NATIONAL COMPETENCY STANDARDS
for the profession of
ORTHOPTICS

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Sections 1.0 and 5.0 of this book are modelled on the Aboriginal and Torres Strait Islanders Health Workers’ National Competency Standards, July 1995.
FOREWORD

Review of Competency Standards 2004

1. Introduction

In 1997 “National Competency Standards for the Profession of Orthoptics” were developed for the Orthoptic Association of Australia Inc. (OAA). In 2004, these Competency Based Standards (CBS) were reviewed.

2. Review Committee

Val Tosswill (NSW)
Julie Barbour (Tasmania)

Consultations made with:
OAA Executive
Helen Wozniak

3. Review Process

In 2004, a review was undertaken by an OAA working party to update the National Competency Standards for the Profession of Orthoptics. Areas of change were identified in the original 1997 document and a search of CBS of other allied health professions was undertaken. Interestingly, a large number of these other professions were currently updating their standards at that time, or a copy of their CBS was not readily available for public viewing. Only minor areas for change in the OAA standards were identified and have been incorporated into this current document.

4. Summary of Key Changes

3.0 Description of Orthoptics

As at 30 June 2004, membership consisted of 279 of orthoptists which represented approximately 63.27% (1) of orthoptists.

All OAA standing committees exist with the exception of the ‘Ethics Committee’ which has been renamed the ‘Professional Conduct Committee’. The Royal Australian College of Ophthalmologists is now known as the Royal Australian and New Zealand College of Ophthalmologists (RANZCO).

10.0 The Development Process

All government bodies, with the exception of the Australian National Training Authority (ANTA) continue to function under the same title – ANTA is now under the umbrella of the Department of Education, Science and Training (DEST).
In 2000 the Australian Orthoptic Board (AOB), formerly the Orthoptic Board of Australia (OBA), assumed the role of assessing the competency of skills by overseas orthoptists. The AOB is an independent national registration body for the profession of orthoptics and holds a register of suitably qualified orthoptists who comply with the CBS. Both the OAA and the AOB endorse these revised CBS.

Overall, changes to the OAA National Competency Standards for the Profession of Orthoptics are minimal. Various medical and government bodies associated with the profession of orthoptics or ophthalmology have been restructured and are now known by other names. The core content of the CBS Units have not altered greatly, with the main change being an expansion of some service provision into the patient’s home. Increased specialised ophthalmic procedures (Unit 10 – Implemented Specialised Ophthalmic Testing Procedures) have been adopted and the standards amended accordingly. The range of preoperative tests listed in Unit 14 (Assist in Management of Ocular Disease) have expanded and been updated in the document. Australian state and federal government legislative changes have occurred since the development of the initial OAA CBS resulting in modifications to Units 19 (Record Clinical Data) and 20 (Assist in Practice Management).

Valerie Tosswill
President, OAA

PART 1:

COMPETENCY STANDARDS
AND THEIR DEVELOPMENT
1.0 INTRODUCTION

These standards are National Competency Standards for the Profession of Orthoptics. They have been developed by the Orthoptic Association of Australia Inc. (OAA) the peak professional association representing orthoptists throughout Australia. Consultations were made with a wide variety of stakeholders such as orthoptists, service providers, related professional groups and government bodies throughout Australia. A Project Management Committee has managed the processes of developing the standards and has undertaken consultations throughout Australia particularly under the guidance of a project officer from the Federal Government’s Community Services and Health Training Australia Ltd.

A number of drafts of the standards were prepared, consulted upon, and modified progressively. The various drafts of the standards were discussed with the stakeholders throughout Australia, detailed feedback was received, and many changes were made. This final draft of the competency standards was prepared in response to all the feedback that has been received on the various drafts.

These competency standards have been endorsed by the OAA as “National Competency Standards for the Profession of Orthoptics”, and will be used to:

• provide equitable assessment of orthoptists with overseas education and work experience,
• guide the development of university curricula,
• assist the OAA in identification of continuing education needs,
• assist in job evaluation
• promote quality delivery of orthoptic services to the wider community.

The endorsed standards will be reviewed nationally every 5 years.

In Part 1 this document outlines the rationale for development of these competency standards and the process by which they were developed. Part 2 details the competency standards in full.

As an orthoptist or related professional group it is hoped that you will find this a valuable document that will help you, your fellow health care providers and the clients to whom you provide a service, to better understand the range of work activities carried by an orthoptist in Australia.

Helen Goodacre
Helen Wozniak
Chairperson, Project Management Committee, OAA
2.0 PROJECT MANAGEMENT COMMITTEE

Chairperson & Author of this Book:

Helen Wozniak (NSW, The University of Sydney Representative)

Committee:

Bev Devidas (Vic)
Julie Green (Vic, La Trobe University Representative)
Sue Sutton (NSW)
Jan Wulff (Qld / NSW, Federal President OAA 96,97)

Consultations made with:

Susan Harris, Senior Project Officer, Community Services and Health Training Australia Ltd.

Council members of the OAA including representatives from all States in Australia and the ACT

Orthoptists from all states in Australia and the ACT

Peter Nomchong, Executive Secretary, Royal Australian College of Ophthalmologists

Chairperson of Orthoptic Board of Australia including the Chairperson of the Examinations Subcommittee

Christine Maple, Royal Blind Society

Ayshe Lewis, Public Service Association

Bert Coquillon, Health and Research Employees Association

Michael Maloney, Allied Health Professionals Association

Rod Felmingham, Community and Public Sector Union
3.0 DESCRIPTION OF ORTHOPTICS

Orthoptists are allied health professionals who specialise in the investigation and management of disorders of vision, eye movements and strabismus. They also specialise in the investigation of diseases of the visual system and provide expertise in the rehabilitation of patients with visual loss.

Orthoptists work in a variety of settings such as private ophthalmic practices, hospital eye clinics, community and rehabilitation centres and their own private practice. They may see patients ranging in age from new born babies to the elderly.

Orthoptists are currently educated at two Universities in Australia: La Trobe University in Melbourne, and The University of Sydney (Cumberland Campus) in Sydney. Students undertake a 3½ to 4 year undergraduate degree. Masters and PhD studies in orthoptics is also available.

Orthoptists have a close relationship with other health professionals. Many work closely with ophthalmologists (eye specialists) in their private rooms. Orthoptists also work with optometrists, with other allied health groups such as occupational therapists in community health teams, or ophthalmic nurses and ophthalmology registrars in eye care teams primarily in public hospitals and may liaise with optical dispensers regarding the prescription of spectacles.

The national professional association for orthoptists in Australia is the Orthoptic Association of Australia Inc (OAA) which has branches in each state. Currently membership consists of 310 orthoptists which represents approximately 70% of orthoptists. The OAA is administered by a Council with representatives from each state. It has several standing committees such as awards, editorial, education, ethics, scientific, political and public relations. Orthoptists are also eligible for associate membership of the Royal Australian College of Ophthalmologists, the peak association for ophthalmologists.
4.0 COMPETENCE AND THE PROFESSIONS

Competency Standards describe the myriad of attributes such as knowledge, abilities, skills and attitudes that underlie professional practice. Competency is a broad area that includes all aspects of practice including:

- skills to perform particular tasks
- managing a number of different tasks / activities within an occupation
- responding to problems and non-routine events, and
- dealing with all the aspects of the workplace including working with others.

The key to an understanding of competency standards is an awareness of the issues that surround a definition of competence. Hager and Gonzi (1991) defined a competent professional as

“having the attributes necessary for job performance to the appropriate standards.”

Attributes that underlie competence may be relatively simple such as a skill (eg. testing vision) or more complex such as knowing when and why the skill should be performed. Attributes such as judgement, or ability to transfer skills to new and different contexts is just as an important part of professional competence as simple attributes.

Competency standards are written with a focus on performance. Thus they help to identify the aspects of performance in the workplace that provide the best means to infer professional competence.

Standards are used to assess and validate competent performance. It is necessary to have criteria to be able to judge whether the standard of performance has been achieved.

Competency standards should be considered as providing a clear statement of what is considered to be important for competent performance in a profession. It should be noted that these competency standards are not able to express all aspects of Orthoptic professional practice, rather competence requires a delicate mix of these competencies and a disciplined way of thinking about the area of practice. Only then can an orthoptist competently respond to the complex and dynamic nature of their practice.

There has been some concern in the professions that development of competency standards may limit the expression of higher level competencies in the standards. Analysis of a professional’s work into a list of activities and tasks can serve to undermine the complex inter-relationship between these tasks. It is incorrect to assume that all people carry out a task in the same way. To ensure that these competency standards do not merely present a list of tasks and subtasks the Project Management Committee decided in the initial stages of development of these standards to adopt an integrated approach to the analysis of the profession. Here the aim is to identify areas of practice where it is essential to demonstrate minimum competence from which the attributes underlying actual performance of these areas can be described. This approach to competency standards development recognises the vital role that professional judgement plays in the practice of a profession.
These Standards relate to one profession but do not describe work in one particular organisation. They describe what is commonly needed to work within a sector of the health care industry, in different types of work contexts, in very different locations, with different communities and clients.

These competency standards are not meant to describe everything that every orthoptist in Australia does. Rather, they describe a range of skills, knowledge and personal attributes which can be used to assess an orthoptist’s level of competence.
5.0 THE STRUCTURE OF NATIONAL COMPETENCY STANDARDS

Units, Elements, Performance Criteria

Competency standards are written in a particular way.

A general area of competence is called a UNIT
Every Unit describes a complete “set” of skills and tasks that are needed to fulfil a major role of the profession. A fully competent person will have all the skills of a Unit.

ELEMENTS are lists of outcomes which make up the unit.
All the Elements together fully describe the unit, or the general area of competence.

PERFORMANCE CRITERIA specify the level of performance required of the worker.
They detail how we can “see” the role is being performed correctly....what the orthoptist will actually do to achieve the outcome which the elements describe.

The RANGE OF VARIABLES specify the situations in which work must be performed.
Words used in the Unit, Elements or Performance Criteria may also be “defined” in the Range of Variables, to ensure all readers will have the same understanding of the Unit.

The EVIDENCE GUIDE has three components. Firstly it outlines the way in which the Unit should be assessed, such as the type of work context or types of patients. Secondly it lists the underpinning knowledge and skills which an orthoptist needs to perform the tasks of the Unit effectively. Lastly it outlines the links to other similar units in competency standards of other occupations.
6.0 STREAMS

Units which are similar are grouped into STREAMS. This enables easier location of the units and greater ability to see links between the units. Figure 1 below represents the relationship between units (boxes) and streams.

Figure 1: Streams

The three streams for the National Competency Standards for the Profession of Orthoptics are as follows:

Self in Workplace:

Units in this stream relate to activities that an orthoptist would carry out during the course of their practice but not specifically with patients. The tasks described in these units may support their practice such as participation in professional development, or relate to the orthoptist’s relationship with others in their workplace.

Clinical Care:

This is the largest stream of these competency standards and relates to various activities that an orthoptist carries out in the direct care of the patient. This stream has been further subdivided into:
- Assessment: where the patient’s problem is identified
- Treatment: where intervention strategies are formulated and carried out
- Community Service: whereby the patient or others in the community are educated about their condition, and ocular health is promoted.

Administration:

This stream relates to the recording of clinical data or the way in which the orthoptist’s practice is managed.
### 7.0 OVERVIEW OF UNITS FOR THESE COMPETENCY STANDARDS

Table 1 below outlines the structure of streams and units for these competency standards. The complete set of standards including unit descriptors, elements performance criteria and evidence guide can be found in Part 2 of this report.

Table 1: Overview of Streams and Units

<table>
<thead>
<tr>
<th>CORE STREAM</th>
<th>UNITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SELF IN WORKPLACE</td>
<td>1. Work effectively with others</td>
</tr>
<tr>
<td></td>
<td>2. Participate in professional development</td>
</tr>
<tr>
<td></td>
<td>3. Demonstrate safe working practices</td>
</tr>
<tr>
<td></td>
<td>4. Teach others</td>
</tr>
<tr>
<td>CLINICAL CARE</td>
<td>5. Interview patient</td>
</tr>
<tr>
<td></td>
<td>6. Plan patient assessment</td>
</tr>
<tr>
<td></td>
<td>7. Assess the sensory state of the eye and visual pathway</td>
</tr>
<tr>
<td></td>
<td>8. Assess the motor function of the eyes</td>
</tr>
<tr>
<td></td>
<td>9. Assess the presence and level of binocular vision</td>
</tr>
<tr>
<td></td>
<td>10. Implement specialised ophthalmic testing procedures</td>
</tr>
<tr>
<td></td>
<td>11. Diagnose ocular motility disorders</td>
</tr>
<tr>
<td></td>
<td>12. Assist in diagnosis of ocular disorders</td>
</tr>
<tr>
<td></td>
<td>13. Plan and provide treatment for ocular motor disorders</td>
</tr>
<tr>
<td></td>
<td>14. Assist in management of ocular disease</td>
</tr>
<tr>
<td></td>
<td>15. Undertake referral</td>
</tr>
<tr>
<td></td>
<td>16. Provide patient education</td>
</tr>
<tr>
<td></td>
<td>17. Provide community education</td>
</tr>
<tr>
<td></td>
<td>18. Promote ocular health</td>
</tr>
<tr>
<td>ADMINISTRATION</td>
<td>19. Record clinical data</td>
</tr>
<tr>
<td></td>
<td>20. Assist in practice management</td>
</tr>
</tbody>
</table>


8.0 THE SCOPE OF THESE STANDARDS AND POSSIBLE FUTURE DIRECTIONS

8.1 Entry-level Standards

These competency standards are describing ENTRY-LEVEL orthoptic practice. This should be interpreted as the standard of performance required in the workplace for competent orthoptic practice. Entry-level should not be confused with the level of ability of a new graduate entering the workplace, so is not concerned with defining the abilities of new graduates who have just completed their tertiary qualification in orthoptics.

