OPR

OPTOMETRIC PRACTICE REFERENCE

STANDARDS OF PRACTICE

COLLEGE OF OPTOMETRISTS OF ONTARIO

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PART 1. The Fundamentals

1. Introduction and Purpose

1.1 Introduction

The College of Optometrists of Ontario is the regulatory body for the optometric profession in Ontario. In order to assist the College in meeting its objects, documents relating to optometric practice are periodically developed and published. This Optometric Practice Reference (OPR) represents a complete revision of The Guide to the Practice of Optometry and supersedes previous versions of The Guide. It will be periodically updated in response to changes in public need, economic forces, advances in health care sciences, and statutory and regulatory requirements.

1.2 The Purpose of the OPR

The OPR fulfills three key functions, as follows:

- **To provide information to the public and patients** and/or their representatives regarding the services and behaviour that can be expected from a member of the College.
- **To inform members of the College** of the principles and criteria which underlie the standards of practice and behaviour of the profession.
- **To assist committees of the College** to carry out their work. Some statutory committees of the College are required to assess the practice of members in the course of fulfilling their mandate to protect the public. The principles, standards, and guidelines described herein serve as a basis for their assessment. The Quality Assurance Committee employs regulatory and professional standards when assessing the practice of individual members and uses the clinical guidelines to help members move towards best practices. The Complaints and Executive Committees consider standards and guidelines for the purpose of case disposition. An alleged breach of a regulatory or professional standard is usually required before a member will be referred to either the Quality Assurance or Discipline Committee.

2. The Practice of Optometry

2.1 Scope of Practice

The *Optometry Act* specifies the scope of practice of optometry as follows:

The practice of optometry is the assessment of the eye and vision system and the diagnosis, treatment and prevention of:

a) disorders of refraction;

b) sensory and oculomotor disorders and dysfunctions of the eye and vision system; and

c) prescribed diseases.

2.2 Authorized Acts

The Province of Ontario uses the concept of *controlled acts* to describe healthcare procedures and responsibilities that are not within the domain of the public. This forms the basis for regulation of healthcare services in the province. Fourteen of these *acts* are described in the *Regulated Health Professions Act* and each profession-specific act, such as the *Optometry Act*, specifies those that are authorized to the professional group.

In the course of engaging in the practice of optometry, optometrists are authorized, subject to the terms, conditions and limitations imposed on their certificate of registration, to perform the following:

1. Communicating a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system or a prescribed disease.

2. Applying a prescribed form of energy.

2.1 Prescribing drugs designated in the regulations.

3. Prescribing or dispensing for vision or eye problems, subnormal vision devices, contact lenses or eye glasses.

2.3 The Practice of Optometry

There are several key principles that form the foundation for the optometric profession. The practice of optometry is:

Professionally based

Above all, the purpose of the optometric profession is to provide for the healthcare needs of patients, by placing the patient's best interest foremost.

Scientifically based

The profession of optometry is founded on research and education in the life and vision sciences, combined with scientific and technological expertise.

The College supports the use of evidenced-based techniques, instrumentation and therapies that have the support of peer-reviewed literature.

Primary health care

Optometrists are independent practitioners who work within Ontario's healthcare system in co-operation with other providers of related services for the ultimate benefit of patients.

Related to eyes and vision

The services generally provided in primary care optometry include:

- the assessment, diagnosis, management and prevention of conditions of the eye and vision system;
- the treatment, correction or rehabilitation of conditions of the eye and vision system;
- the dispensing of eye glasses, contact lenses, and low vision devices;
- referral to, or shared care with, allied health professionals; and
- the promotion of good vision and health through education.

Accountable to the public

The practice of optometry in Ontario is governed by the College of Optometrists of Ontario under the authority of the Regulated Health Professions Act and the Optometry Act. Accountability is assured in a number of ways including public representation on Council and College committees, and open (public) Council meetings and Discipline hearings. In addition, the College publishes an Annual Report and provides annual reports to the Minister of Health and Long-Term Care.

2.4 The Practitioner/Patient Relationship

With reference to the practitioner/patient relationship, the optometrist will:

Be accountable

Optometrists are accountable to their individual patients and to the College for all services provided, both personally and by others who are under their direction and supervision.

Act in the patient's best interest

Optometrists are responsible for fostering a relationship of trust with the patient and putting the patient's interest above their own. The Professional Misconduct

Regulations protect such interests. Examples of acts that are considered to be professional misconduct include:

- treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence; **(O.Reg. 119.94 Part I under the Optometry Act (1. s.10))**
- failing to refer a patient to a regulated health professional when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral and examination. **(O. Reg. 119/94 Part I under the Optometry Act (1. s.11))**

Encourage patient decision-making

Consistent with patient-centered care, optometrists give patients the information and counselling necessary for them to make informed choices about treatment and ongoing care, and respect the choices their patients make.

