupillary distance, test vertex distance and special requirements such as lens material and treatments, frame requirements, utilisation).
5.3 Prescribes contact lenses	Knowledge that written spectacle prescriptions should, in addition to containing the information necessary for correct dispensing, include the date, the optometrist's name, signature and practice address, the patient's name and the prescription expiry date.
5.3.1 The suitability of contact lenses as a form of correction for the patient is assessed and discussed.	Ability to determine patient suitability for contact lenses based on consideration of factors such as lifestyle, vocational needs, risk factors, vision, comfort, duration of wear, contra-indications, ocular integrity, physiology and environment, slitlamp and topography/keratometry observations and results of vital staining.
5.3.2 The patient's refraction, visual requirements and other findings are applied to determine the contact lens prescription.	Ability to discuss with the patient issues relating to their suitability or unsuitability for contact lens wear. Understanding of the need to consider factors such as refractive error, working distances, anisometropia, aniseikonia, vergence and accommodation status, corneal topography, special lenses and treatments, sports requirements, incidental optical effects, lens design, materials and tints in determining the contact lens prescription.
5.3.3 Contact lenses are correctly ordered and checked before being supplied to the patient.	Ability to use appropriate trial lenses, fitting techniques and equipment and dyes to assist in determining the contact lens prescription.
5.3.4 Contact lenses with new fitting parameters are assessed on the eye prior to supply to the patient.	Recognition of the need to consider the ability of the patient to handle contact lenses in determining the type of lens to be prescribed.
5.3.5 The patient is instructed in matters relating to ocular health, vision, contact lens care and maintenance and after-care visits.	Ability to recognise contraindications to contact lens wear and to assess their significance in determining the type of lens to be prescribed.
5.3.6 Contact lens performance, ocular health and patient adherence to wearing and maintenance regimens are monitored.	Understanding of which contact lenses are most appropriate for use as a therapeutic or cosmetic device for aniridia, trauma management, occlusion, recurrent erosion syndrome, basement membrane dystrophy etc.
5.3.7 A contact lens prescription is written in a manner that can be interpreted for correct fabrication of the appliance.	Ability to describe the modifications necessary to the contact lens prescription as a result of the status of oculomotor and binocular function, perceptual testing and disease status.
	Understanding of what information is necessary for inclusion on contact lens orders.
	Ability to check that lenses supplied comply with the lenses prescribed.
	Ability to assess visual acuity with lenses, the lens fit, the over-correction, lens centration, lens movement and lid interactions.
	Knowledge of the information and instructions to be provided to patients about factors such as lens wearing time, after-care visits, replacement schedules, insertion and removal techniques, care and maintenance regimens, indications for lens removal, indications for seeking urgent care and risks of non-compliance, including when plano contact lenses are prescribed.
	Ability to recognise and manage contact lens-related conditions.
	Knowledge of the intervals for after-care visits/recalls/reviews.
	Ability to record information to facilitate monitoring of eye health and lens status during contact lens wear.
	Ability to write a contact lens prescription with all information necessary for dispensing, e.g. lens design, powers, diameter, material, curvatures, wearing schedules, care and maintenance regimens.
	Knowledge that the contact lens prescription should include the date, the optometrist name and practice address, optometrist's signature, patient's name and expiry date on the contact lens prescription.