Entry-level should be considered the minimum level of ability that any orthoptist should be able to demonstrate whether they be recently graduated, returning to the workforce after a period of absence, or educated in orthoptics at a location outside of Australia. The OAA has decided to adopt a similar approach to the term “entry-level” as other professions and so for ease of interpretation, entry level can be considered to refer to graduates up to 2 years after completion of the recognised bachelors degree qualification.

Although these competency standards are describing entry level practice it should be realised that this level still requires complex work activities which may be performed by orthoptists working autonomously within their area of practice and with limited support from colleagues.

8.2 Future development of higher levels:

Specialised areas of practice have been identified by the Project Management Committee and could in future be used to develop other levels of work. (Figure 2)

Figure 2: Possible Format for future development of Competency Standards

Streams of Units

<table>
<thead>
<tr>
<th>Self in Workplace</th>
<th>Clinical Care</th>
<th>Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Specialisation of Practice (future development of these competency standards)

Entry Level Practice (these competency standards)

There are several areas of specialisation that an orthoptist can undertake. For example an orthoptist may specialise in the management of clients with low vision. This area of practice requires specialised assessment techniques, determination of vision needs, prescription of low vision aids and implementation of a low vision management program to optimise the use of any residual vision.
Table 2 below outlines possible specialised higher level units for each stream that could be developed into an expanded set of competency standards in the future.

Table 2: Possible future unit titles for expanded competency standards

<table>
<thead>
<tr>
<th>STREAM SPECIALISATIONS</th>
<th>POSSIBLE HIGHER LEVEL UNITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self in Workplace</td>
<td>Provide clinical education</td>
</tr>
<tr>
<td></td>
<td>Undertake research and development</td>
</tr>
<tr>
<td>Assessment</td>
<td>Assess vision and driving</td>
</tr>
<tr>
<td></td>
<td>Assess vision and sport</td>
</tr>
<tr>
<td></td>
<td>Assess the refractive status of eye</td>
</tr>
<tr>
<td></td>
<td>Establish low vision needs</td>
</tr>
<tr>
<td></td>
<td>Assess rehabilitation needs</td>
</tr>
<tr>
<td></td>
<td>Diagnose vision driving problems</td>
</tr>
<tr>
<td></td>
<td>Diagnose sport’s vision needs</td>
</tr>
<tr>
<td></td>
<td>Diagnose refractive anomalies</td>
</tr>
<tr>
<td>Treatment</td>
<td>Implement strategies for safe driving practice</td>
</tr>
<tr>
<td></td>
<td>Implement sport vision training programs</td>
</tr>
<tr>
<td></td>
<td>Prescribe spectacles</td>
</tr>
<tr>
<td></td>
<td>Prescribe low vision aids</td>
</tr>
<tr>
<td></td>
<td>Implement low vision management program</td>
</tr>
<tr>
<td></td>
<td>Assist in operative care</td>
</tr>
<tr>
<td>Administration</td>
<td>Manage department</td>
</tr>
<tr>
<td></td>
<td>Small business management</td>
</tr>
</tbody>
</table>

8.3 Development of Competency Standards across the wider eye care system

As well as the expansion of these standards within this profession there is also scope for development of competency standards across the wider eye health care sector. Optometrists developed entry level standards in association with the assistance of the National Office of Overseas Skill Recognition (NOOSR) published in 1993, in addition the Ophthalmic Optics Competency Standards Industry Working Party developed a draft of competency statements for Optical Mechanics and Optical Dispensers during 1994-5. This latter project has yet to be completed nationally. There is scope for future development and mapping to occur between these projects and development of competency standards by other groups in the eye care sector.
9.0 CONTEXTS OF ORTHOPTIC PRACTICE

9.1 Contexts of Practice

Throughout this document various contexts of practice are referred to in the Evidence Guide and help to determine the contexts in which the unit should be assessed. Each of the contexts of practice are described below:

**Private Ophthalmology Practice:**
This refers to a work place where an orthoptist is employed by one or more ophthalmologists to carry out orthoptic duties within an ophthalmologists private practice. The orthoptist works closely with the ophthalmologist and other staff which may include administrative staff, or nursing staff. The size of the practice may vary from single to multiple practitioners. The setting generally has complex equipment and may have a day surgery centre contained within the practice where surgical operations are carried out. The setting is usually very busy with considerable time stresses placed on the members of the eye care team. In the 1993-4 Workforce Study\(^5\) 57% of orthoptists worked in this type of employment. A related context of practice that is likely to show growth in future is Private Optometry Practice. This context of work is similar except that the employer is an optometrist. In the Workforce Study 1% of orthoptists were working in this area.

**Hospital:**
This usually refers to a large teaching public hospital that contains an eye outpatient department. Here the orthoptist may work as a single orthoptist or with other orthoptists as part of a larger eye care team. The orthoptist will work closely with ophthalmologists, ophthalmology registrars, other medical specialists, resident doctors, nursing staff including ophthalmic nurses, other health professionals in other departments and clerical staff. They may also assist in the education of a variety of students including medical and orthoptic undergraduates. This environment may also be very busy with complex technical equipment. 24% of orthoptists work in a hospital.

**Community Agency:**
This refers to a variety of private often charitable health organisations that specialise in the care of specific types of patients. Examples include the Royal Blind Society of NSW, The Spastic Centre, The Lions Eye Institute. Here the orthoptist may work with a variety of medical and allied health professionals in a multidisciplinary team. This area of practice involves adaptation of many procedures to the type of patient that the agency serves. 8% of orthoptists work in a community agency.

**Rehabilitation Setting:**
This refers to either private or public agencies that have their primary focus on rehabilitation of patients. This may refer to a rehabilitation section of a public hospital or a community based centre. The orthoptist may work in teams of allied health professionals to ensure integration of all aspects of therapy for the patient. 4% are employed in this setting.

**Private Practice:**
This is where an orthoptist is carrying out practice privately and is therefore self employed. Often this work setting involves practice of orthoptics by a sole practitioner. 16% of orthoptists are self employed.

**Community Setting:**
This refers to a primary health care setting such as a Community Health Centre which is usually public funded and part of an area health region. Here the orthoptist works as
part of a multidisciplinary team and may be particularly involved with the promotion of eye health, prevention of ocular disorders and education of others about eye health care. 10% work in this setting.

NB: Workforce Study data total >100% as some orthoptists are employed in more than one setting.

9.2 Combining Units to describe Orthoptic Practice in Different Contexts

This set of competency standards describes the work done by many orthoptists. All units should be considered core units, that is, an entry level orthoptist should have all the skills necessary to attain competence in each unit. As Orthoptists work in many different work contexts they may not perform tasks from all units in any one context of practice. This is illustrated in Figure 3.

Figure 3: Units Grouped Together Into Different Contexts of Practice

For example an orthoptist working in a private ophthalmology practice may not utilise all units in the clinical care stream such as Unit 15 (Undertake referral), as in this context of practice the main responsibility for referral of patients is taken by the ophthalmologist. They would also have a minor role in community education (Unit 17) and promotion of ocular health (Unit 18). However they would have a prime responsibility for assisting in practice management (Unit 20 in the Administration Stream). Alternatively an orthoptist working in a community setting may have a major responsibility for undertaking referral (Unit 15) and provision of community education (Unit 17) and promotion of ocular health (Unit 18), yet have limited use of Unit 20 (Assist in practice management).
10.0 THE DEVELOPMENT PROCESS

10.1 Background to the competency standards movement:

A major move by the Australian Government during the 1980’s was to restructure the economic base of Australia. Alongside this there was a push to up-grade the skill level of the Australian workforce and organise areas of work more efficiently. Part of this reform was directed at education and training known as the “National Training Reform Agenda”. Its aim was to make vocational education and training more responsive to the needs of the workforce. In 1989 all state Ministers responsible for vocational training decided to move towards a competency based training system where the focus is to place emphasis on what the person can do after training. The National Training Board (NTB) has since played a major consultation and co-ordination role in the development of competency standards across all industries. It endorses national competency standards for all vocationally trained occupations, accredits Competency Standards bodies (CSB - industry groups recognised by the NTB to develop, present and review national competency standards), and maintains a register of competency standards and training providers. The CSB which facilities development of national competency standards for occupations in the community services is the National Community Services and Health Industry Advisory Training Board (NCS&H ITAB).

10.2 The professions and competency standards:

The National Office of Overseas Skills Recognition (NOOSR) was established in 1989 to improve the skills recognition process for overseas trained professionals by encouraging professions to develop and then use competency standards rather than qualifications as a basis of assessment. A series of research papers were produced outlining the competency standards development process and funding was made available to several professions to commence development work on competency standards. Figure 4 outlines the relationship between these government organisations and the process of development of competency standards as it existed when the orthoptic project commenced in 1994.
During the early 1990’s several professions received substantial financial support to develop competency standards including the health professions of pharmacy, dietetics, occupational therapy, optometry and physiotherapy. Funding was targeted at those professions with national registration or those with over 2000 members nation wide. As orthoptics did not meet these criteria no funding could be obtained.

It should be noted that the National Competency Standards for the Profession of Orthoptics presented here have been developed without any financial assistance from outside parties. This fact and the limited resources available to the OAA has inevitably prolonged the process of development as all work towards these standards has been achieved through the unpaid voluntary time of the Project Management Committee outside normal work hours.

The time delay between commencement of this project by the OAA in November 1994 to completion in early 1997 has seen substantial changes in the competency standards movement. NOOSR is no longer overseeing any competency standards development projects and is no longer a major player in the development of competency standards. In fact the competency standards movement has seen a change from development of competency standards for discrete occupations to development of competency standards for whole industry sectors including all levels of work from a basic worker to manager. The NCS&H ITAB though primarily involved in development of vocationally oriented competency standards has provided invaluable assistance to the OAA over the past 2 years. It has not however been able to endorse these competency standards as they represent competency standards for one profession and one level of work (entry-level) . Currently there appears to be no place for professions to gain endorsement of standards.

It is interesting to note that many of the professions who developed competency standards in the early to mid 1990’s did not seek endorsement of their standards by the
NTB, rather chose to leave the professional association as the custodian of the competency standards.\textsuperscript{4,5,6,14,15}

The format of competency standards has also seen changes over the past few years from a relatively simple document listing units, elements and performance criteria (see Optometry standards) to a more complex document including streams of units, unit descriptors, range of variables and evidence guide describing the assessment context, underpinning knowledge and skills and links to other standards. As far as has been possible the OAA has tried to keep a breast of these changes and present these National Competency Standards for the Profession of Orthoptics in the current format for competency standards. This has required considerable redrafting of the standards and patience amongst those involved in their development.

10.3 Phases of development of Competency Standards for Orthoptists

\textbullet\ Literature review, and formulation of the Competency Standards Project Management Committee

A discussion paper was presented to council members of the OAA in November 1993 outlining preliminary information regarding the competency standards movement particularly in relation to development of competency standards for many other professions.\textsuperscript{4,6,7,14} Published reports from the other professions were reviewed, advice and publications received from NOOSR and a guide to development of National Competency Standards was purchased from NCS&H ITAB. Informal discussions also occurred with several other professions who had developed their competency standards: eg Physiotherapy, Occupational Therapy, Medical Radiation Technology, and Social Work.

A Project Management Committee was formed in May 1994 to oversee the process of developing competency standards for the profession of orthoptics. The 5 members of this committee included one representative from each of the universities responsible for education of orthoptists, and one member from each state of NSW, Vic, Qld. Due to the limited resources of the OAA it was not possible to include a representative from each state, however at each stage of development of the competency standards the Council of the OAA with representatives from all states and the ACT were consulted. It should be noted that NSW, Vic and Qld represent 90% of the workforce.\textsuperscript{8}

The working party reviewed the guidelines for development of competency standards from NOOSR and NCS&H ITAB and developed a matrix to outline the dimensions of orthoptic practice (Appendix 1). This matrix was used in the initial stages to guide the development of the competency standards and thus adopting an integrated approach to their development (see Part A, Section 4).

\textbullet\ Development of the initial drafts of the competency standards:
Nov 1994 - May 1995

At the Nov 1994 Annual Scientific Conference of the OAA a paper\textsuperscript{16} was presented outlining many aspects of competency standards such as what are competency standards, where did they come from, what are the benefits & pitfalls, what are other professions doing, how are they developed, and format of competency standards. Following the paper a workshop was conducted with small group activities to gather ideas regarding elements and performance criteria for each unit. The annual conference for orthoptists is attended by approx 100-150 orthoptists each year (representing approx 40% of orthoptists Australia wide) and provided an excellent avenue for input by many orthoptists to the development of the competency standards.
A large amount of time was spent in early 1995 applying for funding to various government organisations for field testing of our draft competency standards. As none was forthcoming it was decided to continue this process without funding. The first draft of the competency standards were provided to the Council of the OAA in May 1995. The 5 members of the working party met in Sydney for a 2 day workshop following this meeting to develop draft 2 of the competency standards with unit descriptors and make changes to the elements and performance criteria following comments from the Council meeting. In addition validation strategies were organised to take place during the second half of 1995.

Validation of competency standards: June 1995 - Dec 1995

The Sub-committee reviewed mechanisms used by other professions to validate their competency standards as well literature detailing the various methodologies. Validation consisted of several stages including field testing by observation and interview, a review of the language and scope of the standards by a large group of the profession and further consultation of other related groups.