When employing techniques, instrumentation and/or therapies that lack the support of peer-reviewed literature, optometrists are expected to discuss the risks and benefits with the patient and obtain informed consent with documentation where appropriate.

Protect confidentiality

Historical and clinical information is gathered in a manner respecting patient privacy. All records are kept confidential and secure. Release of information requires the consent of the patient or their representative(s), except as required or allowed by law, such as the *Personal Health Information Protection Act*.

Be ethical

Optometrists' behaviour and business practices conform to the profession's accepted ethical standards. This is emphasized in the Professional Misconduct Regulation which includes the following as an act of professional misconduct:

- engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical. **(O. Reg. 119/94 Part I under the Optometry Act (1. s.39))**

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3. Standards: Definitions

The Optometric Practice Reference contains **standards of practice** (both regulatory and professional).

3.1 Regulatory Standards

Regulatory standards are found in the legislation of the Province of Ontario, such as the *Regulated Health Professions Act*, the *Ontario Regulations*, and the *Optometry Act*. These standards are mandatory requirements for the profession, and **must** be complied with by the optometrist. Non-compliance with these standards could result in an allegation of professional misconduct.

3.2 Professional Standards

Professional standards describe what a *consensus of prudent practitioners would do in certain circumstances.* Every profession has standards of practice that come from a variety of sources such as educational programs, clinical training, evidence-based literature, informal professional dialogue, and the decisions of a College and the Courts. In addition to writing standards into a regulation, a College may also publish documents that describe the existing generally accepted standards on recurring and /or significant issues. These publications are more valuable if they are the result of a consultation process.

The requirement to maintain the standards of practice is supported by the Professional Misconduct Regulation under the Optometry Act. While the strongest evidence of professional standards of practice is usually expert testimony, College publications and evidence based literature may support or reinforce the expert testimony and make it more likely to be accepted.

Revised: April 2014

PART 2. Optometric Care

4. General Clinical Matters

4.1 Clinical Equipment

Description

Optometrists are expected to be equipped with the instrumentation and supplies required to provide services that meet the standards of practice of the profession.

Regulatory Standard

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Optometrists have access to, and ensure proficient use of equipment, instrumentation, drugs and supplies for the following:

- measurement of visual acuity at distance and near;
- evaluation of visual fields and colour vision;
- determination of refractive status of the eyes, both objectively and subjectively;
- measurement of corneal curvature and thickness;
- assessment of ocular motility and binocular function;
- examination of the eye and ocular adnexa
- measurement of intraocular pressure;
- pupillary dilation, cycloplegia, topical ocular anesthesia, staining ocular tissues;
- measurement of the parameters of spectacles and contact lenses;
- in-office treatment of common primary ocular emergencies;
- disinfection of instruments and diagnostic contact lenses;
- infection control and cleanliness **(OPR 4.7)**.

When optometrists do not have a specific instrument, they must have arrangements in place whereby the tests may be performed elsewhere, by requisition or referral, and the results obtained for analysis and retention in the clinical record.

Optometrists are expected to maintain their equipment and instrumentation in good working order, including the provision of regular re-calibration.

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4.2 Required Clinical Information

The provision of optometric care relies on acquiring, updating and maintaining a complement of information about each patient. Analysis of this data enables optometrists to develop an accurate understanding of the ocular status of patients and devise appropriate management plans. Standards relating to required clinical information are intended to ensure the provision of optimal and efficient patient care.

Regulatory Standard

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

11. Failing to refer a patient to another professional whose profession is regulated under the Regulated Health Professions Act, 1991 when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Required clinical information to be obtained about patients at their first presentation includes:

- the chief concern or request(s);
- a review of ocular or visual symptoms or experiences;
- a general health history, with emphasis on eyes and vision, including medications used and applicable family history;
- the occupational and avocational visual environment and demands;
- the measurement and description of their ophthalmic appliances including purpose and effectiveness; and
- the results of the observation, examination or measurement of:
    - apparent and relevant physical, emotional and mental status;
    - the external eye and adnexa;
    - pupillary function;
    - the *anterior segment* **(OPR 6.1)** and, when indicated, corneal thickness;
    - ocular media;
    - the *posterior segment* **(OPR 6.2);**
    - intraocular pressure in adults and, when indicated, in children;
    - presenting monocular visual acuities at distance;

- presenting visual acuity at near, monocularly when clinically indicated;
- refractive status and best-corrected monocular visual acuity at distance;
- accommodative function, when clinically indicated and for school-age children;
- oculomotor status and, when indicated, fusional reserves;
- other sensory functions, when indicated, such as visual fields, colour vision, stereoacuity, sensory fusion and contrast sensitivity.

