CLINICAL AND EXPERIMENTAL
OPTOMETRY

COMPETENCIES

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

Clin Exp Optom 2009; 92: 4: 362–386 DOI:10.1111/j.1444-0938.2009.00383.x

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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.

Submitted: 9 December 2008
Revised: 14 January 2009
Accepted for publication: 16 January 2009

Key words: competency standards, entry-level, therapeutics

In 1989, the Australian Government began a process of economic reform that included a push for acceptance of a competency-based approach for determining entry into and movement within a profession or trade. The aims were to allow maximum use of skills in the community, increase labour market efficiencies and equity, offer a fairer method of testing overseas trained professionals and assist in mutual recognition arrangements between the states.[1] The Government stated that competency standards for a particular profession belonged to the profession[2] and would be modified only by that profession as required. Professions were able to develop competency standards for entry-level to their profession or

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 therapists[5]).

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 subgrouping 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 1993[7] 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 optometry[10] 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 comprehensive 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.

ACKNOWLEDGEMENTS

The participants in the workshops were Mr Keith Masnick, Dr Michele Madigan (UNSW), Dr Peter Hendicott (QUT), Mr Ian Bluntish, Ms Deborah-Anne Hackett, Ms Shirley Loh, Dr Geoff Sampson, Mr Luke Cahill, Dr Genevieve Napper, Mr Tim Fricke, Ms Annette Morgan (NZAO), Dr Patricia Kiely and Dr Paul Hager (Facilitator).

My thanks to Joe Chakman for his advice on the project and to the members of optometrists registration boards, the academics and the optometrists who gave their time to comment on draft documents and to participate in the workshop.

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Universal competencies are shown in black.

Therapeutic competencies are shown in blue.

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.	1.1.1 Optometric knowledge, equipment and clinical skills are maintained and developed.	Ability to continue to develop skills and knowledge. 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). Understanding of continuing professional development requirements of Optometrists Association Australia and boards of optometric registration. Understanding of the need to have access to appropriate equipment. Understanding of current developments in optometry.
	1.1.2 Developments in clinical theory, optometric techniques and technology are critically appraised and evaluated for their efficacy and relevance to clinical practice.	Understanding of statistical methods and scientific requirements necessary for sound research. Ability to incorporate relevant research findings into practice.
	1.1.3 Newly developed and existing clinical procedures and techniques are applied and adapted to improve patient care.	Understanding of the advantages, disadvantages and limitations of clinical procedures and techniques.
	1.1.4 Clinical experiences and discussions with professional colleagues are used to improve patient care.	Ability to discuss and appraise clinical experiences.
1.2 Practises independently.	1.2.1 Professional independence in optometric decision-making and conduct is maintained.	Recognition of the need for products and services provided to the patient to be appropriate and in the best interests of the patient. Recognition of limitations in clinical skills and ability to care for and manage a patient. Recognition of the need to maintain appropriate independence when working with other health professionals.
	1.2.2 Possible consequences of actions and advice are recognised and responsibility for actions accepted.	Ability to arrange timely referral of a patient. Understanding that patient complaints should be dealt with in a professional and co-operative manner. Recognition of the need to accept responsibility for decisions. Awareness of the need to inform the professional indemnity insurer of cases that are potentially litigious.
	1.2.3 Advice is sought from other optometrists, health and other professionals when it is deemed that a further opinion is required.	Recognition of patients for whom referral to another practitioner is necessary. Understanding of the scope of practice and services offered by other health professionals and when there is a need to seek information from them. Ability to access contact details of other health professionals. Recognition of situations where there is a need for liaison with other health professionals.

