Public consultation on revised guidelines

September 2015

Responses to consultation questions

Please provide your feedback as a word document (not PDF) by email to optomconsultation@ahpra.gov.au by close of business on 20 November 2015.

Stakeholder details

If you wish to include background information about your organisation please provide this as a separate word document (not PDF).

Organisation name
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Your responses to consultation questions

Proposed revised guidelines for continuing professional development for endorsed and non-endorsed optometrists *Please provide your responses to any or all questions in the blank boxes below*
1. Are they clear and easy to understand?
Yes, but too wordy in general.

Proposed revised guidelines for continuing professional development for endorsed and non-endorsed optometrists

Please provide your responses to any or all questions in the blank boxes below

2. Is there any content that needs to be changed or deleted?

Page 7 section 2 mentions “specialisation”. Given the board prevents the use of specialist and frowns upon “specialisation I would be careful using the word in this document.

Page 9 Section 3. Table 2 Bullet 3 "approved training providers” - give reference to page 10 to find them or attach an appendix and reference it.

Page 9 Section 6. Table 2 Bullet 6 “CDP portfolio” - rather than publish somewhere else on the website as noted on page 11, attach it as an appendix and reference it. Many optometrists seem unaware of this part of the CPD requirement.
Page 16 section A4 “minimum of three learning objectives” should be made clear at the beginning of presentation to delegates and assessment questions based around the objectives

Some sections seem to be a little repetitive eg on page 12, Section 4 Absence from practice – second sentence is repeated in 4th paragraph etc

In Appendix A1 on page 15 –

“Clinical Activities must deal with ocular conditions, systemic conditions with ocular side effects, vision and visual perception, optometric management and/or ophthalmological management”
– the “optometric and/or ophthalmological management” I assume relates to the previously listed items, not practice management/ non clinical activities? This could be rewritten to improve clarity to:

Clinical Activities must deal with optometric and/or ophthalmological management of ocular conditions, systemic conditions with ocular side effects, vision and visual perception.

3. Is there anything missing that needs to be added?

It is a requirement for 6 MCQs/hour for accredited Face-to-Face CPD activities but 10 MCQs per hour for independent learning activities. Why the difference in assessment requirements? This is not explained in either the Public Consultation Paper nor the CPD Provider Manual document.

4. Are there any practical issues encountered for the assessment of CPD activities?

Consideration needs to be given to the whole MCQ test concept and its role in enhancing the learning outcomes.

If the minimum requirement of 6 MCQ's per hour is provided, then a delegate can afford to have only one incorrect answer in order to achieve the stipulated pass mark of 70%, and this seems unreasonably hard.

On the issue of providing extra points for assessment following a lecture:

- page 17 under section A6, it states that for the additional CPD point for assessment to be allocated, the assessment component must "provide a follow-up opportunity for

participants to redo the assessment".

This is not consistent with the OBA's "Continuing professional development provider manual" document, on Page 8 (Assessment) the provision for re-testing is not mentioned.

Adult learning theories are very clear in suggesting we learn best when we make mistakes and then repeat the task after reflection. In practice, the same MCQ are simply given again to the applicants and they just get 2 goes at guessing the 1 in 4 MCQ. Stronger and practical guidelines would need to be instigated to actually accomplish what the educational theory calls for: if an applicant fails they should be given a different test to re-sit after reflection on the answers. (Simply repeating the same questions does not add value to the learning experience).

Overall we feel providing re-testing opportunities is unduly onerous on CPD providers (as to do this properly this would necessitate development of supplementary questions for each CPD activity as mentioned above).

Ideally the attendees should have appropriate access to the presented material before submitting (or resubmitting) the assessment questions. This is done very well eg at the TLC OA Tasmania conference but may be difficult for smaller providers and one off events.

A general comment is that provision of questions is rarely done well- they can be so detailed that only an autistic savant would have remembered or spotted the answer in the nanosecond that the appropriate slide is put up, so basic as to be a waste of time, or due to presenter's lack of time, the material has not been covered in the actual lecture.

The issue of double negatives and just poorly worded questions is an additional challenge. Often this makes the MCQ more English comprehension tests rather than knowledge tests. Many providers do not have the appropriate skill base to design appropriate assessment questions (despite coming from academic backgrounds).

Our observations from attending numerous CPD events is that many MCQ questions tend to be too wordy, or too simple, or too esoteric, and, after the test is completed, any discussion of the correct and incorrect answers by the presenters is absent or minimal, thus making the whole exercise of little value as a genuine learning experience.

Assessment is generally poorly conceived, tests low level skills (basic knowledge recall rather than higher level analytical/ critical thinking/ clinical decision making) and too many presenters blatantly tell their audience what the questions/ answers will be. Consideration should be given to adding to Table A2 a specific guideline to say that questions should focus on points which are clinically relevant (ie questions should not be based around nitpicky facts with little clinical relevance but designed to help you make appropriate clinical decisions e.g. the number of the pores within the trabecular meshwork may well be ~20,000 but this is not going to help the average optometrist who is differentiating between POAG and PDS)

Presenters should be prohibited from identifying questions/answers in their presentations by

drawing attention to them with symbols on slides or direct comments.