All required clinical information must be clearly documented in the *patient's health record* **(OPR 5.1)**. In situations where it is not possible to obtain specific required information, justification must be documented.

The information will be kept current by re-evaluation at subsequent examinations. Patient signs, symptoms and risk factors influence decisions optometrists make about the frequency of re-evaluation.

In emergency or urgent situations, it may be impractical to obtain all clinical information at the first visit. In such cases, specific assessment is appropriate. The practitioner may advise the patient to seek a full comprehensive eye exam within a reasonable time frame or send a report to their primary optometrist for continuation of care **(OPR 4.6)**.

The full complement of required clinical information may not be necessary when providing specific assessments or consultation services for referring optometrists, physicians or nurse practitioners. The same applies to patients who have not been directly referred but are already under the established care of another optometrist or ophthalmologist. In such cases, optometrists will determine what is clinically necessary based on the reason for presentation **(OPR 4.8)**

Optometrists completing third party reports involving the clinical information of patients (e.g. MTO, CNIB, employment application reports), must verify the identity of patients using government issued photo identification cards.

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4.3 Delegation and Assignment

Introduction

The Province of Ontario utilizes the concept of "controlled acts" to control who may perform healthcare procedures and responsibilities that have a high risk of harm associated with their performance. The controlled acts are listed in the Regulated Health Professions Act, 1991 (RHPA). Each profession-specific act, such as the Optometry Act, 1991, specifies any controlled acts that the members of the profession are authorized to perform (the profession's "authorized acts"). Each regulated profession has a defined scope of practice and some have corresponding authorized acts set out in the profession-specific Act.

There are also numerous non-controlled procedures, some of which are limited to objective data collection and others, which carry a potential risk of harm to the patient. Although these procedures are in the public domain (i.e. they are NOT controlled acts), they may require specific training and skills.

The term delegation refers to the process whereby a regulated health professional (RHP), who has a controlled act within his/her scope of practice, orders another person who would not otherwise be authorized to do so to perform this act.

The term assignment refers to the process of an RHP assigning the performance of a non-controlled procedure to another person.

Both delegation and assignment of optometric procedures in appropriate circumstances may allow a more timely and efficient delivery of optometric care, making optimal use of time and personnel. In every instance of delegation and assignment, the primary consideration should be the best interests of the patient.

It is a general expectation that optometrists will be responsible for, and appropriately supervise all delegated and assigned activities within their practices. The level of supervision varies with the risk associated with the delegated or assigned procedure. ***Direct supervision*** refers to situations in which the optometrist is physically present in the same clinical location. This allows the optometrist to immediately intervene when necessary. Direct supervision is expected for ALL delegation (controlled acts), and of any assigned activities, which require interpretation in the performance of the procedure and/or may present a risk of harm to the patient. ***Remote supervision*** refers to situations in which the presence of the optometrist is not necessarily required since there is no potential risk of harm to the patient. This would be appropriate for certain clinical procedures and objective data collection.

The responsibility for all aspects of any delegated acts or assigned procedures always remains with the optometrist.

Optometrists may also *receive delegation* of a controlled act not authorized to optometry.

Collaboration with other health professionals

Collaboration with other health professionals is a common occurrence in clinical practice. When an optometrist collaborates with another health professional, the College standards and guidelines on *collaboration* **(OPR 4.8)** will apply.

Regulatory Standards

Controlled Acts

The *Regulated Health Professions Act* identifies 14 controlled acts that may only be performed by members of certain regulated health professions:

1. Communicating to the individual or his or her personal representative a diagnosis identifying a disease or disorder as the cause of symptoms of the individual in circumstances in which it is reasonably foreseeable that the individual or his or her personal representative will rely on the diagnosis.

2. Performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including the scaling of teeth.

3. Setting or casting a fracture of a bone or a dislocation of a joint.

4. Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust.

5. Administering a substance by injection or inhalation.

6. Putting an instrument, hand or finger,

i. beyond the external ear canal,

ii. beyond the point in the nasal passages where they normally narrow,

iii. beyond the larynx,

iv. beyond the opening of the urethra,

v. beyond the labia majora,

vi. beyond the anal verge, or

vii. into an artificial opening into the body.

7. Applying or ordering the application of a form of energy prescribed by the regulations under this Act.

8. Prescribing, dispensing, selling or compounding a drug as defined in the Drug and Pharmacies Regulation Act, or supervising the part of a pharmacy where such drugs are kept.

9. Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses other than simple magnifiers.

