BRITISH AND IRISH ORTHOPTIC SOCIETY

Competency Standards

and

Professional Practice Guidelines

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Introduction

In 1999 in response to concerns within the profession, the Professional Development Committee undertook the development of national standards and guidelines for the Orthoptic profession. Competency standards from Australia, Britain and Canada were reviewed by the Professional Development Committee and the original BOS (now BIOS) Competency Standards and Professional Practice Guidelines document was produced.

The development of competency standards established objectives for optimum standards of Orthoptic practice, consistent with good clinical outcomes. A standard approach to management of Orthoptic services, education and professional development and Orthoptic practice is important to ensure delivery of quality care.

These standards and guidelines were developed with the intention that they be implemented in departments of varying size, providing different services, and which manage their Orthoptic service either independently or in complete/partial liaison with the Ophthalmology service.

The process of development of the standards and guidelines involved the identification of appropriate Orthoptic practice from a departmental and clinical perspective. Liaison was maintained with the Health Quality Service during that time. The standards and guidelines were then released as a two phase pilot study to twelve centres. The final document was approved by the Professional Development Committee and ratified by the council of the British Orthoptic Society in 1999.

A review of the original Competency Standards and Professional Practice Guidelines document was carried out by the BIOS Professional Development Committee in 2007 and in 2014. The Professional Development Committee recognises and wishes to thank all those who contributed to the original document.

Throughout the development of The Orthoptic Competency Standards and Professional Practice Guidelines document, the intention was to provide a framework within which professional judgement may be exercised. This is particularly relevant to the provision of guidelines for practice rather than prescriptive standards. Individual departments may further develop these guidelines for assessment and management of specific types of strabismus and ocular motility disorders. Within the document essential standards indicate those which must be in place in Orthoptic departments. Desirable objectives indicate those which represent good practice. Guidelines also indicate good practice but allow for individual practice and development within these objectives. Of note, not all objectives are applicable in every department but are dependent on the type of service offered and local circumstances.

Once the standards and guidelines have been introduced to a department, it is necessary to evaluate the department's compliance in achieving each standard and in working towards guidelines. Measures of compliance may include documentation of policies and

procedures within the department, audit of administrative procedures or practice, case note review or peer review. Further examples of such measures are provided for each section of this manual.

Section 1 includes essential and desirable standards relating to management of the Orthoptic service and section 2 includes those standards relating to staff development, education and professional responsibilities. Section 3 relates to the standards required for patient care and section 4 provides guidelines for Orthoptic practice.

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

SECTION 1

MANAGEMENT

Aim Each service should be efficiently and effectively organised, managed and staffed to achieve its objectives.

1.1 Administration

1.2 Orthoptic department design

1.3 Staffing

1.4 Policies and procedures

1.5 Quality management and evaluation

1.1 ADMINISTRATION

Overview

This section describes the attributes that are needed for efficient performance in the workplace. It reflects aspects of record maintenance, practice management and quality control.

Essential standards

1.1.1 Data is collected for statistical purposes, e.g. patient attendance, failure to attend, new and old patient numbers.

1.1.2 Full clinical records, which may be paper based or electronic, are maintained for effective clinical management containing up to date patient details, Orthoptic investigations, treatment plan (written details of patient treatment at each visit or on separate treatment sheet) and follow up details (next appointment scheduled and any additional appointments to be attended), thus guarding against medico-legal action due to inaccuracy in case notes. All entries to the notes should be written in black ink or in line with local policy and signed with name, time patient seen and designation written/stamped in print by the Orthoptist.

1.1.3 New members of staff attend staff induction training which includes acquaintance with department and trust policies and procedures. Preceptorship for new graduates if available.

1.1.4 The Orthoptic manager and staff follow designated policies and procedures of the hospital/trust, e.g. patient referral/discharge procedures in order to achieve effective practice.

1.1.5 Management strategies that minimise patient waiting time are implemented.

1.1.6 Suitable vision screening facilities are provided if required (e.g. equipment, associated administrative assistance, suitably experienced staff) with clear guidelines available on the tests to be performed and on pass/recall/refer criteria. The referral procedure is documented and appropriate information provided for the patient/carer and to the referee.