<p>5.4 Prescribes low vision devices.</p>	<p>5.4.1 A range of low vision devices suitable to the patient's needs is selected and demonstrated, where indicated.</p> <p>5.4.2 Low vision devices suited to the patient's visual requirements and functional needs are prescribed.</p> <p>5.4.3 The patient is instructed in the use of prescribed low vision devices.</p> <p>5.4.4 The success of the low vision device is evaluated and monitored and additional or alternative devices or management strategies are prescribed or recommended.</p> <p>5.4.5 The patient is informed of and, if necessary, referred to other rehabilitative services.</p>	<p>Consideration of factors such as working distances, magnification requirements, physical ability of the patient to manage different devices, pathology associated with low vision, incidental optical effects, low vision aid design, special materials, tints, lighting requirements when determining what types of low vision devices may be suitable for the patient.</p> <p>Ability to assess the suitability of aids such as closed circuit television, computer software for low vision, mobility aids, independent living aids, telescopes.</p> <p>Ability to demonstrate and explain the use of low vision devices to the patient.</p> <p>Ability to prescribe a low vision device to meet the needs of the patient.</p> <p>Understanding of the benefit of providing low vision devices for a trial period.</p> <p>Ability to instruct the patient in the use of prescribed low vision devices in terms of working distance, lighting requirements, whether the device is to be used in conjunction with spectacles etc.</p> <p>Understanding of the need for review visits for reassessment of visual performance.</p> <p>Understanding of the need to recommend ongoing primary eye care.</p> <p>Knowledge of organisations offering rehabilitative and other services to patients with low vision.</p> <p>Recognition of the need to inform the patient of rehabilitative services from which they might benefit, e.g. low vision clinics, other health-care practitioners, comanagement and support organisations.</p>
<p>5.5 Prescribes pharmacological, non-pharmacological and therapeutic regimens to treat ocular dysfunction, disease and injury. (At the time of writing the 2008 Standards, not all States had granted optometrists the right to prescribe therapeutic drugs).</p>	<p>5.5.1 Appropriate pharmacological agents are selected and recommended for treatment of the patient's condition.</p>	<p>Universal</p> <p>Consideration of drug actions and interactions, adverse side-effects or allergies in determining non-prescription pharmacologic agents to meet the patient's needs.</p> <p>Adherence to state and federal legal requirements (e.g. Poisons' Act, Optometrists' Registration Acts), when providing advice to the patient on pharmacologic agents.</p> <p>Therapeutic level</p> <p>Ability to interpret and apply current clinical trial findings.</p> <p>Determination of the need for ocular and/or systemic therapy.</p> <p>Ability, when choosing the most appropriate therapeutic agent(s) for the patient, to consider aspects such as:</p> <ul style="list-style-type: none"> ● microbiological factors (e.g. infections, inflammations) ● pharmacological factors (e.g. frequency, dose etc.) ● systemic factors (e.g. allergies, interactions with systemic medications etc.) ● ocular factors (e.g. ocular side effects and effects on the contralateral eye). ● contraindications and side-effects ● issues of antibiotic resistance and quality use of medicines ● diagnosis and prognosis ● available delivery systems (e.g. ointments, drops etc.) ● drug substitution factors (e.g. brand versus generic) ● patient related factors (e.g. dexterity, cognitive state, adherence history) ● understanding of the obligations under the National Health Scheme, the Pharmaceutical Benefits Scheme and the Repatriation Pharmaceutical Benefits Scheme in the prescription of ocular therapeutic medications.

APPENDIX 2: COMPETENCY STANDARDS

- 5.5.2 Ocular therapeutic medications are recommended and a prescription written in a manner that allows accurate supply of the agent.
- Universal**
Understanding of the details to be provided to patients regarding non-prescription ocular medications (e.g. name of medication, how it is to be used).
Use of suitable pharmaceutical reference resources.
- Therapeutic level**
Ability to issue a prescription for ocular therapeutic medication in accordance with federal and state legislation (e.g. name of drug, dosage, how it is to be used and for how long, patient's name, optometrist's name, signature and practice address).
Understanding of legislative requirements regarding general and PBS prescriptions, including comanagement requirements (e.g. glaucoma).
Understanding of legal requirements for record keeping, labelling and dispensing pertaining to therapeutic medications and for storage of any ocular therapeutic medications held by the optometrist.
Ability to use up-to-date pharmaceutical reference material.
Understanding of how to clarify any issues relating to the prescription with the pharmacist.
Understanding of how to store prescription stationery securely.
- 5.5.3 The effect of ocular therapeutic treatment is monitored and appropriate changes in management recommended.
- Universal**
Knowledge of the intervals at which the patient's condition should be reviewed.
Knowledge of the tests to be administered at the patient's review visit.
Knowledge of adverse signs and symptoms and side-effects.
Ability to determine when and how treatment should be modified.
Understanding of when the patient should be referred.
- Therapeutic level**
Ability to alter drug type and dose when necessary, including consideration of comanagement requirements.
Ability to determine the need for additional or alternative medicines.
Ability to determine criteria for the completion of treatment.
- 5.5.4 Patients are instructed on the correct use, administration, storage and disposal of pharmaceutical agents.
- Understanding of the information to be conveyed to patients to describe and demonstrate the correct use of drugs in terms of dose, frequency, timing, method of instillation, hygiene, shaking of bottle etc.
Understanding of the information to be provided to patients regarding shelf-life, storage and disposal of medications.
Understanding of the information to be provided to patients about possible interactions with drugs and other substances.
Understanding of the information to be provided to patients regarding actions to take if adverse reactions occur.
- 5.5.5 Patients are instructed about precautionary procedures and non-pharmacological and palliative management.
- Universal**
Understanding of the information required to counsel patients on non-therapeutic management such as use of sunglasses, lid hygiene procedures, lid scrubs, warm and cold compresses and artificial tears; discontinuation of contact lens wear and/or use of eye make-up.
Understanding of the information required to advise patients of where to obtain alternative care in the optometrist's absence.
- Therapeutic level**
Understanding of the information required to counsel patients regarding the use of eye patches and analgesia.
Understanding of the information required to counsel patients on how to avoid cross-infection and contamination of medication.
- 5.5.6 Patients are instructed in the avoidance of cross-infection.