10. Prescribing a hearing aid for a hearing impaired person.

11. Fitting or dispensing a dental prosthesis, orthodontic or periodontal appliance or a device used inside the mouth to protect teeth from abnormal functioning.

12. Managing labour or conducting the delivery of a baby.

13. Allergy challenge testing of a kind in which a positive result of the test is a significant allergic response.

14. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning.

Optometrists are authorized by the Optometry Act to perform 4 of the 14 controlled acts, as follows:

i. communicating a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system, or a prescribed disease;

ii. applying a prescribed form of energy;

iii. prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses; and

iv. prescribing a drug designated in the regulations.

The RHPA also discusses delegation of controlled acts:

27. (1) No person shall perform a controlled act set out in subsection (2) in the course of providing health care services to an individual unless,

a. the person is a member authorized by a health profession Act to perform the controlled act; or

b. the performance of the controlled act has been delegated to the person by a member described in clause (a). 1991, c. 18, s. 27 (1); 1998, c. 18, Sched. G, s. 6.

28. (1) The delegation of a controlled act by a member must be in accordance with any applicable regulations under the health profession Act governing the member's profession.

Exceptions

29. (1) An act by a person is not a contravention of subsection 27 (1) if it is done in the course of,

b. fulfilling the requirements to become a member of a health profession and the act is within the scope of practice of the profession and is done under the supervision or direction of a member of the profession.

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)**, includes the following acts of professional misconduct:

14. Failing to maintain the standards of practice of the profession.
15. Delegating a controlled act in contravention of the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts.
16. Performing a controlled act that the member is not authorized to perform.
17. Permitting, counselling or assisting a person who is under the supervision of a member to perform an act in contravention of the Act, the *Regulated Health Professions Act, 1991* or the regualtions under either of those Acts.
18. Permitting, counselling or assisting any person who is not a member to perform a controlled act which should be performed by a member.

Professional Standard

Delegation

Optometrist-Patient Relationship

Delegation will only occur after the optometrist has established a formal relationship with the patient, which normally will include an interview, an assessment, recommendations if appropriate, and informed consent about any clinical investigations and proposed therapy. In some cases where an established patient/practitioner relationship exists, delegation may take place before the optometrist sees the patient.

Presence of the Optometrist

Delegation of an authorized act must only take place when the optometrist is present in the same clinical location as the patient and is available to intervene when required.

Process for Delegation

The optometrist must establish a process for delegation that includes:

- education and assessment ensuring the currency of the delegate's knowledge, skills and judgement;
- documentation/references for performance of procedures; and
- ensuring the delegate has been delegated only those acts that form part of the optometrist's regular practice.

Informed Consent

Delegation occurs with the informed consent of the patient. Whether the consent is implicit or explicit will depend on the particular activity being proposed to be delegated.

Supervision

The optometrist supervises the delegated procedure by direct supervision.

Quality Assurance

The optometrist is expected to ensure there is an ongoing quality assurance mechanism.

Assignment

Optometrist-Patient Relationship

Assignment of certain procedures that are not controlled acts may occur as part of the optometric examination and may occur prior to the optometrist assessing the patient. For example, pre-testing using automated instruments may occur prior to the optometrist seeing the patient.

Presence of the Optometrist

Procedures that are completely objective, present no inherent risk of harm and require no interpretation by the person performing the procedure may be performed without the presence of the optometrist and are considered to be remotely supervised. This could include automated procedures such as objective auto-refraction, auto-perimetry and non-mydriatic retinal photography. However, the optometrist is expected to review the results of these remotely supervised procedures and communicate appropriately with the patient. Direct supervision must occur whenever the procedure poses an immediate (e.g. tonometry) or potential (e.g. subjective refraction) risk of harm.

Process for assignment

As with delegation, it is expected that assignment will only occur with certain processes in place, including:

- education and assessment ensuring the currency of the assignee's knowledge, skills and judgement;
- documentation/references for performance of procedures; and
- ensuring only those procedures that form part of the optometrist's regular practice are assigned.

Research Conducted by a University

An exception exists for delegation and assignment where medical direction is delegated with indirect supervision, with the informed consent of the subject, and where the research has received research ethics board approval from an accredited university.