Measures

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

Documentation of trust and departmental policies and procedures which deal with patient's visits and department management.
Audit of patient visits and notes.
Induction programmes.
Waiting times audit.
Evaluation of monthly statistics records.

1.2 ORTHOPTIC DEPARTMENT DESIGN

Overview

The design of the Orthoptic department enables a full and appropriate Orthoptic assessment to be performed and where applicable, assessment of visual fields, auto-refraction, LVA, etc.

1.2.1 Essential standards;

1.2.1.1 The working environment in the Orthoptic department must comply with Health and Safety regulations.

1.2.1.2 The design provides sufficient room to facilitate the teaching of students and other professionals if undertaken.

1.2.1.3 Clinical hand-washing facilities are provided.

1.2.1.4 Wheelchair access complies with Health and Safety requirements and the Disability Discrimination Act 1995 (Northern Ireland) and the Equality Act 2010.

1.2.1.5 The availability of equipment and resources in practice is monitored.

1.2.1.6 Equipment in practice is maintained in good working order and hygienic condition.

1.2.1.7 There is uninterrupted viewing of a LogMAR chart (gold standard) or Snellens chart at the appropriate test distance.

1.2.1.8 There is uninterrupted viewing of appropriate distance and far distance fixation targets.

1.2.1.9 Appropriate lighting conditions are provided with minimum illumination of 100 lux for standard background illumination.

1.2.1.10 Additional chairs are provided for parents/carers/interpreters.

1.2.1.11 There is a suitable waiting area provision for children following local and national requirements

1.2.2 Desirable objectives;

1.2.2.1 The design meets reception/secretarial requirements dependent on local policy.

1.2.2.2 The Head Orthoptist has office space.

1.2.2.3 There is one workstation per Orthoptist for each clinical session.

1.2.2.4 The table top is of a minimum 1.2m wide by 0.75m depth.

1.2.2.5 Equipment storage is available.

1.2.2.6 Occlusion patches storage is available.

1.2.2.7 Height adjustable chairs are provided for the Orthoptist and patient with back adjustment for Orthoptic chairs.

1.2.2.8 There are Orthoptic staff liaison and rest facilities.

Measures

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

Written statement of what is available in the department which could be inspected at random.
Department plan.
Up-to-date equipment inventory.

1.3 STAFFING

Overview

The Orthoptic service is provided and staffed by qualified members of the profession. Members practising within the UK must be registered with the Health and Care Professions Council (HCPC).

1.3.1 Essential standards;

1.3.1.1 A comprehensive current record for each member of staff is kept in a secure location which includes:
- 1.3.1.1.1 Personal details,
- 1.3.1.1.2 Copy of contract,
- 1.3.1.1.3 Job description,
- 1.3.1.1.4 Professional registration details,
- 1.3.1.1.5 Staff absence/leave details,
- 1.3.1.1.6 Professional development plans and KSF outline, if applicable.
- 1.3.1.1.7 Disciplinary details where applicable,
- 1.3.1.1.8 Designations and example signature,
- 1.3.1.1.9 Enhanced disclosure record

1.3.1.2 All unqualified staff (Orthoptic, medical, nursing students), trainees or assistants/technicians working within the service are under the supervision of a registered member of staff.

1.3.2 Desirable objectives

1.3.2.1 A designated mentor is allocated to new graduates or Orthoptists returning to the profession.

Measures

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

Written staff records on file which may be updated following staff appraisals.
Policy relating to 1.3.1.2.
All staff should be aware of to whom they are responsible.
Students should have and be aware of a designated Orthoptist assigned to them.

1.4 POLICIES AND PROCEDURES

Overview

Written policies and procedures which reflect current professional knowledge and principles are kept. These are consistent with relevant regulations and the objectives of the service and are used by staff to guide them in their activities. These policies and procedures are essential standards.