- Field testing:

A field testing guide to help validate the scope (focus) and level of the competency standards was developed by the Project Management Committee. The methodology most appropriate to the resources of the committee included observations and interviews with orthoptists that had graduated within the past 2 years (entry-level). Set interview questions and areas to focus the observations were developed to cover all of the units, elements and performance criteria. Information obtained in the 1994 OAA Workforce survey was included in the field testing guides and used to ensure that the main contexts of orthoptic practice would be included for field testing.

All members of the working party undertook observations and interviews of orthoptists across 5 states of Australia. The states included NSW, Vic, Qld, WA, and Tas. These states represent 92% of the orthoptic workforce. 5 observations and 12 interviews were conducted with orthoptists who had graduated within the past 2 years. This represents approx 38% of the yearly graduating population. (In 1994, 45 students graduated from the two Universities with a BAppSc - Orthoptics).

The majority of interviews and observations (82%) were conducted in the main workplace contexts of private ophthalmology practices and public hospital eye departments. The Workforce data of 1994 showed that 81% of practising orthoptists were working in either or both of these two areas.

Information received from the field testing was used to develop draft 3 of the competency standards which now included a range of variables statement.

- Further consultation with the orthoptic profession and other sectors of the industry.

Another paper tilted: Your typical day: Do our competency standards make the grade was presented at the OAA conference in Melbourne 1995 to approximately 160 orthoptists. All conference participants received a copy of draft 3 along with the feedback sheet to provide comments regarding the language and scope of the standards. Draft 3 of the competency standards were also sent to the groups outlined on page 4. Comments received back resulted in the 4th draft of the competency standards document.
Throughout the development process reports were submitted and discussed at each Council meeting in May and November each year and members were informed of the progress via the official OAA newsletter.

- Final drafts of the competency standards:

During 1996 it came apparent that the format of competency standards had altered from the models used by NOOSR and the professions. With close consultation and input from the NCS&H ITAB the Orthoptic Standards were redrafted to model this change in approach. This resulted in identification of streams of practice and an expansion of the number of units in these standards, as well as a more detailed range of variable statement including links with other profession’s competency standards. Draft 5 was presented to the Council of the OAA in Nov 1996 and consequentially reviewed by orthoptic representatives across Australia. This final feedback was used to formulate this final document.

Although the development of these National Competency Standards for the Profession of Orthoptics was an extended process the profession as a whole has greatly benefited the process of mapping out the diverse roles of the orthoptist, and considers the development of competency standards reflecting a higher, more specialised level of practice to be an important next phase.
11.0 USES OF THESE COMPETENCY STANDARDS

11.1 Benefits to the profession and community:

The development of National Competency Standards for the Profession of Orthoptics provides a number of benefits to the profession, and the community in general. Perceived benefits include:

⇒ Consistent practice standards across Australia:
Although the education of orthoptists in Australia is currently achieved in only two Universities, it is important to have explicit statements of what an orthoptist should be able to do to be a competent practitioner. In this way the general public can be better assured that they are receiving quality services from an orthoptist.

Open and equitable assessment of orthoptists educated outside Australia:
This was initially the primary purpose of development of competency standards in many of the health professions by NOOSR. It remains an important benefit. Currently Orthoptists from overseas are examined by an Examinations Subcommittee of the Orthoptic Board of Australia. This committee after reviewing the standards commented that guidelines currently used are not as “comprehensive” as the National Competency Standards for the Profession of Orthoptics and thus use of these standards would allow “a fairer assessment of professional people”. It should be considered that competency standards do offer an effective means to recognise prior learning and experience of overseas practitioners wishing to work in Australia.

Regulation of the profession:
Currently orthoptists are registered by the Orthoptic Board of Australia, a subcommittee of the Royal Australian College of Ophthalmologists. Currently there are several problems with this form of registration such that orthoptists are regulated by another profession and registration only occurs once in a practitioner’s lifetime. It would appear that maintenance of professional standards and protection of the public from poor practice cannot be assured with this form of registration. Currently the OAA is reviewing these problems and has identified one of its goals to establish the most appropriate national system for registration of orthoptists. These competency standards may assist in regulation of the profession in the future. However this would require careful consideration regarding the advantages and disadvantages of self regulation of the profession and design of appropriate competency standards assessment techniques.

Assistance in identifying suitable continuing professional education programs:
Over the past 5 years there has been a substantial move towards mandating continuing education in the health professions. Competency standards provide an excellent base for identifying continuing education needs as they accurately describe the current standard of performance required to practice as an orthoptist. This is particularly helpful for designing continuing education programs for practitioners who may have trained several years ago or wish to re-enter the workforce. In addition development of expanded competency standards with higher specialised levels also assists in identifying new areas of practice that may be addressed in continuing education programs. The competency standards may also assist practitioners to self assess their current level of competency and help individuals to develop their own self directed learning programs to ensure continued competence.

⇒ Guide to curriculum development:
Competency standards can assist the universities to ensure that existing courses meet the needs of the profession by preparing students to enter the profession with the attributes to
enable development of entry-level competence. Competency standards can be used in the curriculum review process, develop appropriate clinical education assessments and assist students to map their own development of competence.

⇒ **Provide a public statement of the profession:**
A clear set of competency standards assists the community to identify what an orthoptist can do, their unique roles and contexts within which the profession operates. Liaison with many groups outside the profession of orthoptics, such as unions has helped to raise community awareness of the profession.

Identify relationships between the health professions:
The health care setting and specifically eye care team consists of a variety of interrelated professional groups. Competency standards can help to highlight the similarities and differences between each profession. Although orthoptics should be considered a discrete profession in its own right, development of competency standards across disciplines may help to identify future pathways between each profession.

⇒ **Assistance in job evaluation:**
Identification of standards of performance and higher levels of competence can provide assistance in development of career structures. In the past orthoptists have had limited opportunities to demonstrate specialist skills and this is reflected in the narrow base of many orthoptic awards. These competency standards and future developments can help to more clearly identify the many roles of a practising orthoptist, and may in future assist in a more expanded career structure and subsequent improved remuneration for orthoptic work.

⇒ **Improvement of morale within profession:**
The OAA believes that the development of National Competency Standards for the Profession of Orthoptics has boosted the morale in the profession. During the development process there was close liaison with practitioners across the whole of Australia. Discussion of the practice of orthoptics helped orthoptists to identify the richness of their skills and may consequentially promote the development of excellence amongst members of the profession.

11.2 **Incorrect use of the competency standards:**

Whilst several benefits of these standards have been identified, the reader should also be aware of possible misuses of the document.

This document is not a curriculum statement, it merely states what an entry-level practitioner should be able to do in the workplace. It does not specify how the level of competence should be taught. Therefore the competency standards should not be used to judge any curriculum, rather act as a tool to guide developments in the content of any orthoptic curriculum.

The competency standards should be seen as a complete set of competency standards and not dissected to enable a practitioner to demonstrate competence in only some units. All units are core units and competence cannot be achieved unless all units are satisfactorily demonstrated. Fragmentation of the standards would fail to clearly capture the depth, breadth and complexities of orthoptic practice.

The assessment of whether an individual is competent to practice should only be made by orthoptists who have an understanding of the profession. Any assessments should be made by orthoptists who have had adequate training in assessment strategies and who are familiar with these competency standards.
Changes should not be made to these competency standards such as deleting units, elements or performance criteria without consultation and validation by the orthoptic profession, namely the OAA. However a practitioner may wish to add to the elements or performance criteria or change the range of variable statements to better describe their workplace. Even so any changes should be made with care.

Since the profession of orthoptics, through the OAA, has primarily been responsible for the development and validation of these competency standards they should remain the property of the OAA. They should not be used or modified by organisations or persons outside the orthoptic profession.

11.3 **These competency Standards and their future:**

The health care system is continually undergoing rapid change in response to technological advances and new knowledge. Throughout the development and validation of these competency standards the Project Management Committee has attempted to structure them in an adaptable and flexible way, so that future advances can be readily accommodated. It is however recommended that these competency standards be reviewed regularly no longer than 5 years following this report.

To ensure correct use of these competency standards, particularly in the assessment of entry-level competence, assessment strategies should be clearly defined and continually reviewed for reliability, validity and practicality.

It is also recommended that the profession of orthoptics consider the development of the higher level units detailed in section 8.2. This would assist the profession in identifying and articulating the many current areas of specialised practice.

The OAA as endorser of these competency standards should also be the custodian of these standards. However to ensure the benefits of these standards to the community, they should also be submitted to the National Training Board (now Australian National Training Authority -ANTA) for submission into the Register of Profession’s Competency Standards.

As the development of competency standards in the health and community services is always in a process of change the OAA should monitor future developments with the NCS&H ITAB.
12.0 References


17. NCS&HITAB (February 1995) Draft of Section 9: Methodologies and research techniques for Competency Standards Development


Appendix 1: **MATRIX OUTLINING THE DIMENSIONS OF ORTHOPTIC PRACTICE**

THREE DIMENSIONS OF ORTHOPTIC PRACTICE

- Technical Skills
- Knowledge
- Interpretive Skills
- Clinical Reasoning
- Attitudes, Communication & Interpersonal Skills

ROLES / TASKS

- Maintenance of Professional Responsibility
- Patient Interview
- Patient Assessment
- Defining Problem
- Recording of Clinical Data
- Intervention
- Education
- Administration

DOMAINS OF PRACTICE

- Generalist
- Paediatric
- Geriatric
- Rehabilitation
- Developmentally Delayed
PART 2:

NATIONAL COMPETENCY STANDARDS
FOR THE PROFESSION OF ORTHOPTICS
1.0 OVERVIEW OF UNITS & UNIT DESCRIPTORS

The unit descriptors for the current entry level units are stated in Table 3 below.

Table 3: Streams, Units and Unit Descriptors

<table>
<thead>
<tr>
<th>UNIT NO:</th>
<th>STREAM</th>
<th>UNIT DESCRIPTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>SELF IN WORKPLACE: Work effectively with others</td>
<td>This unit describes the competencies required: - to work in health care teams. It includes recognition of the orthoptists role in the team and provision of adequate communication with other members of the team.</td>
</tr>
<tr>
<td>2.</td>
<td>Participate in professional development</td>
<td>- by the orthoptist to maintain practice standards and promote development of the profession.</td>
</tr>
<tr>
<td>3.</td>
<td>Demonstrate safe working practices</td>
<td>- by legislation to ensure own and others safety and well being while implementing practice.</td>
</tr>
<tr>
<td>4.</td>
<td>Teach others</td>
<td>- for teaching in the workplace. It may relate to the teaching of students, co-workers or other health professionals.</td>
</tr>
<tr>
<td>5.</td>
<td>CLINICAL CARE - ASSESSMENT: Interview patient</td>
<td>This unit describes the competencies required: - to gain essential information from the patient which will form the basis of further assessment. It is an integral part of orthoptic practice and involves the attributes of communication and interpersonal skills.</td>
</tr>
<tr>
<td>6.</td>
<td>Plan patient assessment</td>
<td>- to determine the appropriate ocular tests required to diagnose or assist in the diagnosis of the ocular disease or disorder.</td>
</tr>
<tr>
<td>7.</td>
<td>Assess the sensory state of the eye and visual pathway</td>
<td>- to implement and evaluate quantitative and qualitative tests and investigative methods to ascertain the ocular status of the patient.</td>
</tr>
<tr>
<td>8.</td>
<td>Assess the motor function of the eyes</td>
<td>- to implement and evaluate quantitative and qualitative tests and investigative methods to ascertain the motor function of the eyes.</td>
</tr>
<tr>
<td>9.</td>
<td>Assess the presence and level of binocular vision</td>
<td>- to implement and evaluate quantitative and qualitative tests and investigative methods to ascertain the presence and level of binocular vision.</td>
</tr>
<tr>
<td></td>
<td>Task</td>
<td>Description</td>
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<tr>
<td>10.</td>
<td>Implement specialised ophthalmic testing procedures</td>
<td>- to implement and evaluate quantitative and qualitative tests and investigative methods to assist the eye care practitioner to establish the presence or absence of any ocular or visual system disorder.</td>
</tr>
<tr>
<td>11.</td>
<td>Diagnose ocular motility disorders</td>
<td>- to use the information gathered in unit 5, 7, 8, 9 and 10 to establish an accurate diagnosis for the case. It particularly involves the attributes of clinical reasoning and interpretive skills.</td>
</tr>
<tr>
<td>12.</td>
<td>Assist in diagnosis of ocular disorders</td>
<td>- to use the information gathered in unit 5, 7 and 10 to establish a probable diagnosis for the case. It particularly involves the attributes of clinical reasoning and interpretive skills.</td>
</tr>
<tr>
<td>13.</td>
<td>Plan and provide treatment for ocular motor disorders</td>
<td>- to undertake orthoptic management within the context of overall patient care.</td>
</tr>
<tr>
<td>14.</td>
<td>Assist in management of ocular disease</td>
<td>- to assist the eye care practitioner to manage the ocular disorder.</td>
</tr>
<tr>
<td>15.</td>
<td>Undertake referral</td>
<td>- to contribute to the health care of the patient by referring them to another practitioner.</td>
</tr>
<tr>
<td>16.</td>
<td>Provide patient education</td>
<td>- to give advice and instruction to the individual patient and caregiver. This involves the attributes of communication and interpersonal skills.</td>
</tr>
<tr>
<td>17.</td>
<td>Provide community education</td>
<td>- to educate the community about eye care and orthoptic practice. This involves the attributes of communication and interpersonal skills.</td>
</tr>
<tr>
<td>18.</td>
<td>Promote ocular health</td>
<td>- to participate in activities that will contribute to promoting ocular health and preventing ocular problems.</td>
</tr>
<tr>
<td>19.</td>
<td>Record clinical data</td>
<td>- to record and store accurate clinical information to assist in the management of patients. This unit requires adherence to the legal and ethical requirements for the keeping of medical records.</td>
</tr>
<tr>
<td>20.</td>
<td>Assist in practice management</td>
<td>- to provide efficient performance in the workplace including quality assurance practices and small business management when appropriate.</td>
</tr>
</tbody>
</table>
2.0 COMPLETE COMPETENCY STANDARDS DOCUMENT

STREAM 1: SELF IN WORKPLACE

UNITS 1 - 4: Pages 36-46

STREAM 2: CLINICAL CARE

Assessment: UNITS 5 - 12
Treatment: UNITS 13 - 15
Community Service: UNITS 16 - 18

STREAM 3: ADMINISTRATION

UNITS 19 - 20
UNIT 1: Work effectively with others

Unit Descriptor:
This unit describes the competencies required to work in health care teams. It includes recognition of the orthoptists role in the team and provision of adequate communication with other members of the team.