Professional Standard for Receiving Delegation of Controlled Acts

In the public interest, there are situations when an optometrist could receive delegation from another regulated health professional (RHP) to perform a controlled act not authorized to optometry. Other RHP's have delegation regulations and established protocols for delegation of which the member should

be aware. In order for an optometrist to receive delegation from another RHP, all of the following criteria must be met:

i. a process for receiving delegation is in place;

ii. the member will have a reasonable belief that the RHP delegating the act is authorized to delegate the act, has the ability to perform the act competently, and is delegating in accordance with relevant regulations governing his or her profession;

iii. the optometrist should be competent to perform the act safely, effectively, and ethically;

iv. appropriate resources, such as equipment and supplies, are available and serviceable;

v. the delegated act is clearly defined;

vi. the duration of the delegation will be clearly defined and relate to a specific patient;

vii. the optometrist ensures that patient consent to having the act performed under delegation to the optometrist is obtained and recorded in the patient's health recordt;

viii. a mechanism exists to contact the RHP who delegated the act if there is an adverse or unexpected outcome; and

ix. the identity of the RHP delegating the controlled act and of the member

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4.4 The Use And Prescribing Of Drugs In Optometric Practice

Description

Optometrists use diagnostic and therapeutic drugs in the course of providing patient care. The College recognizes that there is a distinction between the use of drugs within a clinical setting and the prescribing of drugs for treatment. Optometrists with authority to prescribe drugs can do so to manage patients with diseases and disorders of the eye and vision system. Such drugs are usually topically applied eye drops or ointments and oral medications for corneal or eyelid infections only.

Regulatory Standard

The Optometry Act, 1991 states that in the course of engaging in the practice of optometry, optometrists are authorized, subject to terms, conditions and limitations imposed on his or her certificate of registration, to perform the following controlled act:

2.1 Prescribing drugs designated in the regulations.

The Designated Drugs and Standards of Practice Regulation, **(O.Reg. 112/11 under the Optometry Act, 1991)** describes the following conditions under which an optometrist may prescribe drugs and the drugs that may be prescribed:

Drugs that may be prescribed

1. For the purposes of paragraph 2.1 of section 4 of the Act, and subject to sections 2, 3 and 4 and Part II of this Regulation, a member may prescribe a drug set out under a category and sub-category heading in Schedule 1.

Limitation

2. Where a limitation or a route of administration is indicated in the sub-category heading set out in Schedule 1, a member shall only prescribe a drug listed under that subcategory in compliance with the limitation and in accordance with the route of administration specified.

Training required

3. No member may prescribe any drug unless he or she has successfully completed the relevant training in pharmacology that has been approved by the Council.

Recording

4. Every time a member prescribes a drug, the member shall record the following in the patient's health record as that record is required to be kept under section 10 of Ontario Regulation 119/94 (General) made under the Act:

1. Details of the prescription, including the drug prescribed, dosage and route of administration.

2. Details of the counselling provided by the member to or on behalf of the

patient respecting the use of the drug prescribed.

Non-prescription drugs

5. In the course of engaging in the practice of optometry a member may prescribe any drug that may lawfully be purchased or acquired without a prescription.

The standards of practice related to the prescribing of drugs for the treatment of glaucoma are as follows:

Prescribing of antiglaucoma agents

6. It is a standard of practice of the profession that in treating glaucoma a member may only prescribe a drug set out under the category of "Antiglaucoma Agents" in Schedule 1.

Open-angle glaucoma

7. (1) Subject to subsection (2) and to section 8, it is a standard of practice of the profession that a member may only treat a patient with glaucoma where the patient has primary open-angle glaucoma the treatment of which is not complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment.

(2) It is a standard of practice of the profession that a member may only treat a patient having open-angle glaucoma, the treatment of which is complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment, in collaboration with a physician with whom the member has established a comanagement model of care for that patient and who is,

(a) certified by the Royal College of Physicians and Surgeons of Canada as a specialist in ophthalmology; or

(b) formally recognized in writing by the College of Physicians and Surgeons of Ontario as a specialist in ophthalmology.

Referral to physician or hospital

8. (1) Subject to subsections (2) and (3), it is a standard of practice of the profession that a member shall immediately refer a patient having a form of glaucoma other than primary open angle glaucoma to a physician or to a hospital.

(2) It is a standard of practice of the profession that a member may initiate treatment for a patient having angle-closure glaucoma only in an emergency and where no physician is available to treat the patient.

(3) It is a standard of practice of the profession that a member shall immediately refer any patient being treated in accordance with subsection (2) to a physician or hospital once the emergency no longer exists or once a physician becomes available, whichever comes first.

(4) In this section, "hospital" means a hospital within the meaning of the Public Hospitals Act.