<p>5.5.7 Non-pharmacological treatment or intervention procedures, therapeutic device fitting and emergency ocular first aid are performed to manage eye conditions and injuries.</p>	<p>Universal Ability to perform non-pharmacologic procedures such as epilation, lid scrubs, lacrimal lavage, irrigation, superficial foreign body removal. Ability to provide emergency management of trauma to the eye and adnexae.</p> <p>Therapeutic level Ability to perform procedures such as punctal occlusion, expression of meibomian glands, insertion of punctal plugs, corneal debridement, embedded foreign body removal etc. Ability to use bandage contact lenses when necessary to manage eye conditions.</p>
<p>5.6 Dispenses spectacle prescriptions accurately.</p>	<p>Ability to resolve ambiguities in optical prescriptions. Understanding of the requirements for dispensing of spectacle prescriptions described in the Australian Standard: AS 2228.1-1992: Spectacles—Spectacle lenses. Ability to assist the patient to select a suitable spectacle frame. Understanding of the advice to be provided to patients on the appropriate lenses and lens treatment for their needs. Ability to take measurements for bifocal, multifocal and varifocal spectacles. Understanding of the process to edge lenses and mount them in the frame appropriately. Ability to check frames and uncut or mounted lenses for damage and for compliance with the prescription. Understanding of standards that apply to spectacle frames and lenses.</p>
<p>5.6.1 The spectacle prescription is interpreted and responsibility for dispensing accepted.</p>	<p>Ability to verify the accuracy and quality of the final spectacles in accordance with the Australian Standard AS 2228.1-1992: Spectacles—Spectacle lenses, e.g. optical centres, powers, parameters of near addition(s), treatments.</p>
<p>5.6.2 The patients are assisted in selecting appliances that are suitable for their needs.</p>	<p>Ability to fit spectacles to the patient to optimise comfort and performance. Understanding of the information to be provided to patients regarding the correct use of spectacles, spectacle maintenance and possible adaptation effects.</p>
<p>5.6.3 Relevant measurements pertaining to the spectacle frame are made, lenses are ordered and finished spectacles are verified according to Australian Standards.</p>	<p>If vision therapy is provided, understanding of:</p> <ul style="list-style-type: none"> ● the sequence of vision therapy ● the time frame for treatment ● discharge criteria ● the need to supply/lend material for vision therapy programs <p>If unable to provide vision therapy, understanding of the need to refer the patient to a suitable practitioner for vision therapy.</p>
<p>5.6.4 The appliance is verified against the prescription prior to delivery.</p>	<p>If vision therapy is provided, understanding of the need to:</p> <ul style="list-style-type: none"> ● ensure that the patient understands the process ● provide written instructions ● supply/lend material for vision therapy programs <p>If vision therapy is provided, understanding of the time frame, expected results, discharge criteria and costs.</p>
<p>5.6.5 The appliance is adjusted and delivered and the patient is instructed in the proper use and maintenance of the appliance and of any adaptation effects which may be expected.</p>	<p>5.7.1 Patients with accommodative, vergence, strabismic and amblyopic conditions are treated or referred for treatment.</p>
<p>5.7 Manages patients requiring vision therapy.</p>	<p>5.7.2 The patient is instructed in the use and maintenance of vision training equipment.</p>
<p>5.7.1 Patients with accommodative, vergence, strabismic and amblyopic conditions are treated or referred for treatment.</p>	<p>5.7.3 Goals of the vision therapy program and criteria for discharge are set.</p>