<table>
<thead>
<tr>
<th>Element:</th>
<th>Performance Criteria:</th>
</tr>
</thead>
</table>
| 1.1 Operate effectively within the health care system | - Practise reflects current health care policies.  
- Roles responsibilities and interrelationships of health care professionals are identified and incorporated into practice strategies.  
- Range of health, community and related services are identified and utilised in practice.  
- Services provided are necessary for the care of the patient.  
- Work is undertaken autonomously in accordance with health care policies.  
- Possible consequences of actions and advice are evaluated and advice is given appropriately.  
- Responsibility for own actions is accepted.  
- Patients are not enticed from colleagues. |
| 1.2 Work as a member of a team | - The role of the orthoptist is explained and promoted to other members of the health care team.  
- The services of other members of the team are enlisted according to their roles and responsibilities.  
- Information is provided to other team members in a way that is understood by the recipient.  
- Team members are advised of issues which need to be jointly resolved. |
| 1.3 Communicate effectively | - Information is conveyed clearly and readily clarified when necessary.  
- Direction and advice is sought when required and followed as appropriate to the situation.  
- Team input is sought and considered wherever desirable and possible.  
- Causes of conflict (and potential conflict) are recognised when they occur and dealt within a manner which prevents escalation.  
- Difficulties in communication are recognised and resolved using appropriate communication skills and techniques.  
- The needs of individual team members are respected and treated in a sensitive manner. |
### 1.4 Manage workload

- Workload is organised in accordance with demands on time.
- Work is managed efficiently and effectively within the resources available.
- Assistance is requested from colleagues and others to complete workload, as appropriate.
- Work functions are carried out in co-operation with other team members.
- Responsibility is delegated to other members in accordance with their roles and abilities.

### Range of Variables Statement:

Health care teams include:
- eye care practitioners
- other medical and nursing practitioners
- allied health professionals
- administrators

Health care system include:
- Federal, State or local government organisations
- public and private health care providers
- health insurance schemes and funds
- or more widely services that provide health and well being for the community or members of the community (eg. schools, retirement villages etc)

Health care policies include:
- Federal, State or local government health or education policies
- Orthoptic Association of Australia Inc policies
- Royal Australian and New Zealand College of Ophthalmologists’ policies including those of the Australian Orthoptic Board.
- organisational policies
- employer directives which guide practice.

### Evidence Guide:

**Assessment context:**
This unit is relevant to all practice contexts but would be best assessed in a public hospital, community agency, rehabilitation and community setting because it is in this context that orthoptists are most likely to function within a discrete health care team.

**Underpinning knowledge & skills:**
- knowledge of team member roles and responsibilities
- skill of explaining and communicating at the appropriate level for the team member
- knowledge of health care system and role of other health care professionals
- knowledge of the support services available in the community
- effective communication skills
- skill of analysis, interpretation and application of information to specific client or clinical situations

Links to other units:
- Australian Physiotherapy Competency Standards (1994):
  - Unit 7: “Operates effectively within the health care system”.
  - Unit 8 “Applies management skills in physiotherapy practice”.
- Draft Competency Standards for Optical Dispensers NSW (1995):
  - Unit 1: “Communicate with clients, practitioner and supplier”:
- Competency Standards for Entry-level to the Profession of Optometry (1993):
  - Unit 1: “Professional development and responsibilities”.
UNIT 2: Participate in professional development

Unit Descriptor:

This unit describes the competencies required by the orthoptist to maintain practice standards and promote development of the profession.

<table>
<thead>
<tr>
<th>Element:</th>
<th>Performance Criteria:</th>
</tr>
</thead>
</table>
| 2.1 Self-evaluate own performance | - Own performance is critically evaluated and changes made to improve practice.  
- Practice is undertaken within the boundaries of own abilities.  
- Information, advice and feedback is sought from other colleagues to improve own practice skills.  
- Suggestions to improve practice are accepted and acted upon. |
| 2.2 Maintain own orthoptic knowledge | - Continuing education requirements and personal objectives are identified and recorded.  
- Resources to meet learning needs are located and accessed.  
- New information published in the area of practice is reviewed and critically evaluated.  
- Technological advances and new clinical techniques relevant to area of practice are reviewed and implemented when appropriate.  
- Contact with colleagues for the purpose of discussion of clinical developments is maintained. |
| 2.3 Contribute to the development of the profession | - Others are provided with education about aspects of orthoptics and eye care.  
- Experiences and new developments are shared with colleagues and undergraduate students.  
- Research activities undertaken by the profession are supported and contributions made. |

Range of Variables Statement:

Continuing education requirements and personal objectives may include:
- need for more current information  
- need for further education or training  
- need for clarification  
- need for assessment of current skill level  
as required by current practice requirements or personal practice goals (eg. to improve knowledge and skills in a new area)
Resources to meet learning needs may include:
- texts and journals
- training and education programs
- colleagues or supervisors
- specialist practitioners
- other health care professionals
- supplying companies representatives

Evidence Guide:

Assessment context:
This unit is relevant to all contexts of orthoptic practice. This may include a private ophthalmology practice, hospital, a private practice, a community setting, a community agency, or a rehabilitation setting.

Assessment may be by colleagues, education providers, other eye health practitioners.

Underpinning knowledge & skills:
- normal ocular function (anatomy, physiology and optics)
- ocular health, process and impact of diseases and their treatment options
- orthoptic practice guidelines
- code of professional conduct for orthoptists
- role of the Orthoptic Association of Australia, and other related professional organisations such as Australian Orthoptic Board.
- Department of Health policies including infectious diseases guidelines
- ability to conduct clinical research or aspects of research (eg. data collection)
- lifelong learning skills and ability to undertake independent learning
- ability to critically evaluate procedures both new and established
- ability to access and retrieve ongoing theoretical material

Links to other units:
- Draft Competency Standards for Optical Dispensers NSW (1995):
  - Unit 2: “Practice in an ethical, equitable, and professional manner”,
  - Unit 5: “Participate in professional development”,
  - Unit 8: “Perform procedures safely”.
- Competency Standards for Entry-level to the Profession of Optometry (1993):
  - Unit 1: “Professional development and responsibilities”.
**UNIT 3: Demonstrate safe working practices**

Unit Descriptor:

This unit describes the competencies required by legislation to ensure own and others safety and well being while implementing practice.

<table>
<thead>
<tr>
<th>Element:</th>
<th>Performance Criteria:</th>
</tr>
</thead>
</table>
| 3.1 Follow organisational and legislative guidelines for infection control and hazard identification and risk | - Organisational guidelines including “standard” and “additional” precautions and infection control procedures are observed.  
- Hazards in the workplace are identified and reported according to organisational guidelines.  
- Organisational guidelines for controlling risks are followed.  
- Organisational guidelines for dealing with emergencies, accidents and fires are followed. |
| 3.2 Recognise and respond to own needs in the workplace | - Safe practices are followed when performing work tasks.  
- Own needs arising from the work hazards and workload are monitored.  
- Strategies to meet needs are identified, implemented and outcomes monitored.  
- Support is sought after stressful incidents. |
| 3.3 Monitor Occupational Health and Safety practice | - Incident reports and other Occupational Health and Safety records are kept as required by legislation and organisational guidelines.  
- The effectiveness of Occupational Health and Safety practices in the workplace is assessed and recorded.  
- Changes to Occupational Health and Safety practice are made or suggested to improve safety. |

Range of Variables Statement:

Organisational guidelines include:
- job procedures and work instructions  
- guidelines for handling toxic substances  
- infection control procedures  
- legislation, organisational or workplace guidelines for safe working practices  
- hazard response policies and procedures  
- emergency fire and accident policies  
- procedures for the use of personal protective clothing and equipment  
- hazard identification procedures
Organisational guidelines are provided by:
- Department of Health policies
- National Health and Medical Research Council guidelines
- a legislative framework
- an employing organisation
- building guidelines for hazard response
- directives from senior workers, other professionals and employers about appropriate safe practices.

Guidelines are found in:
- policy and procedure manuals
- staff manuals
- occupational health and safety manuals
- professional guidelines and standards
- legislation and regulations

“Standard” and “Additional” precautions and infection control procedures may include:
- clean and tidy equipment
- collection and disposal of items
- sterilisation of equipment
- storage and repair of equipment
- instillation and storage of eye medications

Biological hazards are:
- “Standard” such as blood, all other body secretions and excretions (excluding sweat) regardless of whether they contain visible blood, non intact skin, mucous membranes.
- “Additional” such as pathogens transmissible by air-borne means (eg. viruses) or droplet means (eg. rubella)

The “own needs” of the worker may include:
- workload management
- time management
- stress management
- debriefing
- personal or professional support

Evidence Guide:

Assessment Context:
- Any context of practice is recommended for assessment

Underpinning knowledge & skills:
- “Standard” and “Additional” precautions
- safe handling procedures
- occupational health and safety legislation
- organisational occupational health and safety policies, procedures and programs
- identified hazards
- risk assessment and control procedures
- communication and reporting

Links to other units:
- based on various Occupational Health and Safety units of Competency Standards developed by the National Community Services and Health Industry Training Advisory Board to meet the requirement for incorporating Occupational Health and Safety into National Competency Standards. This must be applied to the context of all practice areas.

- Draft Competency Standards for Optical Dispensers NSW (1995):
  - Unit 8 “Perform procedures safely”,
  - Unit 2: “Practice in an ethical, equitable and professional manner”,
  - Unit 3: “Perform workshop skills”
- Australian Physiotherapy Competency Standards (1994):
  - Unit 8: “Applies management skills in physiotherapy practice.”
UNIT 4: Teach Others

Unit Descriptor:

This unit describes the competencies required for teaching in the workplace. It may relate to the teaching of students, co-workers or other health professionals.

<table>
<thead>
<tr>
<th>Element:</th>
<th>Performance Criteria:</th>
</tr>
</thead>
</table>
| 4.1 Prepare for the teaching session | - The education need is identified in consultation with participants and relevant others.  
- The teaching is planned to meet the educational need.  
- Teaching resources are identified and accessed.  
- Participants and relevant others are notified of the purpose, time and place of the teaching session. |
| 4.2 Deliver the teaching session | - The teaching session is presented according to the purpose and the plan.  
- Teaching strategies include explanation, demonstration and feedback.  
- Practice opportunities are provided according to the needs of the student and the purpose of the session.  
- Participant performance is monitored during the teaching session. |
| 4.3 Evaluate the teaching session | - Participants are encouraged to raise problems or difficulties with any aspect of the teaching session.  
- The effectiveness of the teaching session is evaluated with regard to the purpose of the session.  
- Results of the evaluation are used to guide future teaching sessions. |

Range of Variables Statement:

Teaching sessions may include:  
- formal or informal education of others  
- training in specific aspects of work  
- knowledge and skills based education and training  
- discussion forums  
- demonstrations and mentoring arrangements  
- group sessions and one to one teaching situations
Teaching may occur in:
- the workplace
- a school
- a teaching institution
- a patient’s home
- a peer support group
- another workplace

Participants may include:
- undergraduates of orthoptics or other course (eg. medical students)
- support staff, such as secretarial staff
- other health professionals (eg. nurses, allied health professionals)
- other orthoptists
- peer groups
- carers or family members

Teaching resources may include:
- content knowledge
- texts
- audiovisual material
- computer programs or resources from the internet
- patients for demonstration purposes
- equipment for demonstration purposes

Evaluation may be:
- formal or informal
- written or verbal
- of the teaching session and of performance.

Evidence Guide:

Assessment Context:
Any context of practice is recommended for assessment. Assessment should occur in the workplace or by simulation with due regard for participant’s and patient’s comfort, confidentiality and dignity.

Underpinning knowledge & skills:
- knowledge of content for the area being taught
- good communication skills, active listening skills
- teaching and learning process including questioning techniques, adaptation of delivery level to recipient
- observation and assessment skills
Links to other units:
- Category 1: The Revised Workplace Trainers Competency Standards (Endorsed 30th June 1994 valid until July 1999)
- Draft Competency Standards for Optical Dispensers (NSW) 1995:
  - Unit 1: “Communicate with clients, practitioners and suppliers”
  - Unit 7: “Apply business principles”
- Competency Standards for Entry-level to the Profession of Optometry (1993):
  - Unit 7: “Practice Management”
STREAM 1: SELF IN WORKPLACE

UNITS 1 - 4 : Pages 36-46

STREAM 2: CLINICAL CARE

Assessment: UNITS 5 - 12
Treatment: UNITS 13 - 15
Community Service: UNITS 16 - 18

STREAM 3: ADMINISTRATION

UNITS 19 - 20
UNIT 5: Interview Patient

Unit Descriptor:

This unit describes the competencies required to gain essential information from the patient which will form the basis of further assessment. It is an integral part of orthoptic practice and involves the attributes of communication and interpersonal skills.