1.3 Acts in accordance with the standards of ethical behaviour of the profession.	1.3.1 Optometric services are provided as necessary for the management of the patient.	Understanding of the role of the optometrist in society. Ability to identify ocular and visual conditions that require additional assessment by the optometrist. Ability to assess patient requests.
	1.3.2 Patient eye care interests and comfort are held paramount.	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. Ability to put patient interests ahead of self-interest. 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.
	1.3.3 Advantage (in a physical, emotional or other way) is not taken of the relationship with the patient.	Recognition of the obligation of optometrists to respect the dignity and rights of the patient.
	1.3.4 The services of optometric assistants are used appropriately.	Ability to determine whether it is suitable to delegate specific tasks to optometric assistants. Recognition of the need to provide training and supervision for optometric assistants to whom tasks are delegated.
	1.3.5 The ethical standards of the profession are maintained.	Recognition of the need to conform to standards of practice of the Optometrists Association of Australia and standards of other relevant organisations.
1.4 Communicates appropriate advice and information to patients and others.	1.4.1 Information is clearly communicated to patients, patient carers, staff, colleagues and other professionals.	Provision of sufficient information in a suitable form to assist patients to give informed consent regarding their management. 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. Recognition of the need for patients to be provided with an opportunity to ask questions regarding their care. Understanding of when the services of interpreters should be utilised. Ability to obtain information about accessing the services of an interpreter. Ability to use the services of an interpreter. 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. Understanding of patient privacy issues. Understanding of the need to verify accuracy/success of communication.
	1.4.2 Liaison with other professionals is maintained.	Ability to access details of suitable health professionals, eye care professionals or teachers for referral and reporting. Understanding of what information should be included in referral/report letters.
	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.	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.
1.5 Uses resources from optometric and other organisations to enhance patient care.	1.5.1 The various functions of, and resources available from, optometric and other organisations are understood and used.	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). Ability to access information from the different organisations described above.

	1.5.2 Community and other resources are recommended to patients.	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.
1.6 Understands the general principles of the development and maintenance of an optometric practice.	1.6.1 The roles of practice staff and the need for staff training are understood.	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.
	1.6.2 Equipment is maintained in a safe, accurate, working state.	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. Understanding of the need for a staff member to be assigned to ensure that spare parts such as new globes and batteries are available.
	1.6.3 Personal and general safety, comfort, tidiness and hygiene are maintained in the practice.	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.: • 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. 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.
	1.6.4 Patient appointments are scheduled according to the time required for procedures.	Recognition of the need to allocate adequate appointment times for patients, with attention to changes to scheduling when pupil dilation is to be performed. Recognition of when follow-up appointments need to be organised. Recognition of the need to accommodate emergency appointments in the appointment schedule.
	1.6.5 Financial obligations associated with optometric practice are recognised.	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. 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.
1.7 Understands the legal obligations involved in optometric practice.	1.7.1 Optometric fee structures are interpreted and applied.	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.

	1.7.2 Relevant legislation, common law obligations relevant to practice and Australian Standards are understood and implemented.	**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. **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.
1.8 Provides for the care of patients with special needs.	1.8.1 Subsidised eye care schemes are understood and explained, recommended or made available to patients who are entitled to them.	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.
	1.8.2 Domiciliary optometric care can be provided.	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.
	1.8.3 Culturally inclusive optometric services are delivered.	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.
1.9 Provides or directs patients to emergency care.	1.9.1 Situations requiring emergency optometric care and general first aid are identified.	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.

	1.9.2 Emergency ocular treatment and general first aid can be provided.	Understanding of what form of emergency ocular treatment/management should be provided to patients with urgent clinical presentations. Ability to provide general first-aid and cardiopulmonary resuscitation or evidence of the ability through first aid and cardiopulmonary resuscitation qualifications. Understanding the need for at least one staff member to have an up-to-date first aid and cardiopulmonary resuscitation qualification.
	1.9.3 Emergency care is organised for times when the optometrist is unavailable.	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.
1.10 Promotes issues of eye and vision care to the community.	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.	Ability to access and interpret information on eye and vision care. Ability to integrate information on eye and vision care into advice provided to patients. 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.
	1.10.2 Advice is provided on eye protection for occupational and home-based activities and for recreational pursuits.	Knowledge of the types of eye protection that meet the requirements in Australian and New Zealand Standards, e.g. safety lenses, radiation protection, sunglasses. 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.
1.11 Understands factors affecting the community's need for eye care services.	1.11.1 The demography, social determinants of health and epidemiology of the community and the patient population are understood.	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. Ability to research information about demography and epidemiology through suitable methods such as database analysis, questionnaires and other means. Understanding of how social determinants of health affect presentations to optometrists.
	1.11.2 Current trends and topical issues regarding eyes, vision and health care are evaluated.	Ability to provide a balanced viewpoint of current trends and topical issues to patients.