SCHEDULE 1

ANTI-INFECTIVE AGENTS

Antibacterials (topical)

azithromycin
besifloxacin
ciprofloxacin
erythromycin
framycetin
fusidic acid
gatifloxacin
gentamicin
moxifloxacin
ofloxacin
polymyxin B/gramicidin/neomycin
polymyxin B/neomycin/bacitracin
polymyxin B/trimethoprim
sulfacetamide
tetracycline
tobramycin

Antifungals (topical)

natamycin

Antivirals (topical)

trifluridine
Acyclovir

Antibacterials (oral) –

for corneal or eyelid infections only and for a duration not exceeding 14 days

amoxicillin
amoxicillin/clavulanic acid
azithromycin
cephalexin
ciprofloxacin
clarithromycin
clindamycin
cloxacillin
doxycycline
erythromycin
levofloxacin
minocycline
moxifloxacin

tetracycline

Antivirals (oral) – for corneal or eyelid infections only

acyclovir
famciclovir
valacyclovir

ANTI-INFLAMMATORY AGENTS

Corticosteroids (topical)

dexamethasone
difluprednate
fluorometholone
loteprednol
prednisolone
rimexolone

Corticosteroids (topical) - for the purpose of treating conditions of the eye and adnexa

triamcinolone

Immunomodulators (topical)

cyclosporine

Nonsteroidal anti-inflammatory agents (topical)

bromfenac
diclofenac
ketorolac
nepafenac

ANTI-INFECTIVE/ANTI-INFLAMMATORY AGENTS

Antibacterials /corticosteroids (topical)

framycetin/gramicidin/dexamethasone
gentamicin/betamethasone
neomycin/fluorometholone
neomycin/polymyxin B/dexamethasone
neomycin/bacitracin/polymyxin B/hydrocortisone
sulfacetamide/prednisolone
tobramycin/dexamethasone

MYDRIATICS

Mydriatics (topical)

atropine
cyclopentolate
homatropine

tropicamide

ANTI-ALLERGIC AGENTS

Anti-allergic agents (topical)

bepotastine
emedastine
ketotifen
levocabastine
lodoxamide
nedocromil
olopatadine
tacrolimus – for the purpose of treating conditions of the eye and adnexa and for a duration not exceeding 42 days

ANTIGLAUCOMA AGENTS

ß-Adrenergic blocking agents (topical)

betaxolol
levobunolol
timolol

Carbonic anhydrase inhibitors (topical)

brinzolamide
dorzolamide

Miotics (topical)

carbachol
pilocarpine

Prostaglandin analogs (topical)

bimatoprost
latanoprost
tafluprost
travoprost

α-Adrenergic agonists (topical)

apraclonidine
brimonidine

α-Adrenergic agonists/ß-adrenergic blocking agents (topical)

brimonidine/timolol

Carbonic anhydrase inhibitors/ß-adrenergic blocking agents (topical)

brinzolamide/timolol
dorzolamide/timolol

Prostaglandin analogs/ß-adrenergic blocking agents (topical)

latanoprost/timolol

travoprost/timolol

Carbonic anhydrase inhibitors (oral) – to lower intraocular pressure only and a member shall immediately refer the patient to a physician or to a hospital

acetazolamide

SECRETAGOGUES

Secretagogues (oral) – for Sjögren's syndrome only and only in collaboration with a physician with whom the member has established a co-management model of care

pilocarpine

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The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.(3)

8. Failing to reveal the exact nature of a secret remedy or treatment used by the member following a patient's request to do so.

9. Making a misrepresentation with respect to a remedy, treatment or device.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Optometrists utilizing drugs within their practices for diagnostic and therapeutic purposes will:

- use only drugs for which they have been appropriately trained, establish a diagnosis and management plan based upon case history, clinical findings and accepted treatment modalities
- not dispense a drug

- document the drug(s) used, including concentration (when applicable) and dosage
- provide appropriate patient counselling including:
- general information, including management options, a description of the treatment(s), expected outcomes and normal healing course
- specific information including any potential significant risks and complications requiring *urgent or emergency care* **(OPR 4.6)**
    - how to access after-hours support and emergency care
    - arrange appropriate follow-up care as indicated
- refer the patient to an appropriate health care provider when clinically indicated

Prescribing of Drugs by Optometrists with Authority to Prescribe Drugs

In addition to the above conditions, those with authority to prescribe drugs:

- will maintain appropriate continuing education relevant to the treatment of eye disease by drug therapy as specified by the College
- may issue a *prescription* **(OPR 5.2)** and document the treatment and counselling in the *patient health record* **(OPR 5.1)**

Use of Drugs by Optometrists without Authority to Prescribe Drugs

Optometrists without authority to prescribe drugs have several options for the treatment of patients with conditions requiring drug therapy, such as:

- refer to another optometrist with authority to prescribe drugs;
- refer to another regulated health care provider who can provide such care appropriate to the condition;
- initiate office treatment, then, make a referral, as above, if required for the condition

It is professional misconduct if a prescription for drugs is issued by an optometrist without authority to prescribe drugs.