The best experiences the panel has had with assessment questions have been when the presenter has taken the time to go thru the answers with a brief explanation of the pros and cons of each option- a true learning opportunity (but this is really the exception as a large number of providers are not doing this).

5. Do you have any other comments?

It would be worthwhile to try to simplify the CPD system, for both optometrists and administrators, e.g. by reviewing whether it is necessary to track some types of accredited CPD activity (namely, independent learning, academic, and non-clinical).

We feel that that promoting an event as an opportunity to get all your points in one sitting is contrary to the intention of the OBA CPD requirements.

When advertising their CPD events, the CPD providers should be discouraged from using such terms as "obtain all your CPD points in one go" or "obtain 30 points in one day", etc. It might be worthwhile for the OBA to suggest that CPD program schedules have no more than X hours of attendance per day, and X hours of breaks per Y hours of presentations.

We feel that the allocation of 20 points over 2 registration periods for activities related to optical goods and equipment provided by suppliers or manufacturers is too high. Rarely are they anything more than an opportunity for promotion for the organisation presenting, dressed up as a “clinical” meeting. From this point of view we would like to see the number of points allocated to these events capped at say 1 point, and additional MCQ and attached points not being appropriate so not available for this type of function.

Where the supplier is confident that their presentation does meet the clinical guidelines then some mechanism for an independent assessment could be provided as an exception. (eg if an ophthalmologist has been employed to talk on advanced OCT etc)

On page 29: requirement for accredited CPD providers to renew annually. This sounds unduly onerous when there are surely limited changes occurring in these institutions? Should a longer accreditation period be considered (eg 2-3 years?)

The CPR requirement is inconsistent with the evidence based practice that we are all meant to strive to accomplish. Current evidence suggests that delivery of CPR by non-medically trained personnel has a small (2%) chance of contributing to patient survival. It appears AHPRA is driving this requirement but it is also incongruous that the requirement is to refresh CPR skills every 3 years (which is at odds with the 1 year recommendation by providers and many non-AHPRA associated professions – eg construction workers). This entire policy seems to lack an evidence base and might benefit from a revisit.

Current definition of CPR on page 13 is wrong - current guidelines for adults only recommend chest compressions. Only in children are rescue breaths recommended and even then they may be moving away from this for kids too.

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In table 3 on page 10: Exactly what constitutes therapeutic education has been a little nebulous at some CPD events. Could greater clarity be provided here? Eg a contact lens company presentation suggesting that a new self-moisturising lens that could reduce dry eye symptoms could well be turned into a therapeutic event. For therapeutic points it MUST discuss THERAPEUTIC management (it is ok for the therapeutic management plan to not involve delivery of an S4/S3/OTC medicine in the end but it should be core to the clinical considerations).

Many of the learning objectives seen at CPD events are quite diffuse. Ideally they should follow some kind of hierarchal classification (eg Bloom's) and given they are being presented to registered optometrists they should really be operating at the higher level domains (eg analytical / creative domains rather than knowledge recall / simple description. This is recommended but in practice not achieved.

Points allocation: There should be an absolute requirement that the applicant must be present in the room (for face to face assessment) and not having coffee while their mate presses 10 clickers in rapid succession. This is a major loophole in the current system and is ubiquitous to every conference that I've been to over the last few years where clickers are used. The system which is used by the American Academy of Optometry may help in making sure that people actually attend the lectures and it is really effective.

You must be in the room within 10 mins of the talk commencing to get the points. (they hand out a slip that you stick your personalise barcode onto until 10 mins after the lecture starts. You are welcome to enter later but you don't get a slip and therefore no points for you… oh and your mate can't take 10 slips and stick everyone's barcode onto them- it's one slip given out per person)

You can't leave the room within 5 mins of the talk ending to get the points. (they only collect the slip plus barcode at the defined time and if not collected then no points and again you can't drop off a wad of completed slips)

Proposed revised guidelines on the prescription of optical appliances

Please provide your responses to any or all questions in the blank boxes below

6. Are they clear and easy to understand?

7. Is there any content that needs to be changed or deleted?

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8. Is there anything missing that needs to be added?

9. Do you have any other comments?

- p23 "Guidelines on the prescription of optical appliances" point 1a mentions that a person must not prescribe an optical appliance unless the person is an optometrist or medical practitioner.

Should an overt reference or clarification be made to ophthalmologist instead of leaving it as broad as "medical practitioner", to reflect adequate training and expertise in prescribing.

- page 24 "Spectacle Prescriptions"

  Optometrists are not generally expected to include the PD in a prescription for spectacles. However, the PD should be provided if it is specifically requested

Could we consider substituting "may" instead of "should" in this paragraph to make the requirement somewhat less emphatic. It is a minor point, but may address some sensitivity expressed by certain optometrists in providing PDs for spectacles that may be dispensed through other less-regulated channels (eg. online).