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)
2.1 Communicates with the patient.	2.1.1 Modes and methods of communication are employed which take into account the physical, emotional, intellectual and cultural background of the patient.	Proficiency in spoken and written English. Understanding of how communication can be facilitated through the use of interpreters, Auslan interpreters, questionnaires, written means etc. Understanding of the need to use appropriate language, vocabulary and terminology when communicating with the patient/carer/guardian. Understanding of the need to phrase/rephrase questions to enhance understanding. Recognition of the need to verify understanding (optometrist/patient/carer/guardian).

	2.1.2 A structured, efficient, rational and comfortable exchange of information between the optometrist and the patient occurs.	Recognition of the need for optometrists to greet the patient, to introduce themselves and to establish the patient's identity. Understanding of the need for the optometrist to direct the discussion during the consultation. Recognition of the need to develop a rapport with the patient through attending to their statements, making tactful comments/questions, being empathetic.
	2.1.3 Privacy of patient communications and consultations is ensured.	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. Understanding of the need to obtain patient permission for the presence of a third party during the consultation. Understanding of privacy legislation.
2.2 Makes general observations of patient.	2.2.1 Physical and behavioural characteristics of the patient are noted and taken into account.	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. Ability to investigate issues relating to patient well-being, health and comfort.
2.3 Obtains the case history.	2.3.1 The reasons for the patient's visit are elicited in a structured way.	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. Understanding of the need to determine patient and/or parent (guardian) expectations.
	2.3.2 Information required for diagnosis and management is elicited from the patient and/or others.	Understanding of the need to investigate the patient history throughout the examination and to explore and record information in relevant areas such as: • 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.
2.4 Obtains and interprets patient information from sources other than the patient.	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.	Understanding of the need to gather information about the patient through reading previous record cards and associated paperwork. Ability to recognise situations when further information needs to be obtained from other health professionals whom the patient has consulted. Recognition of when patient/parent/guardian permission needs to be obtained in order to seek information from other health professionals. Ability to interpret outcomes/implications of clinical tests performed by other optometrists or other health professionals. Ability to interpret and integrate information from different sources to assist in determining the management of the patient.

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

UNIT 3. PATIENT EXAMINATION

Elements	Performance criteria	Some suggested indicators (this is not an exhaustive list)
3.1 Formulates an examination plan.	3.1.1 An examination plan based on the patient history is designed to obtain the information necessary for diagnosis and management.	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.
	3.1.2 Tests and procedures appropriate to the patient's condition and abilities are selected.	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. Ability to select tests that will investigate the problems described by the patient. Ability to consider tests targeting conditions that are associated with a patient's known conditions.
	3.1.3 Relevant investigations not necessarily associated with the patient's history are considered.	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.
3.2 Implements examination plan.	3.2.1 Tests and procedures which efficiently provide the information required for diagnosis are performed.	Ability to be proficient, safe and accurate with equipment and in the performance of techniques. 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. Ability to recognise that the patient has fully understood explanations. Understanding of when and how patient informed consent is to be obtained. Ability to recognise what tests should be included or excluded for different patient presentations and the order in which tests should be performed.
	3.2.2 The examination plan and procedures are progressively modified on the basis of findings.	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.
3.3 Assesses the ocular adnexae and the eye.	3.3.1 The components of the ocular adnexae are assessed for their structure, health and functional ability.	**Universal:** 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. Ability to use tests/equipment such as: • 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. Ability to describe and follow infection control measures relevant to optometric practice, e.g. instrument disinfection, use of disposable gloves, management of waste etc. Ability to perform punctal dilation and lacrimal lavage using appropriate equipment.

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.
3.3.2 The components of the anterior segment are assessed for their structure, health and functional ability.	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; keratoscopy, 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
3.3.3 The components of the ocular media are assessed for their structure, health and functional ability.	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

3.3.4 The components of the posterior segment are assessed for their structure, health and functional ability.		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. Ability to use, and interpret results/images from, tests/equipment such as: • 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 Ability to interpret results/images from, tests/equipment such as: • diagnostic imaging (e.g. OCT, HRT) • ultrasound Ability to use auxiliary lenses for fundus viewing and optic nerve head (ONH) assessment. Ability to interpret/use optical coherence tomography and techniques for nerve fibre layer analysis.
3.4 Assesses central and peripheral sensory visual function and the integrity of the visual pathways.	3.4.1 Vision and visual acuity are measured.	Ability to investigate vision and visual acuity using tests/equipment/assessment such as: • 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. Ability to select appropriate lighting and distances for the performance of tests. Ability to interpret the results of vision and visual acuity tests.