<table>
<thead>
<tr>
<th>Element:</th>
<th>Performance Criteria:</th>
</tr>
</thead>
</table>
| 5.1 Establish rapport with patient or patient’s caregiver | - Role of the orthoptist is discussed with patient.  
- Patient is addressed correctly.  
- Genuine interest in the patient is demonstrated.  
- Cultural background and individuality of the patient is respected.  
- Specific needs of the patient are identified in consultation with the patient and responded to in accordance with the resources available.  
- Communication techniques are adjusted to best meet the patient’s needs.  
- Dealings with patient show compassion and respect for human dignity.  
- Motives of profit or bias are not permitted to influence their free and independent judgement on behalf of patients.  
- The right of patients to confidentiality of their medical records is respected, as per Commonwealth Privacy Act (2000). |
| 5.2 Obtain a case history | - Patient’s presenting problem is ascertained and noted in consultation with the patient.  
- History of the presenting problem including onset, duration, progression, possible causes, severity and previous treatment is gathered from patient and other appropriate sources.  
- Other information relevant to the care of the patient including age, birth history, eye history, general medical history, and relevant family history is identified and gathered.  
- Questions and statements are phrased so that adequate information can be elicited.  
- Questions and statements are modified and adapted according to the information gained.  
- Information gained from patient is integrated with other sources of information about the patient.  
- Information gained in interview is accurately and concisely recorded. |
Range of Variables Statement:

Other sources of patient history information include:
- referral letters
- school reports
- medical records
- other health professionals (with permission of the patient or caregiver)
- a caregiver (if the patient is unable to provide the information)

Evidence Guide:

Assessment context:
This unit needs to be assessed in any of the following contexts:
- private ophthalmology practice
- hospital
- private practice
- community setting
- community agency
- rehabilitation setting
- patient’s home

Patient interviews would need to be undertaken on two types of patients from the following groups:
- paediatric
- developmentally delayed
- adult
- geriatric
- low vision
- neurological impairment
- communication difficulties

All elements & performance criteria would need to be satisfied. The number of patients interviewed to meet this would vary according to the context of the workplace. It is suggested that one new patient be interviewed.

Knowledge may be assessed on or off the job. Practice skills should be assessed on the job or by simulation, with due regard for the patient’s comfort, confidentially and dignity.

This unit should be assessed in conjunction with the all other units of the Clinical Care stream except 15, 16, 17, and 18; and Unit 19 of the Administration stream.

Underpinning knowledge & skills:
- recognition of communication barriers and methods of effective communication
- knowledge of presenting visual problems- signs and symptoms
- history taking procedures
- questioning techniques
- observation skills
- clinical reasoning skills which involve the selection of appropriate components of the patient interview, integration of the total interview information leading to a focus on the appropriate selection and sequencing of assessment techniques.

Links to other units:
- Competency Standards for Entry-level to the Profession of Optometry (1993):
  - Unit 2 “Patient History”.
- Draft Competency Standards for Optical Dispensers NSW (1995):
  - Unit 1: “Communicate with clients, practitioners and suppliers”.
- Australian Physiotherapy Competency Standards (1994):
  - Unit 1: “Assess the client’s abilities, problems and needs”. 
UNIT 6: Plan Patient Assessment

Unit Descriptor:

This unit describes the competencies required to determine the appropriate ocular tests required to diagnose or assist in the diagnosis of the ocular disease or disorder.

<table>
<thead>
<tr>
<th>Element:</th>
<th>Performance Criteria:</th>
</tr>
</thead>
</table>
| 6.1 Observe patient, including their eyes, ocular adnexa, adaptive head postures, body responses and behaviour | - Observations are focused to the most relevant information for each patient.  
- Observations are used to modify actions during the interview and examination of the patient.  
- Non-verbal cues from the patient are used to modify clinical procedures to be undertaken. |
| 6.2 Apply knowledge of the visual system and its abnormalities, as well as clinical reasoning skills, to plan the assessment process | - Testing procedures are selected to clarify information acquired during patient interview.  
- Testing procedures are selected and modified according to the age and capability of the patient.  
- Test sequence and timing are determined according to the patient’s problems and priorities.  
- Testing procedures are varied creatively according to the patient’s responses.  
- Testing procedures selected are appropriate for the purpose of the assessment (the reason for the patient’s visit).  
- Testing procedures reflect possible generated hypotheses regarding the patient’s problem. |

Range of Variables Statement:

Assessment may be for the purposes of:
- determining the sensory state of the eyes and visual pathway  
- ascertaining the motor function of the eyes  
- establishing the presence and level of binocular vision  
- undertaking specialised ophthalmic testing procedures in the ophthalmic setting to assist the ophthalmologist in diagnosing the ocular disorder.

Testing procedures include those specific tests required for determination of the above assessment purposes (testing procedures are outlined in the Range of Variables statement in Unit 7, 8, 9, &10).
Evidence guide:

Assessment context:
This unit needs to be assessed in any of the following contexts:
- private ophthalmology practice
- hospital
- private practice
- community setting
- rehabilitation setting
- community agency
- patient’s home

Patient assessments would need to be undertaken on two types of patients from the following groups:
- paediatric
- developmentally delayed
- adult
- geriatric
- low vision
- neurological impairment
- communication difficulties

This unit should be assessed in conjunction with other units: Interview patient and the relevant assessment unit. Knowledge may be assessed on or off the job. Practice skills should be assessed on the job or by simulation, with due regard for the patient’s comfort, confidentially and dignity.

Underpinning knowledge & skills:
- observation skills
- knowledge of anatomy, physiology, optics of the visual system and other general body systems such as circulatory system, nervous system
- knowledge of normal paediatric visual development and normal physiological processes of aging in relation to the visual system
- knowledge of disorders and pathogenesis of disorders that can affect the visual system
- knowledge and application of available testing procedures
- knowledge and application of all visual testing apparatus
- knowledge of abnormal and normal responses to visual testing
- ability to appropriately select visual testing apparatus
- ability to creatively adapt standard testing procedures for each patient’s capabilities and different clinical presentations
- ability to analyse and interpret patient responses then integrate the outcome into the assessment plan

Links to other units:
- Competency Standards for Entry-level to the Profession of Optometry (1993):
  - Unit 3 “Patient Examination”.
- Draft Competency Standards for Optical Dispensers NSW (1995):
  - Unit 4: “Dispense products and services”
# UNIT 7: Assess the Sensory State of the Eye and Visual Pathway

**Unit Descriptor:**

This unit describes the competencies required to implement and evaluate quantitative and qualitative tests and investigative methods to ascertain the ocular status of the patient.

<table>
<thead>
<tr>
<th>Element:</th>
<th>Performance Criteria:</th>
</tr>
</thead>
</table>
| **7.1 Use appropriate interpersonal/communication skills to carry out the patient assessment** | - Patient or caregiver is advised of the purpose of the tests.  
- Appropriate instructions and questions are given to the patient or caregiver to enable adequate responses to the tests.  
- Patient questions and concerns are addressed sufficiently.  
- Patient is reassured as required throughout the testing procedures. |
| **7.2 Use quantitative and qualitative tests to investigate the ocular status of the patient** | - Appropriate testing equipment is selected and positioned correctly.  
- Testing equipment is operated according to specifications.  
- Test results are recorded in patient records in accordance with practice requirements.  
- Test responses are interpreted and used to adapt or introduce alternative testing procedures. |
| **7.3 Observe patient’s responses to the tests** | - Patterns of normal and abnormal responses to testing procedures are recognised and noted.  
- Verbal and non-verbal cues from the patient are noted to ensure accurate recording of responses.  
- Observations made are accurately recorded. |

**Range of Variables Statement:**

Qualitative and quantitative tests and investigative methods to assess the sensory state of the eyes and visual pathway may include a wide range of:
- visual acuity tests for testing vision on both adult and paediatric patients  
- visual field tests  
- colour vision tests  
- tests for pupillary function  
- electrodiagnostic tests
Testing equipment may include a wide variety of tests that can be both portable or stationary, applied manually or computer generated.

Specifications for testing may include:
- positioning of equipment
- distance of equipment from patient
- speed at which test should be performed
- required level or type of illumination
- whether patient should wear glasses or other optical aids
- calibration of equipment
- identified national conventions

Practice requirements for recording test results include:
- terminology
- accepted abbreviations
- accepted diagrams

**Evidence guide:**

**Assessment context:**
This unit needs to be assessed in any of the following contexts:
- private ophthalmology practice
- hospital
- private practice
- community setting
- community agency
- rehabilitation setting
- patient’s home

Patient assessments would need to be undertaken on two types of patients from the following groups:
- paediatric
- developmentally delayed
- adult
- geriatric
- low vision
- neurological impairment
- communication difficulties

This unit should be assessed in conjunction with other units in the Clinical Care Stream such as Unit 5 “Interview patient” and Unit 6: “Plan patient assessment” Knowledge may be assessed on or off the job. Practice skills should be assessed on the job or by simulation, with due regard for the patient’s comfort, confidentiality and dignity.
Underpinning knowledge & skills:
- observation skills
- knowledge of anatomy, physiology, optics of the visual system and other general body systems such as nervous system
- knowledge of normal visual development and normal physiological processes of aging in relation to the visual sensory system
- knowledge of disorders and pathogenesis of disorders that can affect the visual sensory system
- knowledge and application of available testing procedures
- knowledge and application of all visual testing apparatus for assessing the sensory state of the eyes and visual pathway
- ability to use visual testing apparatus
- knowledge of abnormal and normal responses to sensory vision testing
- ability to creatively adapt standard testing procedures for each patient’s capability and different clinical presentations
- ability to analyse and interpret patient responses to obtain information
- interpersonal skills

Links to other units:
- Competency Standards for Entry-level to the Profession of Optometry (1993):
  - Unit 3 “Patient Examination”
## UNIT 8: Assess the Motor Function of the Eyes

### Unit Descriptor:

This unit describes the competencies required to implement and evaluate quantitative and qualitative tests and investigative methods to ascertain the motor function of the eyes.

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance Criteria:</th>
</tr>
</thead>
</table>
| **8.1 Use appropriate interpersonal/communication skills to carry out the patient assessment** | - Patient or caregiver is advised of the purpose of the tests.  
- Appropriate instructions and questions are given to the patient or caregiver to enable adequate responses to the tests.  
- Patient questions and concerns are addressed sufficiently.  
- Patient is reassured as required throughout the testing procedures. |
| **8.2 Use quantitative and qualitative tests to investigate the ocular status of the patient** | - Appropriate testing equipment is selected and positioned correctly.  
- Testing equipment is operated according to specifications.  
- Test results are recorded in patient records in accordance with practice requirements.  
- Test responses are interpreted and used to adapt or introduce alternative testing procedures. |
| **8.3 Observe patient’s responses to the tests** | - Patterns of normal and abnormal responses to testing procedures are recognised and noted.  
- Verbal and non-verbal cues from the patient are noted to ensure accurate recording of responses.  
- Observations made are accurately recorded. |

### Range of Variables Statement:

Qualitative and quantitative tests and investigative procedures to assess the motor function of the eyes may include a wide range of:
- tests to detect and measure all types of ocular deviations (eg. cover test- cover uncover and alternate cover test, prism cover test, Maddox Rod, Maddox Wing, Synoptophore, Hess Chart)
- tests to assess all aspects of ocular motility such as saccadic, smooth pursuit and vergence systems as well as ocular muscle imbalance.
Testing equipment may include a wide variety of tests that can be both portable or stationary, applied manually or computer generated.

Specification for testing may include:
- positioning of equipment
- distance of equipment from patient
- speed at which test should be performed
- required level or type of illumination
- whether patient should wear glasses or other optical aids
- calibration of equipment
- identified national conventions

Practice requirements for recording test results include:
- terminology
- accepted abbreviations
- accepted diagrams

**Evidence guide:**

**Assessment context:**
This unit needs to be assessed in any of the following contexts:
- private ophthalmology practice
- hospital
- private practice
- community setting
- community agency
- rehabilitation setting
- patient’s home

Patient assessments would need to be undertaken on two types of patients from the following groups:
- paediatric
- developmentally delayed
- adult
- geriatric
- low vision
- neurological impairment
- communication difficulties

This unit should be assessed in conjunction with other units in the Clinical Care Stream such as Unit 5 “Interview patient” and Unit 6: “Plan patient assessment”. Knowledge may be assessed on or off the job. Practice skills should be assessed on the job or by simulation, with due regard for the patient’s comfort, confidentially and dignity.
Underpinning knowledge & skills:
- observation skills
- knowledge of anatomy and physiology of the ocular motor system and other general body systems such as the central and peripheral nervous systems
- knowledge of normal visual development and normal physiological processes of aging in relation to the ocular motor system
- knowledge of disorders and pathogenesis of disorders that can affect the ocular motor system
- knowledge and application of available testing procedures
- knowledge and application of all visual testing apparatus for assessment of motor function of the eyes
- ability to use visual testing apparatus
- knowledge of abnormal and normal responses to ocular motor testing
- ability to creatively adapt standard testing procedures for each patient’s capability and different clinical presentations
- ability to analyse and interpret patient responses to obtain information
- interpersonal skills

Links to other units:
- Competency Standards for Entry-level to the Profession of Optometry (1993):
  - Unit 3 “Patient Examination”
UNIT 9: Assess the Presence and Level of Binocular Vision

Unit Descriptor:

This unit describes the competencies required to implement and evaluate quantitative and qualitative tests and investigative methods to ascertain the presence and level of binocular vision.