APPENDIX 2: COMPETENCY STANDARDS

5.7.4	Progress of the vision therapy program is monitored.	If vision therapy is provided, understanding of the time when review visits should be provided and the tests to be performed.
5.8	Provides legal certification.	Understanding of the situations in which a certificate for sick leave can be provided by an optometrist and what information must be recorded on the certificate.
5.8.1	A certificate for sick leave is provided.	Understanding of the situations in which a statutory declaration can be witnessed by an optometrist and what information must be recorded on the declaration.
5.8.2	Statutory declarations are witnessed.	Understanding of situations in which the patient requires the services of another optometrist, another health care practitioner or another professional.
5.9	Refers the patient.	Understanding of personal limitations when determining the need for referral.
5.9.1	The need for referral to other professionals for assessment and/or treatment is recognised, discussed with the patient and a suitable professional is recommended.	Understanding of the need to consider the scope and limitations of services provided by health and other professionals (e.g. welfare, education) when determining to whom the patient should be referred.
5.9.2	Timely referral, with supporting documentation, is made to other professionals.	Ability to determine the type of practitioner to whom the patient should be referred.
5.9.3	Patients can be jointly managed with other health care practitioners.	Ability to access contact details of other health professionals.
5.10	Co-operates with ophthalmologist/s in the provision of pre- and post-operative management of patients.	Understanding of the need to consider the experience and location of the practitioner to whom the patient is to be referred.
5.10.1	Pre-operative assessment and advice is provided.	Recognition of the need to consider the urgency of the patient's condition when arranging a referral.
5.10.2	Post-surgical follow-up assessment and monitoring of signs according to the surgeon's requirements and the procedure are undertaken.	Ability to convey appropriate information to the practitioner to whom the patient is referred through a suitable means, e.g. telephone, referral letter.
5.10.3	Emergency management for observed post-surgical complications is provided.	Understanding of the requirements for participation in the comanagement of patients with other health professionals.
5.10.4	Appropriate referral for further post-operative treatment or assessment of complications is arranged.	Understanding of the roles and responsibilities of different practitioners in comanagement arrangements.
		Understanding of the need to consider the patient's condition and expectations of surgery and to discuss risks, benefits, costs, complications and options.
		Understanding of how effective communication can be instigated with the ophthalmologist(s).
		Understanding of local waiting list length and costs.
		Understanding of indications and contraindications for surgery.
		Understanding of current laser refractive error correction, cataract extraction and other surgical/non-surgical procedures.
		Understanding of standard post-operative monitoring protocols and pharmacological regimens.
		Understanding of the normal course of recovery and the need for urgent/non-urgent referral back to the surgeon.
		Ability to recognise the situations in which emergency management is necessary for a post-surgical complication.
		Understanding of how to institute appropriate emergency management.
		Ability to recognise when there is a need for further post-operative treatment or further assessment of complications.
		Understanding of the need to differentiate between urgent and non-urgent post-operative referral to the surgeon.

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| <p>5.11 Provides advice on vision, eye health and safety in the workplace and recreational settings.</p> | <p>5.11.1 Vision screenings for occupational or other purposes are provided.</p> <p>5.11.2 Advice is provided on eye protection, visual standards and visual ergonomics in the workplace and recreational settings.</p> | <p>Understanding of the optometric testing procedures necessary for a vision screening.</p> <p>Understanding of the billing procedures relevant to vision screening in relation to Medicare.</p> <p>Determination of screening protocols based on the group targeted in the vision screening.</p> <p>Ability to perform industrial and environmental analysis to determine the need for radiation protection, safety lenses, tinted safety lenses etc.</p> <p>Understanding of the advice on eye protection to be provided in industry and for recreational pursuits.</p> <p>Understanding of the advice to be provided on lighting and ergonomic design in the workplace and for recreational pursuits.</p> |
| <p>5.11.3 Individuals are counselled on the suitability of their vision for certain occupations.</p> | <p>5.11.3 Individuals are counselled on the suitability of their vision for certain occupations.</p> | <p>Understanding of lighting and vision standards for their application in industry and for recreational pursuits.</p> <p>Understanding of industry and other occupational requirements for colour vision, visual acuity, spectacle powers, etc.</p> <p>Ability to communicate with employee and employer organisations.</p> |
| <p>5.11.4 Certification of an individual's visual suitability for designated occupations or tasks is provided.</p> | <p>5.11.4 Certification of an individual's visual suitability for designated occupations or tasks is provided.</p> | <p>Understanding of the visual and ocular requirements specified in any standards relating to a particular activity (e.g. driving) and how these standards can be applied to determine the suitability of a person for a particular activity.</p> <p>Understanding of the requirement when certifying suitability of a person for a specific occupation/task through the preparation of a report that includes relevant information.</p> <p>Ability to access vision standards for different occupations.</p> |
| <p>5.11.5 The patient or parent/guardian is advised of the presence of conditions that have implications for other family members.</p> | <p>5.11.5 The patient or parent/guardian is advised of the presence of conditions that have implications for other family members.</p> | <p>Understanding of patient conditions that have ramifications for other family members in terms of the need for them to have a medical or optometric assessment.</p> |