Last Reviewed: September 2017

First published: April 2004
(The Guideline for the Use of Drugs by Optometrists)

Revised: April 2011
(The Use and Prescribing of Drugs in Optometric Practice)

April 2014

February 2017

4.5 Referrals

Description

A referral is a request for consultation and/or the provision of treatment made to another regulated health professional when a patient requires care that exceeds the optometrist's scope of practice or ability.

Regulatory Standard

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Optometrists must be proficient in determining the necessity of appropriate referral for care. Their decisions, about the urgency and choice of consultant are influenced by the ocular and/or systemic conditions and risk factors of patients, the community in which optometrists practise and the availability of appropriate consultation.

Once the decision has been made to make a referral, appropriate documentation in the patient's *health record* **(OPR 5.1)** is necessary, including:

- confirmation of when the referral was requested (e.g. fax information or written documentation of telephone conversation);
- appointment date, time, and consultant;
- confirmation with the patient of the appointment time and location; and
- a copy of the pertinent clinical information forwarded to the consultant.

Timeliness of Referral

Acute conditions that pose an immediate threat to the health and/or vision of the patient require a prompt referral. Examples of these conditions include, but are not limited to:

- acute glaucoma;
- retinal detachment;
- papilledema;
- wet AMD
- central corneal ulcer;
- sudden, unexplained vision loss; or
- vision-threatening trauma.

If the patient is placed at risk because the referral appointment is not available within an appropriate amount of time, optometrists are required to advocate on their patient's behalf to attempt to arrange a more timely appointment. Otherwise, optometrists may need to seek an alternative source of care such as a hospital emergency department.

Last Reviewed: July 2022

First Published: January 2007
Revised: April 2014
September 2014
September 2022

4.6 Ocular Urgencies and Emergencies

Description

Urgencies and emergencies represent potential threats to the ocular and/or systemic health and well being of patients if not dealt with appropriately. Accordingly, specific examinations are performed to provide prompt assistance, intervention, and/or action to limit potential sequelae.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation which a consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

In urgent or emergency situations, any treatment initiated by optometrists will be within the profession's scope of practice **(OPR 2.1)**, and will not exceed their experience or competence. An exception to this would be if a controlled act has been delegated **(OPR 4.3)** by a member of another regulated health profession with that authority; optometrists receiving such delegation must be properly trained to do so. Generally, optometrists are expected to:

- establish appropriate protocols and ensure that staff members are trained to recognize and respond to urgent and emergency situations;
- conduct a specific examination to evaluate the immediate problem;
- counsel 'at-risk' patients about signs and symptoms that may require further care (for example, possible retinal detachment symptoms following a posterior vitreous detachment);
- counsel patients to whom they have prescribed drugs regarding potential adverse reactions, and when the need for emergency services may be required; and
- make themselves available for contact by patients to whom they have initiated treatment of an urgent condition.

If the treatment involves a *referral* **(OPR 4.5)** to another health professional, the timeliness of the appointment will be appropriate to the condition and remains the responsibility of optometrists even if a staff member makes the appointment.

Last Reviewed: September 2012

First Published: September 2007

Revised: May 2009

February 2013

April 2014

4.7 Infection Control in the Optometric Office

Description

Within all health care facilities there is a risk of transmission of infectious agents. Standards demand that all health care workers must mitigate that risk by being educated and proactive in the area of infection control. Documents and guidelines on the topic of infection control are published and periodically updated by government agencies, health care groups and academic institutions. All optometrists must be cognizant of current information on infection control and take appropriate measures within their practices.

Regulatory Standard

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

14. Failing to maintain the standards of practice of the profession.

39. Engaging in conduct or performing an act that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, unprofessional or unethical.

Professional Standard

Optometrists must take reasonable and appropriate measures to minimize the risk of contamination and subsequent transmission of infectious agents within their professional practices.

Optometrists should follow the recommendations of their local public health units.

Last Reviewed: May 2022

First published: April 2011

Revised: February 2013

April 2014

June 2022

4.8 Collaboration and Shared Care

Description

The term "collaboration" has arisen to describe sharing of care between professionals. Such shared care is usually complementary. It has become apparent that professionals who provide complementary health care services to patients often will find ways to work together to co-manage/share care of patients. This is often beneficial to patients as it may allow better accessibility to the health care system, lower costs to the system and patients and allow more specialized practitioners to devote more time to their area of expertise.

Optometrists collaborate with many health care professionals including other optometrists, ophthalmologists, family physicians, other medical practitioners, nurse practitioners and opticians. This document describes the characteristics and conditions of collaboration as they apply to the profession of optometry.