<table>
<thead>
<tr>
<th>Element:</th>
<th>Performance Criteria:</th>
</tr>
</thead>
</table>
| 9.1 Use appropriate interpersonal/communication skills to carry out the patient assessment | - Patient or caregiver is advised of the purpose of the tests.  
- Appropriate instructions and questions are given to the patient or caregiver to enable adequate responses to the tests.  
- Patient questions and concerns are addressed sufficiently.  
- Patient is reassured as required throughout the testing procedures. |
| 9.2 Use quantitative and qualitative tests to investigate the ocular status of the patient | - Appropriate testing equipment is selected and positioned correctly.  
- Testing equipment is operated according to specifications.  
- Test results are recorded in patient records in accordance with practice requirements.  
- Test responses are interpreted and used to adapt or introduce alternative testing procedures. |
| 9.3 Observe patient’s responses to the tests | - Patterns of normal and abnormal responses to testing procedures are recognised and noted.  
- Verbal and non-verbal cues from the patient are noted to ensure accurate recording of responses.  
- Observations made are accurately recorded. |

Range of Variables Statement:

Qualitative and quantitative tests and investigative procedures to assess the presence and level of binocular vision may include a wide range of tests to:
- detect and evaluate presence of simultaneous perception and superimposition  
- confirm sensory fusion  
- measure the range of fusional vergences  
- detect and measure degree of stereopsis  
- detect and measure area and depth of suppression
Testing equipment may include a wide variety of tests that can be both portable or stationary, applied manually or computer generated.

Specification for testing may include:
- positioning of equipment
- distance of equipment from patient
- speed at which test should be performed
- required level or type of illumination
- whether patient should wear glasses or other optical aids
- calibration of equipment
- identified national conventions

Practice requirements for recording test results include:
- terminology
- accepted abbreviations
- accepted diagrams

Evidence guide:

Assessment context:
This unit needs to be assessed in any of the following contexts:
- private ophthalmology practice
- hospital
- private practice
- community agency
- rehabilitation setting
- community setting
- patient’s home

Patient assessments would need to be undertaken on two types of patients from the following groups:
- paediatric
- developmentally delayed
- adult
- geriatric
- low vision
- neurological impairment
- communication difficulties

This unit should be assessed in conjunction with other units in the Clinical Care Stream such as Unit 5 “Interview patient” and Unit 6: “Plan patient assessment”. Knowledge may be assessed on or off the job. Practice skills should be assessed on the job or by simulation, with due regard for the patient’s comfort, confidentially and dignity.
Underpinning knowledge & skills:
- observation skills
- knowledge of anatomy, physiology, optics of the binocular vision system and other general body systems such as nervous system
- knowledge of normal visual development and normal physiological processes of aging in relation to binocular vision
- knowledge of disorders and pathogenesis of disorders that can affect binocular vision
- knowledge and application of available testing procedures
- knowledge and application of all visual testing apparatus for detecting the presence and level of binocular vision
- ability to use visual testing apparatus
- knowledge of abnormal and normal responses to binocular vision testing
- ability to creatively adapt standard testing procedures for each patient’s capability and different clinical presentations
- ability to analyse and interpret patient responses to obtain information
- interpersonal skills

Links to other units:
- Competency Standards for Entry-level to the Profession of Optometry (1993):
  - Unit 3 “Patient Examination”
## UNIT 10: Implement Specialised Ophthalmic Testing Procedures

### Unit Descriptor:

This unit describes the competencies required to implement and evaluate quantitative and qualitative tests and investigative methods to assist the eye care practitioner to establish the presence or absence of any ocular or visual system disorder.

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance Criteria:</th>
</tr>
</thead>
</table>
| 10.1 Use specialised ophthalmic procedures to reveal possible ocular or visual system disorders | - Eye care practitioner is consulted as appropriate.  
- Testing requirements including timing and sequencing are discussed with the eye care practitioner.  
- Assessment plan meets the requirements of the eye care practitioner. |
| 10.2 Use appropriate interpersonal/communication skills to carry out the patient assessment | - Patient or caregiver is advised of the purpose of the tests.  
- Appropriate instructions and questions are given to the patient or caregiver to enable adequate responses to the tests.  
- Patient questions and concerns are addressed sufficiently.  
- Patient is reassured as required throughout the testing procedures. |
| 10.3 Use quantitative and qualitative tests to investigate the ocular status of the patient | - Appropriate testing equipment is selected and positioned correctly.  
- Testing equipment is operated according to specifications.  
- Test results are recorded in patient records in accordance with practice requirements.  
- Test responses are interpreted and used to adapt or introduce alternative testing procedures. |
| 10.4 Observe patient’s responses to the tests | - Patterns of normal and abnormal responses to testing procedures are recognised and noted.  
- Verbal and non-verbal cues from the patient are noted to ensure accurate recording of responses.  
- Observations made are accurately recorded. |
| 10.5 Assist the eye care practitioner to carry out specialised ophthalmic testing procedures | - Patient is made ready for the testing procedure.  
- Equipment is made ready for the testing procedure.  
- Assistance is given to the eye care practitioner during the testing procedure. |
Range of Variables Statement:

Specialised ophthalmic procedures may include:
- vertometry and estimation of the power of optical lenses
- tonometery
- keratometry
- slit lamp examination
- ultrasonography
- ophthalmic photography including slit lamp, fundus and fluorescein angiography
- refraction: objective, subjective, and automated
- visual field examination such as computerised perimetry, Goldmann, Bjerrum, Amsler and confrontation methods
- contact lens assessment
- set up of operating equipment for diagnostic procedures
- instillation of ocular medication such as ointment and eye drops
- pachymetry
- corneal topography

Testing procedures may include a wide variety of tests that can be both portable or stationary, applied manually or computer generated.

Eye care practitioner may include:
- ophthalmologist
- optometrist
- optical dispenser
- ophthalmic nurse

Specification for testing may include:
- positioning of equipment
- distance of equipment from patient
- speed at which test should be performed
- required level or type of illumination
- whether patient should wear glasses or other optical aids
- calibration of equipment
- identified national conventions

Practice requirements for recording test results include:
- terminology
- accepted abbreviations
- accepted diagrams

Patient is made ready refers to:
- instillation of ophthalmic medications prior to the testing procedure
- evaluation of the effect of ophthalmic medications
Equipment is made ready refers to:
- setting up ophthalmic preparations for use during testing procedure, including minor operative procedures room
- ensuring equipment is functioning and ready to be used
- maintenance of equipment
- cleaning and sterilisation of equipment

Evidence guide:

Assessment context:
This unit needs to be assessed in any of the following contexts:
- private ophthalmology practice
- hospital
- private practice
- community setting
- community agency
- rehabilitation setting

Patient assessments would need to be undertaken on two types of patients from the following groups:
- paediatric
- developmentally delayed
- adult
- geriatric
- low vision
- neurological impairment
- communication difficulties

This unit should be assessed in conjunction with other units in the Clinical Care Stream such as Unit 5 “Interview patient” and Unit 6: “Plan patient assessment”. Knowledge may be assessed on or off the job. Practice skills should be assessed on the job or by simulation, with due regard for the patient’s comfort, confidentially and dignity

Underpinning knowledge & skills:
- observation skills
- knowledge of anatomy, physiology, optics of the visual system and other general body systems such as circulatory system, nervous system
- knowledge of normal visual development and normal physiological processes of aging in relation to the visual system
- knowledge of disorders and pathogenesis of disorders that can affect the visual system
- knowledge of pharmacology and its effects on the visual system
- knowledge of sterile techniques
- knowledge and application of available specialised ophthalmic testing procedures
- knowledge and application of all specialised ophthalmic testing apparatus
- ability to use specialised ophthalmic testing apparatus
- knowledge of abnormal and normal responses to specialised ophthalmic testing procedures
- ability to creatively adapt standard testing procedures for each patient’s capability and different clinical presentations
- ability to analyse and interpret patient responses to obtain information
- interpersonal skills

Links to other units:
- Competency Standards for Entry-level to the Profession of Optometry (1993):
  - Unit 3 “Patient Examination”
UNIT 11: Diagnose ocular motility disorders

Unit Descriptor:

This unit describes the competencies required to use the information gathered in unit 5, 7, 8, 9 and 10 to establish an accurate diagnosis for the case. It particularly involves the attributes of clinical reasoning and interpretive skills.

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance Criteria</th>
</tr>
</thead>
</table>
| 11.1 Interpret information gained in patient assessment to establish possible ocular motor diagnosis. | - Additional tests to further investigate possible diagnoses are selected and noted.  
- When clinical findings reveal a possible change in direction of patient management appropriate actions are made.  
- The areas of intervention that will be required are established. For example sensory, motor or optical intervention, rehabilitation or further monitoring of condition. |
| 11.2 Establish the diagnosis/es in cases of ocular motor disturbances | - Tests are reviewed for evidence of the diagnosis of the ocular motor disturbance.  
- The most important information gained in the assessment is highlighted even if inconsistencies in results are obtained.  
- The ocular and general history are considered in conjunction with test results when making conclusions about the diagnosis.  
- The probable reason/s for the ocular motor disturbance is accurately determined and recorded. |

Range of Variables Statement:

In the context of ocular motility practice the orthoptist plays a major role in the assessment and diagnosis of any ocular motor disturbances and should be competent in most aspects of diagnosing these types of problems.

Evidence Guide:

Assessment context:

This unit needs to be assessed in any of the following contexts:  
- private ophthalmology practice  
- hospital  
- private practice  
- community setting  
- rehabilitation setting  
- community agency
- patient’s home

This unit would need to use patient data that includes two categories of patients from the following groups:
- paediatric
- developmentally delayed
- adult
- geriatric
- low vision
- neurological impairment
- communication difficulties

Knowledge may be assessed on or off the job. Practice skills should be assessed on the job or by simulation, with due regard for the patient’s comfort, confidentially and dignity.

Underpinning knowledge & skills:
- clinical reasoning and problem solving skills
- knowledge of which interventions are appropriate for which patient problems
- knowledge of strategies used to determine differential diagnoses eg. hypothesis testing, decision making
- aetiology of ocular motor disturbances
- use of a holistic approach to the patient by being able to relate the visual problem to total patient care

Links to other units
- Competency Standards for Entry-level to the Profession of Optometry (1993):
  - Unit 4 “Diagnosis”.

National Competency Standards for the Profession of Orthoptics
1997; Revised 2004
UNIT 12: Assist in diagnosis of ocular disorders

Unit Descriptor:

This unit describes the competencies required to use the information gathered in unit 5, 7 and 10 to establish a probable diagnosis for the case. It particularly involves the attributes of clinical reasoning and interpretive skills.

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance Criteria</th>
</tr>
</thead>
</table>
| 12.1 Interpret information gained in patient assessment to establish possible ocular diagnoses | - Additional tests to further investigate possible diagnoses are selected.  
- When clinical findings reveal a possible change in direction of patient management appropriate actions are made.  
- The area of intervention that will be required is established. |
| 12.2 Assist the eye care professional in the diagnosis of the ocular disorder | - Determines if the tests provide evidence for the diagnosis of the ocular disorder.  
- Is able to highlight the most important information gained in the assessment if inconsistencies in results are obtained.  
- The ocular and general history are considered in conjunction with test results when making conclusions about the diagnosis. |

Range of Variables Statement:

The extent of assisting in the diagnosis of ocular disorder will vary according to context of the workplace. For example an Orthoptist working in a private ophthalmology practice may not have overall responsibility for the patient’s management and they will not have the responsibility for making the definitive ocular diagnosis. It is important however, for the orthoptist to establish what the possible diagnoses could be as this will influence the assessment procedures used by the orthoptist.

Area of intervention may include:
- sensory or motor treatment
- optical
- medical
- surgical
- rehabilitation
- monitoring of condition.
Evidence Guide:

Assessment context:
This unit needs to be assessed in any of the following contexts:
- private ophthalmology practice
- hospital
- private practice
- community agency
- rehabilitation setting
- patient’s home

This unit would need to use patient data that includes two categories of patients from the following groups:
- paediatric
- developmentally delayed
- adult
- geriatric
- low vision
- neurological impairment
- communication difficulties

Underpinning knowledge & skills:
- clinical reasoning and problem solving skills
- knowledge of which interventions are appropriate for which patient problems
- knowledge of strategies used to determine differential diagnoses eg. hypothesis testing, decision making
- aetiology of ocular motor disturbances
- use of a holistic approach to the patient by being able to relate the visual problem to total patient care

Links to other units
- Competency Standards for Entry-level to the Profession of Optometry (1993):
  - Unit 3 “Patient Examination”
UNIT 13: Plan and provide treatment for ocular motor disorders

Unit Descriptor:

This unit describes the competencies required to undertake orthoptic management within the context of overall patient care.

<table>
<thead>
<tr>
<th>Element:</th>
<th>Performance Criteria:</th>
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</thead>
</table>
| 13.1 Design orthoptic treatment plan. | - The established diagnosis is reviewed.  
- Relevant short term and long term treatment goals are established and recorded.  
- Orthoptic treatment options are considered.  
- Factors impinging on treatment options are noted and their implications are determined.  
- Appropriate forms of intervention are selected in consultation with the patient and caregiver.  
- The treatment plan is recorded. |
| 13.2 Gain patient consent | - The orthoptic treatment plan is explained in appropriate terminology to the patient or the patient’s caregiver.  
- The patient or caregiver’s understanding is checked to ensure diagnosis and treatment plan is understood.  
- Other options and costs of treatment are explained to the patient or caregiver.  
- The patient’s level of consent to the treatment plan is established.  
- The patient’s consent is recorded in patient’s notes. |
| 13.3 Implement treatment plan | - The treatment plan addresses the patient’s immediate needs and ocular condition.  
- Clinical treatment strategies are implemented in accordance with established procedures.  
- Treatment plan is sequenced appropriately.  
- Patient is educated to implement aspects of the treatment plan in their home environment. |
13.4 Evaluate treatment plan

- The progress of the treatment plan is reviewed as needed in accordance with treatment goals.
- The patient or caregiver is consulted about the progress of the treatment plan.
- The treatment plan is modified as required to meet treatment goals.
- Treatment is terminated at an appropriate time.