	3.4.2 Visual fields are measured.	Ability to select appropriate tests to investigate visual fields using tests/equipment/assessment such as: • Amsler 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 Ability to interpret the results of visual field testing.
	3.4.3 Colour vision is assessed.	Ability to select the appropriate tests to assess colour vision using tests and testing conditions such as: • pseudo-isochromatic tests • hue ordering tests • monocular/binocular measurements • flicker • colour matching. Ability to interpret the results of colour vision testing and discriminate between the different types of acquired and congenital colour vision defects.
	3.4.4 Pupil function is assessed.	Ability to assess pupils and pupil reactions for symmetry, response rate and cycle times using tests and testing conditions such as: • varied lighting conditions • swinging flashlight tests • pharmacological testing Ability to interpret the results of a pupil assessment.
3.5 Assesses refractive status.	3.5.1 The spherical, astigmatic and presbyopic components of the correction are measured.	Demonstration of a working knowledge of refractive testing methodologies. Ability to select and apply appropriate tests to determine the spherical, astigmatic and presbyopic components of the refractive status for a range of presentations. Understanding of when cycloplegia is indicated. Ability to use cycloplegia.
3.6 Assesses oculomotor and binocular function.	3.6.1 Eye alignment and the state of fixation are assessed.	Ability to assess ocular alignment and binocular function in terms of: • manifest deviation (strabismus detection, direction, magnitude, laterality, constancy, comitancy) • latent deviation (heterophoria direction and magnitude) • fixation (quality and eccentricity) Ability to assess nystagmus (particularly to determine if nystagmus is an ocular emergency) Ability to use tests/equipment which enable assessment of binocular status, such as: • prisms • cover test (near/distance) in primary and other direction(s) of gaze • head tilt test

	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: • 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: • 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: • posture of accommodation • relative accommodation • accommodative facility • monocular and binocular amplitudes of accommodation • AC/A ratio
3.7 Assesses visual information processing.	3.7.1 Visual information processing abilities are investigated and compared to normal values for age.	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. Ability to determine when it is necessary to analyse or refer for analysis of areas such as: • visual spatial skills (laterality, directionality) • visual analysis skills • visual motor integration
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.	3.8.1 Pertinent ocular signs and/or visual symptoms found during the ocular examination are identified and their relevance determined.	Ability to identify ocular signs and/or visual 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. 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.

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.	**Universal** 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. **Therapeutic level** 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.	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.
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 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. Ability to assess patient understanding of their condition and its management and to provide responses regarding diagnosis and prognosis. Ability to provide written information about the patient's condition/disease.
	5.1.2 The relative importance or urgency of the presenting problems and examination findings is determined and addressed in the management plan.	Understanding of the urgency with which treatment/management of the patent'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.
	5.1.3 Management options to address the patient's needs are discussed.	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).

	5.1.5 The informed consent of the patient/carer is sought and obtained for the initiation and continuation of management.	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. Understanding of the need to answer patient queries and clarify ambiguities and misinterpretations. Ability to recognise situations in which specific informed consent must be obtained from patients and the manner in which this should be documented.
	5.1.6 Patients requiring ongoing care and review are recalled as their clinical condition indicates and management is modified as indicated.	Ability to organise and schedule review visits. Ability to modify the management plan based on results obtained. Understanding of how and when recalls are conveyed. Ability to recognise situations in which it is necessary to make contact with the patient to assess progress. Understanding of the need to provide patients with information regarding emergency after-hours numbers or where emergency after-hours care can be accessed.
	5.1.7 Patients with life- or sight-threatening conditions who do not attend a scheduled review or referral are followed up promptly.	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. 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.
5.2 Prescribes spectacles	5.2.1 The suitability of spectacles as a form of correction for the patient is assessed.	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.
	5.2.2 The patient's refraction, visual requirements and other findings are applied to determine the spectacle prescription and lens form.	Ability to determine the final spectacle prescription through consideration of factors such as: • 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 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.