1.4.1 Policies relating to staff include;

1.4.1.1 Supervision of qualified and unqualified staff.

1.4.1.2 Health and safety in line with hospital/trust policy and Health and Safety at Work Act 1974.

1.4.1.3 Storage and handling of equipment.

1.4.1.4 Fire policies.

1.4.1.5 Child protection policy.

1.4.1.6 Drug policy (use, storage, risk assessment, Patient Group and/or Patient Specific Directives).

1.4.1.7 Equality and Diversity.

1.4.1.8 CPR Policy.

1.4.1.9 Infection control policy.

1.4.2 Procedures relating to staff include;

1.4.2.1 Annual leave.

1.4.2.2 Sick leave.

1.4.2.3 Complaints procedure.

1.4.2.4 Grievance procedure.

1.4.2.5 Discipline procedure.

1.4.2.6 Family friendly working/work life balance.

1.4.2.7 Critical Incident Reporting.

1.4.2.8 Locally lead personal development review procedure.

1.4.3 Policies relating to patients include;

1.4.3.1 Patient confidentiality.

1.4.3.2 Documentation in accordance with Data Protection Act.

1.4.3.3 Patient safety.

1.4.3.4 Freedom of Information Act.

1.4.4 Procedures relating to patients include;

1.4.4.1 Referral to, and discharge from, the service.

1.4.4.2 Reporting back to the referrer.

1.4.4.3 Information issued to patients e.g. leaflets on strabismus and amblyopia.

1.4.4.4 Recording of care given.

1.4.4.5 On-going care e.g. referral systems inside and outside the hospital/trust.

1.4.4.6 Failure to attend/Did Not Attend and Can Not Attend.

1.4.4.7 Complaints procedure.

Measures

Measures should be reviewed annually and staff required to sign as evidence they have read and are aware of these. Methods that may be used to determine compliance with the above may include;
Written evidence of policies and procedures.
Statement documented in patient records as to when patients required referral to other specialities and when need to be seen in ophthalmology clinic.
Record of complaints, action and outcome.
Audit of practice.

1.5 QUALITY MANAGEMENT AND EVALUATION

Overview

Clinical audit and evaluation of compliance with departmental and local and national policies are undertaken by the service and are consistent with the quality improvement strategy.

Essential standards;

There is evidence that quality indicators are reviewed on a service wide basis including:

1.5.1 Failure to attend policies (both DNA and CNA).

1.5.2 Inappropriate referrals e.g. tonometry appointment booked as Orthoptic assessment.

1.5.3 Pre-appointment waiting times in compliance with local and/or national standards.

1.5.4 Post-appointment waiting times in compliance with charter standards (length of time patients wait in clinic before seen). Audit of waiting times in clinic i.e. time of appointment compared to time seen.

1.5.5 Discharge (planned, appropriate and co-ordinated).

Measures

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

Audit of practice and waiting times.
Patient questionnaire.
Audit of discharge policy.
Evidence of policies and procedures.

SECTION 2

STAFF DEVELOPMENT, EDUCATION AND PROFESSIONAL RESPONSIBILITIES

Aim Quality clinical education is provided for Orthoptic undergraduates. Continuing professional development is essential for qualified Orthoptists in order to maintain registration with the governing body and quality of care in the profession.

2.1 Education

2.2 Professional development

2.3 Education of the patient/public and health professionals

2.1 EDUCATION

Overview

This section addresses the provision of clinical education for Orthoptic undergraduates.

Essential standards;

2.1.1 All Orthoptic students are given clinical teaching in accredited clinical education centres which fulfil BIOS criteria and HCPC standards of education and training (standard 5). The teaching must be at the correct level for their abilities with respect given to the patients' rights at all times. A 1:1 or 1:2 tutor:student ratio should be utilised.

2.1.2 The student curriculum and clinical objectives are made available to all Orthoptic staff involved in clinical teaching.

2.1.3 Time is allocated for students' clinical teaching in the clinic, such as tutorials and demonstrations, consistent with the aims and learning outcomes from the University.

2.1.4 Patient records are assessed to determine their suitability for the student.

2.1.5 The patient/carer is asked prior to the student testing him/her if they are willing to participate in clinical teaching.

2.1.6 The student is supervised by a qualified Orthoptist at all times. Supervising orthoptists must be deemed competent to supervise students by the clinical tutor and Head of Department.

2.1.7 Any entries made into the case record by the student are signed, and then countersigned by a qualified Orthoptist.

2.1.8 Patients are not seen at every visit by students e.g. on the third consecutive visit, the patient is seen by a qualified member of staff.