Range of Variables Statement:

Orthoptic treatment options and strategies are determined by the current knowledge base of the profession and include:
- occlusion treatment
- binocular vision exercises such as antisuppression treatment and fusion training
- use of prisms and other optical devices
- use of pharmacological agents in consultation with eye care practitioners
- surgical treatment in consultation with eye care practitioners

Factors impinging on treatment options include:
- prognostic indicators
- available resources
- adverse side effects
- level of patient involvement
- level of patient understanding and co-operation

Appropriate persons include:
- patient
- patient’s caregiver
- other health professionals
- other professionals involved with the care of the patient such as preschool teachers and school teachers.

Other options and costs include:
- alternate treatments
- frequency of visits
- health fund rebates
- consequences of no treatment

Level of consent may be to:
- parts of the treatment plan
- complete treatment plan
Progress is determined by:
- questioning
- observations
- evaluation of performance following each treatment option
- clinical assessment procedures

Treatment plan can be modified by:
- using alternative treatment options
- simplifying current treatment plan into several stages

Treatment plan is terminated when:
- treatment goals are reached
- patient consent is not able to be obtained
- priorities for treatment change

Evidence guide:

Assessment context:
This unit must be assessed in conjunction with units 7, 8, 9, 11 and could be assessed in any of the following contexts:
- private ophthalmology practice
- hospital
- private practice
- community setting
- community agency
- rehabilitation setting
- patient’s home

Treatment would need to be undertaken on two types of patients from the following groups:
- paediatric
- developmentally delay
- adult
- geriatric
- low vision
- neurological impairment
- communication difficulties

Knowledge may be assessed on or off the job. Practice skills should be assessed on the job or by simulation, with due regard for the patient’s comfort, confidentiality and dignity.

Underpinning knowledge & skills:
- broad and detailed knowledge of practical and technical orthoptic treatment techniques and approaches to interventions
- broad and detailed knowledge of ophthalmic management of ocular motor disorders such as surgery, medications etc.
- understanding of the influence of occupational, social, socioeconomic, environmental and workplace factors on an individual patient’s treatment decisions.
- knowledge of anatomy, physiology, optics of the visual system and other general body systems such as circulatory system, nervous system
- knowledge of normal visual development and normal physiological processes of aging in relation to the visual system
- knowledge of disorders and pathogenesis of disorders that can affect the visual system
- knowledge and application of available testing procedures
- knowledge and application of all visual testing and treatment apparatus
- knowledge of abnormal and normal responses to visual testing
- ability to use visual testing and treatment apparatus
- ability to evaluate, adapt and modify treatment procedures to produce the desired outcomes
- observation skills
- interpersonal skills

Links to other units:
- National Competency Standards for the Profession of Orthoptics (1996):
  - Unit 11 “Diagnose ocular motility disorder”
- Competency Standards for Entry-level to the Profession of Optometry (1993):
  - Unit 5 “Treatment Strategies”.
- Australian Physiotherapy Competency Standards (1994)
  - Unit 1: “Assess the client’s abilities, problems and needs”,
  - Unit 3 “Develops a physiotherapy intervention plan to meet defined goals”,
  - Unit 4 “Implements physiotherapy intervention strategies”,
  - Unit 5 “Evaluates the effectiveness of physiotherapy intervention.”
UNIT 14: Assist in management of ocular disease

Unit Descriptor:

This unit describes the competencies required to assist the eye care practitioner to manage the ocular disorder.

<table>
<thead>
<tr>
<th>Element:</th>
<th>Performance Criteria:</th>
</tr>
</thead>
</table>
| 14.1 Provide information | - The ophthalmic treatment procedure is explained in appropriate terminology to the patient or the patient’s caregiver.  
- Genuine interest in the patient is demonstrated.  
- Cultural background and individuality of the patient is respected.  
- Specific needs of the patient for information are identified in consultation with the patient and responded to.  
- Needs of the patient are considered and communication techniques adjusted accordingly to best meet the patient’s needs.  
- Dealings with patient show compassion and respect for human dignity.  
- When necessary family members are liaised with regarding the ophthalmic care.  
- Information is provided about the relevant ophthalmic care. |
| 14.2 Assist in pre-operative and operative care of the patient | - Preoperative testing is performed when indicated.  
- Patient is made ready for the treatment procedure.  
- Equipment is made ready for the treatment procedure.  
- Assistance is given to the eye care practitioner during the treatment procedure. |
| 14.3 Assist in immediate post-operative care | - Post-operative care needs are ascertained and noted.  
- Patient needs are attended to.  
- Follow up tests are performed as required.  
- Patient progress is monitored.  
- Post-operative care strategy is modified as required.  
- Patient is supported as required.  
- Patient is discharged when immediate care needs have been addressed. |
14.4 Instruct and train patient about use of management strategies to be used in the home

- Needs are determined in consultation with the eye care professional and patient or caregiver.
- Home management strategies are determined and noted.
- The patient or caregiver is informed of home management strategies.
- Patient understanding of the home management strategies and how to implement them is checked and noted.
- Additional information or demonstrations are provided to ensure the patient is able to implement home management strategies.

Range of Variables Statement:

Preoperative testing may include:
- Visual acuity testing
- Ultrasonography eg. A scan, angiography
- Keratometry
- Ophthalmic photography
- Specialised ophthalmic procedures (as per unit 10)

Patient is made ready refers to:
- instillation of ophthalmic medications prior to the treatment procedure
- evaluation of the effect of ophthalmic medications
- positioning of patient
- preparation of the operative site

Equipment is made ready refers to:
- setting up ophthalmic preparations for use during procedure, including minor operative procedures room
- ensuring equipment is functioning and ready to be used
- maintenance of equipment
- cleaning and sterilisation of equipment

Treatment procedures include:
- laser treatment
- surgical treatment
- medical treatment

Post operative care needs include:
- instillation of medications
- fitting of dressings
- patient positioning
- monitoring of side effects (eg. of anaesthetic)

Post operative testing may include any of the testing devices outlined in units 7, 8, 9 or 10.
Home management strategies include:
- instillation of medications
- cleaning of wound
- other ophthalmic treatments such as hot spoon bathing, lid hygiene etc.
- use of optical aids
- insertion and removal and care of contact lenses
- vision training such as eccentric viewing,
- use of visual aids and ergonomic and typoscopic reading equipment.
- use of home testing devices to monitor patient’s ocular disease (eg. Amsler chart for age-related macular degeneration)
- use of lighting in home
- locating home appliances to enable optimal use of visual capabilities
- discussion of impact of visual disorder on activities of daily living.

Evidence guide:

Assessment context:
This unit needs to be assessed in conjunction with units 10 and 12 and in the contexts of a private ophthalmology practice or hospital or a rehabilitation setting.

Management of ocular disease would need to be undertaken on two types of patients from the following groups:
- paediatric
- developmentally delayed
- adult
- geriatric
- low vision
- neurological impairment
- communication difficulties

Knowledge may be assessed on or off the job. Practice skills should be assessed on the job or by simulation, with due regard for the patient’s comfort, confidentially and dignity.

Underpinning knowledge & skills:
- broad knowledge of ophthalmic procedures and management of ophthalmic problems such as surgery, medications etc.
- understanding of the influence of occupational, social, socioeconomic, environmental and workplace factors on an individual patient’s treatment decisions.
- interpersonal skills
- observation skills
- knowledge of anatomy, physiology, optics of the visual system and other general body systems such as circulatory system, nervous system
- knowledge of disorders and pathogenesis of disorders that can affect the visual system
- knowledge of pharmacology and its effects on the visual system
- knowledge of normal visual development and normal physiological processes of aging in relation to the visual system
- knowledge of sterile techniques
- knowledge of all types of optical aids including contact lenses and their care
- knowledge and application of available testing procedures
- knowledge and application of all visual testing apparatus
- knowledge of abnormal and normal responses to visual testing
- ability to use visual testing apparatus
- ability to creatively adapt standard testing procedures for each patient’s capability and different clinical presentations

Links to other units:
- Competency Standards for Entry-level to the Profession of Optometry (1993):
  - Unit 5 “Treatment Strategies”.
- Draft Competency Standards for Optical Dispensers NSW (1995):
  - Unit 4: “Dispense products and services”.
- Australian Physiotherapy Competency Standards (1994)
  - Unit 1: “Assess the client’s abilities, problems and needs”
  - Unit 4: “Implements physiotherapy intervention strategies.”
UNIT 15: Undertake Referral

Unit Descriptor:

This unit describes the competencies required to contribute to the health care of the patient by referring them to another practitioner.

<table>
<thead>
<tr>
<th>Element:</th>
<th>Performance Criteria:</th>
</tr>
</thead>
</table>
| 15.1 Assess referral needs | - Clinical judgement is used to establish possible need for referral.  
- Patient needs for continued further care are assessed in consultation with the patient and referring practitioner when necessary.
- Referral options are identified and noted.
- Factors affecting referral needs are considered and the appropriateness of options is prioritised. |
| 15.2 Provide referral service | - Patient or caregiver is advised of referral options.  
- Referring practitioner is advised of advice given to patient.
- Information is given in a way that is understandable to the recipient.
- The patient or caregiver’s understanding of the information is checked and further information is given as needed. |
| 15.3 Assist the patient to access referral options required | - Patient is assisted to select the appropriate referral option/s.
- Information is given to enable the patient or caregiver to access the referral option.
- The referral option is contacted when appropriate to assist in formulating the referral.
- Referral reports are made with the consent of the patient or caregiver. |

Range of Variables Statement:

Referring practitioner may include:
- ophthalmologist
- general practitioner
- specialist medial practitioner
- optometrist
- community nurse
- allied health professional such as occupational therapist
- school teacher
Referral options may include:
- medical practitioner
- specialist practitioner
- allied health practitioner
- agencies such as those providing services for the blind
- specialist agencies such as the driving rehabilitation centre
- educational support services
- consumer support groups such as the Glaucoma Foundation
- self referral

In each case specific practitioners should not be named when suggesting the referral.

**Evidence Guide:**

**Assessment context:**
This unit can be assessed in any of the following contexts:
- private ophthalmology practice
- hospital
- private practice
- community agency
- rehabilitation setting
- community setting
- patient’s home

This unit should be assessed in conjunction with Unit 13, 14,15 & 19

Knowledge may be assessed on or off the job. Practice skills should be assessed on the job or by simulation, with due regard for the patient’s comfort, confidentially and dignity.

**Underpinning knowledge & skills:**
- broad knowledge of orthoptic treatment techniques and approaches to interventions
- broad knowledge of ophthalmic procedures and management of ophthalmic problems such as surgery, medications etc.
- understanding of the influence of occupational, social, socioeconomic, environmental and workplace factors on an individual patient’s treatment decisions.
- knowledge of health care system, referral responsibilities of the orthoptist, and role of other health care professionals
- knowledge of the support services available in the community
- interpersonal skills
- skill of explaining and communicating at the appropriate level for the patient and caregiver
- recognition of communication barriers and methods of effective communication

**Links to other units:**
- Competency Standards for Entry-level to the Profession of Optometry (1993):
  - Unit 5 “Treatment Strategies”
- Australian Physiotherapy Competency Standards (1994)
  - Unit 4: “Implements physiotherapy intervention strategies.”
**UNIT 16: Provide Patient Education**

**Unit Descriptor:**

This unit describes the competencies required to give advice and instruction to the individual patient and caregiver. This involves the attributes of communication and interpersonal skills.

<table>
<thead>
<tr>
<th>Element:</th>
<th>Performance Criteria:</th>
</tr>
</thead>
</table>
| **16.1 Establish rapport with patient or patient’s caregiver** | - Role of the orthoptist is discussed with patient.  
- Patient is addressed correctly.  
- Genuine interest in the patient is demonstrated.  
- Cultural background and individuality of the patient is respected.  
- Specific needs of the patient are identified in consultation with the patient and responded to in accordance with the resources available.  
- Needs of the patient are considered and communication techniques adjusted accordingly to best meet the patient’s needs.  
- Dealings with patient show compassion and respect for human dignity.  
- Motives of profit or bias are not permitted to influence their free and independent judgement on behalf of patients.  
- The right of patients to confidentiality of their medical records is respected. |
| **16.2 Educate the patient / caregiver** | - Information is provided to the patient about their eye condition using appropriate language and explanatory strategies.  
- Information is provided about the effect of the condition on the patient’s lifestyle.  
- Information is provided about treatment options and prognosis.  
- The patient / caregiver’s understanding is checked and further explanation is given as required.  
- The patient /. caregiver’s concerns are addressed adequately. |
| **16.3 Provide information on other eye care or health care services** | - Patient’s additional service needs are identified in consultation with the patient or caregiver and eye care professional.  
- The range and availability of services in the patient’s area is identified and noted.  
- Methods of access is determined and noted.  
- The patient is advised of service options and how to access these services. |
Range of Variables Statement:

Explanatory strategies and communication techniques include:
- use of models
- pamphlets
- diagrams
- demonstration
- audiovisual aids
- interpreter services
- internet

Other eye care or health care services may include:
- Federal government including Department of Social Security, Department of Veteran’s Affairs Commonwealth Rehabilitation Services
- State government health services such as public hospitals,
- State government education services such as Vision Impairment services for schools.

Access refers to:
- contact details
- waiting lists
- special eligibility
- costs
- contact personnel
- location

Lifestyle may refer to:
- driving ability
- occupational suitability
- any restrictions
- aftercare
- specific requirements

Evidence Guide:

Assessment context:
This unit needs to be assessed in any of the following contexts:
- private ophthalmology practice
- hospital
- private practice
- community agency
- rehabilitation setting
- community setting
- patient’s home
Patient education would need to be undertaken for two types of patients from the following groups:
- paediatric
- developmentally delayed
- adult
- geriatric
- low vision
- neurological impairment
- communication difficulties

This unit should be assessed in conjunction with Unit 13 and 14.