	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). 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 Prescribes contact lenses	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. Ability to discuss with the patient issues relating to their suitability or unsuitability for contact lens wear.
	5.3.2 The patient's refraction, visual requirements and other findings are applied to determine the contact lens prescription.	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. Ability to use appropriate trial lenses, fitting techniques and equipment and dyes to assist in determining the contact lens prescription. Recognition of the need to consider the ability of the patient to handle contact lenses in determining the type of lens to be prescribed. Ability to recognise contraindications to contact lens wear and to assess their significance in determining the type of lens to be prescribed. 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. 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.
	5.3.3 Contact lenses are correctly ordered and checked before being supplied to the patient.	Understanding of what information is necessary for inclusion on contact lens orders. Ability to check that lenses supplied comply with the lenses prescribed.
	5.3.4 Contact lenses with new fitting parameters are assessed on the eye prior to supply to the patient.	Ability to assess visual acuity with lenses, the lens fit, the over-correction, lens centration, lens movement and lid interactions.
	5.3.5 The patient is instructed in matters relating to ocular health, vision, contact lens care and maintenance and after-care visits.	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.
	5.3.6 Contact lens performance, ocular health and patient adherence to wearing and maintenance regimens are monitored.	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.
	5.3.7 A contact lens prescription is written in a manner that can be interpreted for correct fabrication of the appliance.	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.

5.4 Prescribes low vision devices.	5.4.1 A range of low vision devices suitable to the patient's needs is selected and demonstrated, where indicated.	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. Ability to assess the suitability of aids such as closed circuit television, computer software for low vision, mobility aids, independent living aids, telescopes. Ability to demonstrate and explain the use of low vision devices to the patient.
	5.4.2 Low vision devices suited to the patient's visual requirements and functional needs are prescribed.	Ability to prescribe a low vision device to meet the needs of the patient. Understanding of the benefit of providing low vision devices for a trial period.
	5.4.3 The patient is instructed in the use of prescribed low vision devices.	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.
	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.	Understanding of the need for review visits for reassessment of visual performance. Understanding of the need to recommend ongoing primary eye care.
	5.4.5 The patient is informed of and, if necessary, referred to other rehabilitative services.	Knowledge of organisations offering rehabilitative and other services to patients with low vision. 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.
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).	5.5.1 Appropriate pharmacological agents are selected and recommended for treatment of the patient's condition.	**Universal** Consideration of drug actions and interactions, adverse side-effects or allergies in determining non-prescription pharmacologic agents to meet the patient's needs. Adherence to state and federal legal requirements (e.g. Poisons' Act, Optometrists' Registration Acts), when providing advice to the patient on pharmacologic agents. **Therapeutic level** Ability to interpret and apply current clinical trial findings. Determination of the need for ocular and/or systemic therapy. Ability, when choosing the most appropriate therapeutic agent(s) for the patient, to consider aspects such as: • 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.

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.
5.5.6 Patients are instructed in the avoidance of cross-infection.	Understanding of the information required to counsel patients on how to avoid cross-infection and contamination of medication.

	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.	**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. **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.
5.6 Dispenses spectacle prescriptions accurately.	5.6.1 The spectacle prescription is interpreted and responsibility for dispensing accepted.	Ability to resolve ambiguities in optical prescriptions. Understanding of the requirements for dispensing of spectacle prescriptions described in the Australia Standard: AS 2228.1-1992: Spectacles—Spectacle lenses.
	5.6.2 The patients are assisted in selecting appliances that are suitable for their needs.	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.
	5.6.3 Relevant measurements pertaining to the spectacle frame are made, lenses are ordered and finished spectacles are verified according to Australian Standards.	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.
	5.6.4 The appliance is verified against the prescription prior to delivery.	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.
	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.	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.
5.7 Manages patients requiring vision therapy.	5.7.1 Patients with accommodative, vergence, strabismic and amblyopic conditions are treated or referred for treatment.	If vision therapy is provided, understanding of: • the sequence of vision therapy • the time frame for treatment • discharge criteria • the need to supply/lend material for vision therapy programs If unable to provide vision therapy, understanding of the need to refer the patient to a suitable practitioner for vision therapy.
	5.7.2 The patient is instructed in the use and maintenance of vision training equipment.	If vision therapy is provided, understanding of the need to: • ensure that the patient understands the process • provide written instructions • supply/lend material for vision therapy programs
	5.7.3 Goals of the vision therapy program and criteria for discharge are set.	If vision therapy is provided, understanding of the time frame, expected results, discharge criteria and costs.