Measures

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

Written policy of student activity.

Timetable examples.
Appraisal of information provided to staff prior to receiving students.
Notice for patients informing them of student attendance.
Student evaluation forms (provided by the University)

2.2 PROFESSIONAL DEVELOPMENT

Overview

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

2.2.1 Essential standards;

2.2.1.1 Orthoptists are responsible for maintaining their professional Orthoptic standards and working within the ethical code of practice (Declaration of Helsinki and for members practising in the UK the HCPC standards of proficiency). This ensures quality assurance for the Orthoptic profession.

2.2.1.2 Orthoptists ensure Orthoptic knowledge and clinical experience remain at a professional level.

2.2.1.3 Orthoptists maintain a record of professional development evidence. Orthoptists practising in the UK must adhere to the HCPC standards for Continuing Professional Development.

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

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

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

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

Measures

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

The onus is on the individual to record professional development evidence. The Head Orthoptist is responsible for Personal Development Review (PDR) process in line with the requirements of KSF or equivalent review system to determine training needs and to allocate courses and places at conferences. This should be kept on record with staff details. Allocation of courses and places at conferences is largely dictated by the financial constraints of the service and will vary locally.

2.3 EDUCATION OF THE PATIENT/PUBLIC AND HEALTH PROFESSIONALS

Overview

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

2.3.1 Essential standards for education of patient/public;

The Orthoptist…

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

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

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

2.3.2 Desirable objectives for education of patient/public;

The Orthoptist...

2.3.2.1 Provides information about further assessment procedures to be performed.

2.3.2.2 Educates the patient or carer about his/her condition and its effect on the individual.

2.3.2.3 Provides information on the range of eye care services and agencies available to the patient and the community in line with local/national policy.

2.3.2.4 Provides information to the community about the practice of Orthoptics and its place in the allied health system.

2.3.3 Desirable objectives for education of health professionals;

The Orthoptist...

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

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

2.3.3.3 Uses methods of information dissemination such as in-service talks and lectures.

Measures

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

Written report in case notes of information given verbally or in written format to the patient.
Examples of patient leaflets or posters.
Patient questionnaire.
Evidence of programmes of lectures/training provided by the Orthoptic service.

SECTION 3

PATIENT CARE

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

3.1 Patient interview

3.2 Patient assessment

3.3 Diagnosis

3.4 Management

3.5 Recording of clinical data

3.1 PATIENT INTERVIEW

Overview

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

3.1.1 Essential standards;

3.1.1.1 The intellectual needs of the patient are considered and communication techniques adjusted accordingly to best meet the patient's needs.

3.1.1.2 The language needs of the patient and/or carer are considered.

3.1.1.3 Questions and statements are phrased so that adequate information can be elicited.

3.1.1.4 Information gained in interview is recorded accurately and concisely and may include:

- 3.1.1.4.1 Name, address, date of birth
- 3.1.1.4.2 GP and address
- 3.1.1.4.3 Relationship of carer to patient and their name
- 3.1.1.4.4 Occupation//Child's School
- 3.1.1.4.5 Source of referral
- 3.1.1.4.6 Reason for attendance
- 3.1.1.4.7 Family history
- 3.1.1.4.8 General health
- 3.1.1.4.9 Birth history
- 3.1.1.4.10 Previous ophthalmic history
- 3.1.1.4.11 Symptoms
- 3.1.1.4.12 Signs
- 3.1.1.4.13 Age at onset
- 3.1.1.4.14 Mode of onset
- 3.1.1.4.15 Deviating eye
- 3.1.1.4.16 Change in deviation
- 3.1.1.4.17 Variation in angle
- 3.1.1.4.18 Precipitating/attributed cause

3.1.1.5 The Orthoptist establishes a rapport with the patient/carer, introduces self and discusses the role of the Orthoptist at the first visit and introduces self at each subsequent visit.

3.1.1.6 The Orthoptist addresses the patient by name and makes eye contact.

3.1.1.7 The Orthoptist shows an interest in the patient and respects the individual needs of the patient.

Measures

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

General statement of intent during investigation and communication.
Patient questionnaire.
Audit of documented information in case notes.