Universal competencies are shown in black.
Therapeutic competencies are shown in blue.

UNIT 6. RECORDING OF CLINICAL DATA

Elements	Performance criteria	Some suggested indicators (this is not an exhaustive list)
<p>6.1 Records patient information and data in a legible, secure, accessible, permanent and unambiguous manner.</p>	<p>6.1.1 All relevant information pertaining to the patient is recorded promptly in a format which is understandable and useable by any optometrist and his/her colleagues.</p>	<p>Universal Understanding of the need to create a separate, distinct record for each patient either in paper form or electronically.</p> <p>Ability to create records that are legible and can be interpreted by another optometrist.</p> <p>Knowledge of the information to be included on/with the patient record, e.g. the patient's name and address, the name of the examining practitioner, the patient history, procedures performed, clinical observations and results of all tests performed, diagnoses, management strategies, summary of advice given to the patient, photographic and video information for all consultations, dates and information relating to all patient contacts, timing of review.</p> <p>Understanding of the need to include copies of referral letters and reports with the patient record.</p> <p>Knowledge of accepted abbreviations and grading scales to be used in optometric records.</p> <p>Therapeutic level Understanding of the need to include details of medications prescribed, microbiological tests and results and modifications to management on the patient record.</p>

APPENDIX 2: COMPETENCY STANDARDS

6.1.2 Patient records are kept in a readily retrievable format and are physically secure.	Recognition of the need for storage systems for patient records that ensure security but allow easy access by the optometrist or authorised practice staff.
	Recognition of the need to ensure that records are filed correctly and that staff understand the filing system.
	Recognition of the need to use appropriate firewall, virus protection and back-up systems to safeguard computer records.
	Recognition of the need to initial and date corrections to patient records for paper records.
	Recognition of the need to provide an electronic method to show corrections and modifications to electronic records.
	Understanding that non-authorised persons must not access patient records.
	Understanding that confidentiality of patient information is to be safeguarded.
	Recognition of the need to maintain records in accordance with clinical standards and the law.
	Understanding of the legal requirements related to confidentiality and privacy and health records.
	Recognition of the need to obtain patient consent for the release of their personal information or the transfer of the patient record or a copy of a patient record.
	Recognition of the right of the patient to access his or her patient record.
	Recognition of the right of the patient to have a summary or a copy of their patient record.
	Understanding of privacy and security requirements when patient information is communicated to others through electronic transfer, facsimile transmission or via telephone communication.
	Knowledge of the minimum periods by law for which patient records must be kept in the case of children and adults.
	Understanding that processes to archive or destroy patient records must ensure privacy of patient information.
	Knowledge of the minimum period by law for which practice documentation such as appointment books and therapeutic prescriptions must be kept.
6.2 Maintains confidentiality of patient records.	
6.2.1	Access to records is limited to authorised personnel.
6.2.2	Information from patient records and/or obtained from patients is released only with the consent of the patient.
6.2.3	The rights of a patient to access his or her patient record are understood and observed.
6.2.4	Patient privacy is addressed when patient information is transferred.
6.3 Meets legislative requirements regarding retention and destruction of patient records and other practice documentation.	
6.3.1	The requirements regarding the retention of records for adults and children under the age of 18 years are understood and observed.
6.3.2	The requirements regarding archiving or destruction of records to ensure patient privacy are understood and observed.
6.3.3	The requirement for the retention of practice documentation other than patient records is understood and observed.