Knowledge may be assessed on or off the job. Practice skills should be assessed on the job or by simulation, with due regard for the patient’s comfort, confidentially and dignity.

Underpinning knowledge & skills:
- knowledge of a broad range of disorders of the visual system and their impact on the patient and community
- skill of explaining and communicating at the appropriate level for the patient and caregiver
- knowledge of health care system and role of other health care professionals
- knowledge of the support services available in the community
- knowledge of methods to promote adequate eye health care
- recognition of communication barriers and methods of effective communication

Links to other units:
- Competency Standards for Entry-level to the Profession of Optometry (1993):
  - Unit 1: “Professional development and responsibilities”
  - Unit 2 “Patient History”.
  - Unit 5 “Treatment Strategies”
- Draft Competency Standards for Optical Dispensers NSW (1995):
  - Unit 1: “Communicate with clients, practitioners and suppliers”.

National Competency Standards for the Profession of Orthoptics
1997; Revised 2004
UNIT 17: Provide Community Education

Unit Descriptor:

This unit describes the competencies required to educate the community about eye care and orthoptic practice. This involves the attributes of communication and interpersonal skills.

<table>
<thead>
<tr>
<th>Element:</th>
<th>Performance Criteria:</th>
</tr>
</thead>
</table>
| 17.1 Provide information to the community about eye care and function | - Community needs for eye care information are recognised.  
- Opportunities for information dissemination are identified and accessed.  
- Information is given to the community in a manner that is understood by the lay person.  
- Advice is given about access to eye health professionals. |
| 17.2 Provide information to the community about orthoptic practice | - The role of the orthoptist in the total eye care team is recognised.  
- Information about orthoptic practices is given to the community in a manner that is understood by the lay person.  
- Opportunities for information dissemination are identified and accessed.  
- Advice is given about access to local orthoptists. |

Range of Variables Statement:

Opportunities for information dissemination include:  
- promotional activities undertaken by the OAA such as “Orthoptic Awareness Week”  
- inservice sessions  
- community meetings  
- pamphlets  
- press releases

Evidence Guide:

Assessment context:
This unit can be assessed in any of the following contexts:  
- private ophthalmology practice  
- hospital  
- private practice  
- community agency  
- rehabilitation setting  
- community setting
This unit can be assessed in isolation.

**Underpinning knowledge & skills:**
- knowledge of a broad range of disorders of the visual system and their impact on the patient and community
- skill of explaining and communicating at the appropriate level for the patient and caregiver
- knowledge of health care system and role of other health care professionals
- knowledge of the community in which the orthoptist is working such as the culture of the community, its local information dissemination opportunities
- knowledge of the support services available in the community
- knowledge of committees with community representation
- knowledge of methods to promote adequate eye health care
- recognition of communication barriers and methods of effective communication

**Links to other units:**
- Competency Standards for Entry-level to the Profession of Optometry (1993):
  - Unit 8 “Public Health Optometry”
- Draft Competency Standards for Optical Dispensers NSW (1995):
  - Unit 1 “Communicate with clients, practitioners and suppliers”.
  - Unit 6 “Market products and services”
UNIT 18: Promote Ocular Health

Unit Descriptor:

This unit describes the competencies required to participate in activities that will contribute to promoting ocular health and preventing ocular problems.

<table>
<thead>
<tr>
<th>Element:</th>
<th>Performance Criteria:</th>
</tr>
</thead>
</table>
| 18.1 Participate in screening services | - The population to be screened is identified and tested as appropriate.  
- Appropriate tests are used to screen for visual disorders.  
- Records are kept of the screening results.  
- The participant in the screening program is advised of the results of the screening.  
- The participant is referred for appropriate follow-up as required. |
| 18.2 Participate in ocular health risk reduction activities | - Advice is provided on eye protection strategies.  
- Advice is provided on visual ergonomics in the home and workplace.  
- Education programs are developed to promote implementation of risk reduction strategies. |

Range of Variables Statement:

Visual disorders that may be detected at screening programs include:
- strabismus  
- amblyopia  
- refractive error  
- glaucoma  
- ocular motor  
- diabetic retinopathy

Appropriate tests for screening should be:
- simple, quick and easy to interpret  
- acceptable to the public  
- accurate  
- repeatable  
- low cost

The population to be screened will generally be “at risk” populations and includes:
- preverbal children and paediatric populations  
- people with developmental delay  
- the geriatric population  
- those with a family history of ocular problems  
- those with systemic disorders  
- those with brain injury
Ocular health risk reduction activities may occur
- in the workplace
- in the home
- at the place of education

Advice may be given in relation to:
- eye protection
- lighting needs
- location of computer equipment and other aspects of visual ergonomics
- most appropriate seating in classroom
- ocular hygiene

**Evidence Guide:**

**Assessment context:**
This unit can be assessed in any of the following contexts:
- private ophthalmology practice
- hospital
- private practice
- community agency
- rehabilitation setting
- community setting

This unit can be assessed with any of the clinical care units.

**Underpinning knowledge & skills:**
- observation skills
- knowledge of anatomy, physiology, optics of the visual system and other general body systems such as nervous system
- knowledge of disorders and pathogenesis of disorders that can affect the visual system
- knowledge of normal visual development and normal physiological processes of aging in relation to the visual system
- knowledge of available testing procedures
- knowledge of all visual testing apparatus
- ability to use visual testing apparatus
- knowledge of abnormal and normal responses to visual testing
- interpersonal skills
- skill of explaining and communicating at the appropriate level for the patient and caregiver
- knowledge of methods to promote adequate eye health care
- recognition of communication barriers and methods of effective communication
- knowledge of the role of epidemiology in ocular disorders, including role of vision screening in detection of ocular disorders
- knowledge of activities that may affect ocular health and the means of reducing these risks
Links to other units:
- Competency Standards for Entry-level to the Profession of Optometry (1993):
  - Unit 8 “Public Health Optometry”
- Australian Physiotherapy Competency Standards (1994)
  - Unit 8: “Applies management skills in physiotherapy”.
STREAM 1: SELF IN WORKPLACE

UNITS 1 - 4: Pages 36-46

STREAM 2: CLINICAL CARE

Assessment: UNITS 5 - 12
Treatment: UNITS 13 - 15
Community Service: UNITS 16 - 18

STREAM 3: ADMINISTRATION

UNITS 19 - 20
UNIT 19: Record Clinical Data

Unit Descriptor:

This unit describes the competencies required to record and store accurate clinical information to assist in the management of patients. This unit requires adherance to the legal and ethical requirements for the keeping of medical records (refer to Commonwealth Privacy Act 2000).

<table>
<thead>
<tr>
<th>Element:</th>
<th>Performance Criteria:</th>
</tr>
</thead>
</table>
| 19.1 Record clinical information | - Information is gathered by direct observation from assessment and treatment techniques.  
- Verified information is legibly recorded in the patient records.  
- Terminology, abbreviations and diagrams used are in accordance with recognised eye care standards.  
- The records include a summary of clinical findings.  
- The record lists any other persons present at the time of consultation  
- Information recorded relates directly to the patient’s eye health care.  
- Patient records are signed and dated by the treating practitioner. |
| 19.2 Report clinical information | - Referring practitioner is informed about the patient’s progress.  
- Reports to a third party are made only with the patient or caregiver’s consent.  
- Reports are given in a form that is understandable to the receiver.  
- Reports refer to matters relating to the patient’s eye care only. |
| 19.3 Store clinical data | - A permanent copy of the information is kept for every consultation with a patient.  
- Records should be stored as per Commonwealth Privacy Act (2000).  
- Records can be readily recalled from the filing system. |
### 19.4 Use data for statistical purposes

- The database used enables collection of data from clinical records for statistical analysis.
- Information from the records is accurate and relevant.
- Data is analysed to assist in the planning of future services.
- The chief practitioner is informed of relevant statistical data.
- Consent is gained from patient when appropriate

### 19.5 Maintain client confidentiality (as per Commonwealth Privacy Act 2000)

- Records are kept in a secure place.
- Access to records is only available to authorised personnel.
- Informed consent of the patient is documented before files are released to another party.
- Reports to a third party are only made with the patient’s consent.
- Patient records only contain information relevant to the patient’s eye care needs.

**Range of Variables Statement:**

Patient records may include:
- practice record
- hospital medical record
- other patient records such as the NSW Department of Health’s Personal Health Record used for child health records

Reports may be done by:
- a standardised report form
- individual letter
- telephone conversation with details outlined on patient’s medical record
- directly with the receiver (face to face)

Authorised personnel may include:
- personnel working in the practice who have responsibility for the patient’s care
- personnel who have gained written consent by the patient for release of the medical record information

Collection of statistical data may not necessarily be carried out at all times and only when collection purposes arise (eg. Case Mix data collection)

**Evidence guide:**

**Assessment context:**
The attainment of aspects of this unit depends on the context of workplace and organisational procedures used in the practice, as responsibility for patient medical records and patient management will vary.
In the hospital setting medical record storage is not the responsibility of the orthoptist.

In private ophthalmology practice the orthoptist does not have overall responsibility for patient management. For the element related to patient confidentiality the ophthalmologist would be consulted for any action in relation to release of patient information. This situation may be different in private practice, community agency, rehabilitation or community setting where the orthoptist may be asked for confidential patient information.

The method of assessing this unit would depend on the responsibility that the orthoptist has for recording and maintaining patient data and depends on the workplace context. At a minimum the orthoptists would be required to meet the first and fourth element and be aware of the ethical requirements of an orthoptist in relation to patient confidentiality.

This unit should be assessed in conjunction with all the clinical care units except unit 16 & 18.

Underpinning knowledge & skills:
- knowledge of orthoptic and ophthalmic abbreviations
- knowledge of differences in medical records and informed consent procedures for each context of practice.
- knowledge of professional code of ethics for orthoptists (OAA Code of Professional Conduct 1995)
- knowledge of organisational procedures regarding health information management

Links to other units:
- Competency Standards for Entry-level to the Profession of Optometry (1993):
  - Unit 6 “Recording of Clinical Data”
- Draft Competency Standards for Optical Dispensers NSW (1995):
  - Unit 4 “Dispense products and services”
- Australian Physiotherapy Competency Standards (1994)
  - Unit 1 “Assess the client’s abilities, problems and needs.”
  - Unit 5 “Evaluates the effectiveness of physiotherapy intervention.”
# UNIT 20: Assist in Practice Management

## Unit Descriptor:

This unit describes the competencies required to provide efficient performance in the workplace including quality assurance practices and small business management when appropriate.

<table>
<thead>
<tr>
<th>Element</th>
<th>Performance Criteria:</th>
</tr>
</thead>
</table>
| **20.1 Provide effective practice management procedures** | - Management strategies are used that minimise patient waiting time.  
- Aspects related to patient access to practice are considered.  
- A safe working environment is provided for all personnel and patients.  
- Patient’s needs are considered when designing own work area. |
| **20.2 Monitor and maintain equipment and supplies** | - Checks are regularly carried out on equipment.  
- Services and or repairs are arranged.  
- Records of services or repairs are kept in accordance with practice guidelines.  
- Supplies are monitored and ordered to maintain appropriate quality and levels.  
- Supplies are stored in accordance with practice guidelines.  
- Supplies are distributed in accordance with practice guidelines.  
- Supplies are disposed of in accordance with practice guidelines. |
| **20.3 Fulfil financial and legal responsibilities** | - Records that include correct information about fees and procedures are kept in each practice.  
- Professional practices meet with legislative requirements at State and Federal level. |
| **20.4 Practice in accordance with the Orthoptic Association of Australia’s code of professional conduct** | - Patients are shown compassion and respect for human dignity and dealt with honestly.  
- Motives of profit or bias do not influence the orthoptist’s free and independent judgement on behalf of patients.  
- Patient confidentiality is maintained.  
- Patients are not enticed from colleagues.  
- Advice is sought from other health professionals when appropriate. |
Range of Variables Statement:

Management strategies include:
- prioritizing of urgent and non urgent cases
- booking system that limits numbers of complex or new patients each session
- information being provided to patients about the length of waiting time

Aspects related to patient access includes:
- wheel chair access

Equipment may include all equipment that is required to perform the assessment and treatment procedures in the clinical care units.

Supplies may include all supplies that are required to perform the assessment and treatment procedures in the clinical care units such as disposable items.

Practice guidelines include:
- procedures manuals
- Occupational Health and Safety manuals
- Equipment operating manuals

Legislative requirements include:
- Optometrical Act, dependent on State legislation
- By laws of the OAA
- By laws of the Australian Orthoptic Board
- Commonwealth Privacy Act (2000)

Evidence Guide:

Assessment context:
This unit is best assessed in a private ophthalmology practice or hospital.
The performance of the second element may overlap with the responsibilities of other health professionals in the workplace. For example in the hospital setting nurses may have overall responsibility for ordering disposable goods.

Underpinning knowledge & skills:
- time management strategies
- knowledge of principles of occupational health and safety
- knowledge of sources of equipment and personnel that assist in the maintenance of equipment
- knowledge of small business management practices
- knowledge of fee structures
- knowledge of practice procedures
Links to other units:
- Competency Standards for Entry-level to the Profession of Optometry (1993):
  - Unit 1 “Professional Development and Responsibilities”
  - Unit 7 “Practice Management”
- Draft Competency Standards for Optical Dispensers NSW (1995):
  - Unit 7 “Apply business principles”
- Australian Physiotherapy Competency Standards (1994)
  - Unit 6 “Demonstrates professional behaviour appropriate to physiotherapy”
  - Unit 8 “Applies management skills in physiotherapy practice”