3.2 PATIENT ASSESSMENT

Overview

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

3.2.1 Essential standards;

3.2.1.1 The assessment makes observations of patient which are documented and may include;

- 3.2.1.1.1 Strabismus
- 3.2.1.1.2 Ocular adnexa
- 3.2.1.1.3 Head postures
- 3.2.1.1.4 Nystagmus
- 3.2.1.1.5 Asymmetry of facial features
- 3.2.1.1.6 Pupil reactions
- 3.2.1.1.7 Glasses prescription and fitting
- 3.2.1.1.8 Mobility/gait/physical appearance
- 3.2.1.1.9 Disability

3.2.1.2 The Orthoptist uses knowledge of the visual system and its abnormalities to formulate strategies to assess the patient.

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

3.2.1.4 The Orthoptist correctly uses quantitative and qualitative tests to investigate further the ocular status of the patient which determines;

- 3.2.1.4.1 The sensory state of the eyes and visual pathway
- 3.2.1.4.2 The motor function of the eyes
- 3.2.1.4.3 The presence and level of binocular vision.

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

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

3.2.1.7 The test results are critically evaluated for differential diagnosis.

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

3.2.2 Desirable objectives;

3.2.2.1 The Orthoptist may undertake specialised ophthalmic testing procedures in the ophthalmic setting in which the Orthoptist has been deemed competent; the standards for practice in the following areas are given in "Competency standards and Professional Practice Guidelines for the Extended role of the Orthoptist";

3.2.2.1.1 Glaucoma diagnostics and monitoring services
3.2.2.1.2 Stroke assessment and rehabilitation
3.2.2.1.3 Retinoscopy and refraction
3.2.2.1.4 Visual Field assessment
3.2.2.1.5 Visual assessment of children with special needs
3.2.2.1.6 Cataract assessment
3.2.2.1.7 Specific Learning Difficulties
3.2.2.1.8 Neuro-Ophthalmology/Neuro-Orthoptics
3.2.2.1.9 Low Vision Assessment and Low Vision Aids

Additional testing procedures may include;

3.2.2.1.10 Ultrasonography,
3.2.2.1.11 Auto-refraction
3.2.2.1.12 Contact lens assessment
3.2.2.1.13 Surgical assisting.

Measures

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

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

3.3 DIAGNOSIS

Overview

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

Essential standards;

The Orthoptist...

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

3.3.2 Selects or identifies additional tests to further investigate possible diagnoses.

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

3.3.4 Establishes area of intervention that will be required e.g sensory, motor, optical, rehabilitation or further monitoring of condition.

3.3.5 Is able to determine if the tests provide evidence for the diagnosis of the ocular motor disturbance.

3.3.6 When inconsistencies arise, is able to highlight the most important information gained in the assessment.

3.3.7 Considers the ocular and general history in conjunction with test results in summarising the findings with regard to the diagnosis and possible cause.

Measures

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

Random review of case notes.
Audit of practice.
Peer review.
Case presentations and discussions.

3.4 MANAGEMENT

Overview

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

Essential standards;

The Orthoptist...

3.4.1 Designs and implements Orthoptic treatment plans with the patient/carers' involvement and consent/assent (which may be verbal for non-invasive treatment).

3.4.2 Demonstrates a knowledge of the practical and technical aspects of the therapeutics for Orthoptic treatment including;
3.4.2.1 Occlusion methods
3.4.2.2 Binocular vision exercises
3.4.2.3 Prismatic and optical influences on vision and binocular vision
3.4.2.4 Pharmacological effects on visual function
3.4.2.5 The implications of ocular surgery and botulinum toxin treatment.

3.4.3 Explains the diagnosis in appropriate terminology to the patient or carer.

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

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

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

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

3.4.8 Terminates the treatment at an appropriate time.

3.4.9 Assists in the management of pre- and post-operative care.

Measures

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

Policies and procedures relating to treatment and care plans.
Random review of case notes.
Patient questionnaire.
Case presentation and discussion.

3.5 RECORDING OF CLINICAL DATA

Overview

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

3.5.1 Essential standards;

The Orthoptist...