	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.	5.8.1 A certificate for sick leave is provided.	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.
	5.8.2 Statutory declarations are witnessed.	Understanding of the situations in which a statutory declaration can be witnessed by an optometrist and what information must be recorded on the declaration.
5.9 Refers the patient.	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 situations in which the patient requires the services of another optometrist, another health care practitioner or another professional. Understanding of personal limitations when determining the need for referral. 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. Ability to determine the type of practitioner to whom the patient should be referred. Ability to access contact details of other health professionals. Understanding of the need to consider the experience and location of the practitioner to whom the patient is to be referred.
	5.9.2 Timely referral, with supporting documentation, is made to other professionals.	Recognition of the need to consider the urgency of the patient's condition when arranging a referral. Ability to convey appropriate information to the practitioner to whom the patient is referred through a suitable means, e.g. telephone, referral letter.
	5.9.3 Patients can be jointly managed with other health care practitioners.	Understanding of the requirements for participation in the comanagement of patients with other health professionals. Understanding of the roles and responsibilities of different practitioners in comanagement arrangements.
5.10 Co-operates with ophthalmologist/s in the provision of pre- and post-operative management of patients.	5.10.1 Pre-operative assessment and advice is provided.	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.
	5.10.2 Post-surgical follow-up assessment and monitoring of signs according to the surgeon's requirements and the procedure are undertaken.	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.
	5.10.3 Emergency management for observed post-surgical complications is provided.	Ability to recognise the situations in which emergency management is necessary for a post-surgical complication. Understanding of how to institute appropriate emergency management.
	5.10.4 Appropriate referral for further post-operative treatment or assessment of complications is arranged.	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.

5.11 Provides advice on vision, eye health and safety in the workplace and recreational settings.	5.11.1 Vision screenings for occupational or other purposes are provided.	Understanding of the optometric testing procedures necessary for a vision screening. Understanding of the billing procedures relevant to vision screening in relation to Medicare. Determination of screening protocols based on the group targeted in the vision screening.
	5.11.2 Advice is provided on eye protection, visual standards and visual ergonomics in the workplace and recreational settings.	Ability to perform industrial and environmental analysis to determine the need for radiation protection, safety lenses, tinted safety lenses etc. Understanding of the advice on eye protection to be provided in industry and for recreational pursuits. Understanding of the advice to be provided on lighting and ergonomic design in the workplace and for recreational pursuits. Understanding of lighting and vision standards for their application in industry and for recreational pursuits.
	5.11.3 Individuals are counselled on the suitability of their vision for certain occupations.	Understanding of industry and other occupational requirements for colour vision, visual acuity, spectacle powers, etc. Ability to communicate with employee and employer organisations.
	5.11.4 Certification of an individual's visual suitability for designated occupations or tasks is provided.	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. 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. Ability to access vision standards for different occupations.
	5.11.5 The patient or parent/ guardian is advised of the presence of conditions that have implications for other family members.	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.

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)
6.1 Records patient information and data in a legible, secure, accessible, permanent and unambiguous manner.	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.	**Universal** Understanding of the need to create a separate, distinct record for each patient either in paper form or electronically. Ability to create records that are legible and can be interpreted by another optometrist. 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. Understanding of the need to include copies of referral letters and reports with the patient record. Knowledge of accepted abbreviations and grading scales to be used in optometric records. **Therapeutic level** Understanding of the need to include details of medications prescribed, microbiological tests and results and modifications to management on the patient record.

	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.	
	6.1.3 Corrections to records are made in accordance with legislation.	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.	
6.2 Maintains confidentiality of patient records.	6.2.1 Access to records is limited to authorised personnel.	Understanding that non-authorised persons must not access patient records.	
		Understanding that confidentiality of patient information is to be safeguarded.	
	6.2.2 Information from patient records and/or obtained from patients is released only with the consent of the patient.	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.	
	6.2.3 The rights of a patient to access his or her patient record are understood and observed.	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.	
	6.2.4 Patient privacy is addressed when patient information is transferred.	Understanding of privacy and security requirements when patient information is communicated to others through electronic transfer, facsimile transmission or via telephone communication.	
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.	Knowledge of the minimum periods by law for which patient records must be kept in the case of children and adults.	
	6.3.2 The requirements regarding archiving or destruction of records to ensure patient privacy are understood and observed.	Understanding that processes to archive or destroy patient records must ensure privacy of patient information.	
	6.3.3 The requirement for the retention of practice documentation other than patient records is understood and observed.	Knowledge of the minimum period by law for which practice documentation such as appointment books and therapeutic prescriptions must be kept.	