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

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

3.5.1.3 Ensures permanent copies of files are kept for every consultation where possible.

3.5.1.4 Uses abbreviations and diagrams that are recognised by the Orthoptic and ophthalmic professions on all Orthoptic records as listed in the Dictionary of Common Terms in Orthoptic Practice (BIOS) and Diagramatic Representation Ocular movements (BIOS).

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

3.5.1.6 Maintains confidentiality of patient records.

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

3.5.1.8 Ensures documentation of informed consent is gained before releasing Orthoptic files and personal histories to services outside the hospital/trust (dependent on local policy) such as educational providers and non health care professions.

3.5.2 Essential standards (dependent on local referral policy);

The Orthoptist

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

3.5.2.2 When necessary refers the patient to an Ophthalmologist

3.5.2.3 Refers the patient back to the referring specialist if clinical judgement indicates possible additional pathology.

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

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

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

Measures

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

Audit of clinical practice.
Policies and procedures for referrals and data handling (case notes).
Random review of case notes.

SECTION 4

ORTHOPTIC PRACTICE

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

4.1 Orthoptic investigative procedures

4.2 Assessment and management of amblyopia

4.3 Assessment and management of heterophoria

4.4 Assessment and management of constant concomitant strabismus

4.5 Assessment and management of intermittent concomitant strabismus

4.6 Assessment and management of microtropia

4.7 Assessment and management of incomitant strabismus

4.1 ORTHOPTIC INVESTIGATIVE PROCEDURES

4.1.1 Visual Acuity

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

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

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

The existence of crowding should be evaluated as appropriate.

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

4.1.2 Cover Test (CT)

The cover test is performed:

-with/without corrective prescription,

-with/without accommodative target,

-with/without abnormal head posture,

-for near and distant fixation, and other distances where appropriate.

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

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

4.1.3 Binocular Single Vision (BSV)

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

Free space tests are recommended for evaluation of retinal correspondence and binocular single vision.

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

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

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

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

Vertical motor fusion and fusional vergences should be assessed in cases with vertical deviations.

4.1.4 Ocular Motility

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

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

4.1.5 Measurement of Ocular Deviation

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

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

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

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

4.2 ASSESSMENT AND MANAGEMENT OF AMBLYOPIA

For assessment of visual acuity/function, see section 4.1

Management

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

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

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

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

Where optimum VA is achieved with appropriate occlusion, occlusion is reduced and the outcome monitored carefully. Binocular functions are reviewed during occlusion therapy.

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

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

4.3 ASSESSMENT AND MANAGEMENT OF HETEROPHORIA

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

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

Assessment

Ensure refraction, fundus and media examination are carried out.

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

Assessment may include:

Case history
Visual acuity testing
Cover Test
Assessment of ocular motility
Assessment of convergence/accommodation range
Assessment of Binocular Single Vision
Measurement of angle of deviation
Assessment of fixation
Measurement of AC/A ratio
Monocular occlusion to differentiate between ocular and non-ocular symptoms

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

Management

Ensure appropriate refractive correction where indicated
Amblyopia and/or anti-suppression treatment
Orthoptic exercises to increase fusional vergences (positive for exophoria, negative for esophoria)
Prism therapy
Refer for surgery and/or botulinum toxin where there is a large angle of deviation and reassess postoperatively for further conservative treatment to consolidate result.

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

4.4 ASSESSMENT AND MANAGEMENT OF CONSTANT CONCOMITANT STRABISMUS

All patients have a relevant Orthoptic investigation from which a diagnosis and prognosis are formed and an appropriate care plan implemented. The investigation is made in accordance with the patient's age and ability.
The aim is to achieve optimum visual acuity, an absence of symptoms, and acceptable alignment.

Assessment

Ensure refraction, fundus and media examination are carried out.

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

Assessment may include:

Case history
Visual acuity testing
Cover Test
Assessment of ocular motility and convergence
BSV assessment/ investigation of suppression - area and density if appropriate
Measurement of the angle of deviation
Assessment of fixation
Post operative diplopia test
Prism adaptation test

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

Management

Ensure appropriate refractive prescription where indicated
Amblyopia therapy where indicated
Referral for surgery or botulinum toxin where indicated to achieve improved alignment or functional result dependant on state of binocular function
Reassess binocular function potential postoperatively as may require further Orthoptic or optical treatment to consolidate the result

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

4.5 ASSESSMENT AND MANAGEMENT OF INTERMITTENT CONCOMITANT STRABISMUS

All patients have a relevant Orthoptic investigation from which a diagnosis and prognosis are formed and an appropriate care plan implemented. The investigation is made in accordance with the patient's age and ability.
The aim is to achieve optimum visual acuity, good control, using the optimum refractive correction to achieve asymptomatic BSV.

Assessment

Ensure refraction, fundus and media examination are carried out.

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

Assessment may include:

Case history
Visual acuity testing
Cover Test
Assessment of ocular motility and convergence
Assessment of BSV/suppression
Measurement of the angle of deviation
Assessment of fixation
Measurement of the AC/A ratio and diagnostic occlusion

The care plan and prognosis is dependant on the presence or absence of symptoms/amblyopia, age, size of deviation, previous treatment and refraction.

Management

Ensure appropriate refractive prescription where indicated
Amblyopia and/or suppression treatment where indicated
Optical lenses or prisms
Miotics
Occlusion to improve sensory binocular function in divergent deviations
Orthoptic treatment to improve negative fusional vergences for convergent deviations and positive fusional vergences for divergent deviations
Surgery or botulinum toxin where indicated for angle of deviation and reassess postoperatively to assess binocular potential and for further conservative treatment to consolidate result.

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

4.6 ASSESSMENT AND MANAGEMENT OF MICROTROPIA

All patients have a relevant Orthoptic investigation from which a diagnosis and prognosis are formed and an appropriate care plan implemented. The investigation is made in accordance with the patient's age and ability.
The aim is to achieve optimum visual acuity, maximum control, use of optimum refractive correction, asymptomatic BSV where previously decompensated, acceptable alignment to restore BSV and patient/carer satisfaction.

Assessment

Refraction, fundus and media examination.

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

Assessment may include:

Case history
Visual acuity testing
Cover Test
Assessment of ocular motility
Assessment of convergence
Assessment of BSV (normal or abnormal)
4 dioptre prism test – BO and BI for central suppression
Fixation ophthalmoscope
Measurement of the angle of deviation – may require simultaneous prism & cover test

The care plan and prognosis are dependant on the presence or absence of symptoms/amblyopia, age, size of deviation, previous treatment and refraction.

Management

Ensure appropriate refractive prescription where indicated
Amblyopia treatment where indicated
Orthoptic exercises to improve binocular function where there is an associated decompensating heterophoria
Optical lenses (appropriate refractive correction should be ordered where indicated)
Prisms to alleviate symptoms of decompensation
Surgery may be considered where there has been decompensation into a large angle deviation or where control of the deviation is poor

Postoperative evaluation to reassess binocular potential and further conservative treatment to consolidate result.
Following patient review treatment may be adapted according to clinical findings and patient compliance.

4.7 ASSESSMENT AND MANAGEMENT OF INCOMITANT STRABISMUS

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

Classification and associated findings of incomitant strabismus:

Neurogenic
Mechanical
Myogenic
Nuclear
Internuclear
Supranuclear
Ptosis/pupil anomaly A/V pattern
Accommodative/convergence anomaly
Nystagmus

Assessment

All patients require a thorough assessment at their initial visit, and assessment as indicated by their diagnosis and care plan at subsequent visits. Where tests are not possible due, for example, to young age or poor ability, this is documented in the Orthoptic report.
Orthoptic investigation should aim to clarify whether ocular motility disorders are long-standing congenital or recently acquired, and the type of defect.

Assessment may include

Case history
Visual acuity testing
Cover Test
Assessment of ocular motility – smooth pursuit, saccades, vestibulo-ocular reflex, OKN, as appropriate.
Assessment of BSV
Assessment of convergence/accommodation range
The angle of deviation is measured in relevant positions of gaze and fixing either eye
Measurement of torsion
Field of BSV
Field of uniocular fixation
Lees/ Hess screen
BHTT
Contrast Sensitivity
Assessment of Nystagmus

Assessment of pupils and lid function

Management

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