History

Optometrists have the regulatory obligation to refer patients to an appropriate regulated health professional (RHP) when the patient's condition and/or treatment is beyond the scope of practice of the optometrist. This has usually resulted in referral to family physicians or ophthalmologists to institute medical and/or surgical care. Various shared care relationships have developed in this regard including *glaucoma* management **(OPR 7.2)**, *cataract* surgery **(OPR 7.3)** and *refractive surgery* **(OPR 7.8).** Although these relationships are common, formal arrangements are usually not developed.

The Health Professions Regulatory Advisory Counsel (HPRAC) made recommendations in its New Directions report (2006) that optometrists and physicians develop formal collaborative relationships with opticians regarding the latter professional group providing refractive data to assist in the development of a *prescription* **(OPR 6.3)** for vision correction. HPRAC also recommended that optometrists and ophthalmologists develop collaborative relationships with regards to the management of *glaucoma* patients. **(OPR 7.2)**

Regulatory Standards

Controlled Acts

The *Regulated Health Professions Act* (RPHA) identifies 14 controlled acts that may only be performed by members of certain regulated health professions. Optometrists are authorized by the *Optometry Act* to perform 4 of the 14 controlled acts, as follows:

- communicating a diagnosis identifying as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system, or a prescribed disease;
- applying a prescribed form of energy;
- prescribing or dispensing, for vision or eye problems, subnormal vision devices,

contact lenses or eye glasses; and
- prescribing a drug designated in the regulation.

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

7. Engaging in the practice of the profession while in a conflict of interest as described in Part II.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

15. Delegating a controlled act in contravention of the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts.

16. Performing a controlled act that the member is not authorized to perform.

17. Permitting, counselling or assisting a person who is under the supervision of a member to perform an act in contravention of the Act, the *Regulated Health Professions Act, 1991* or the regulations under either of those Acts.

18. Permitting, counselling or assisting any person who is not a member to perform a controlled act which should be performed by a member

Professional Standard

When an optometrist establishes a collaborative relationship with another RHP, that relationship must be in the best interests of the patient. A formal collaborative relationship will:

- have a verifiable agreement between collaborating professionals which outlines the various responsibilities, accountabilities and exchange of appropriate information for each person;
- ensure that patients fully understand the roles and responsibilities of the professionals involved and any associated fees;

- ensure that patients understand their options for care;
- have a mechanism for conflict resolution amongst all parties; and ensure the collaborating professionals adhere to any applicable standards of practice and conflict of interest regulations for each profession.

Intra-professional Collaborative Practice Among Optometrists:

An optometrist may refer to another optometrist for specific assessment and treatment, for example, dry eye therapy, binocular vision therapy, myopia management, imaging, visual fields.

The primary, referring optometrist, must communicate to the patient what their role will be during the referral process and protocol for further follow up. A requisition to the referring optometrist must include pertinent clinical information.

The optometrist who accepts the requisition must communicate to the patient the nature of their role, including which elements of care they are responsible for and the anticipated duration of care. The optometrist must maintain a patient health record including the requisition information and results.Any new symptoms or concerns should be referred back to the primary optometrist as they are responsible for the components of a comprehensive eye examination.

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September 2017
September 2022

5. Documentation

5.1 The Patient Record

Description

The Patient Record is comprised of two essential parts: the Patient Health Record, including all clinical documentation, and the Financial Record, summarizing diagnostic and treatment fees charged to and paid by the patient. The record is a legal document, with a purpose of meeting professional regulatory requirements, and shall be available for use in the following College processes: Inquiries Complaints and Reports, Discipline and Quality Assurance.

Regulatory Standard

Optometrists shall take all reasonable steps necessary (including verification at reasonable intervals) to ensure that records in relation to their practice are kept in accordance with the regulations.

The regulations governing record keeping are contained in **O.Reg.119/94, Part IV, s. 7-12** as follows:

PART IV
RECORDS

7. (1) A member shall take all reasonable steps necessary to ensure that records in relation to his or her practice are kept in accordance with this Part. **O. Reg. 749/94, s. 3.**

(2) Reasonable steps under subsection (1) shall include the verification by the member, at reasonable intervals, that the records are kept in accordance with this Part. **O. Reg. 749/94, s. 3.**

8. Every member shall keep a daily appointment record that sets out the name of each patient whom the member examines or treats or to whom the member provides any service. **O. Reg. 749/94, s. 3.**

9. (1) Every member shall keep a financial record for each patient. **O. Reg. 749/94, s. 3.**

(2) The financial record must include the member's fees for services and any commercial laboratory costs charged to the member. **O. Reg. 749/94, s. 3.**

10. (1) Every member shall keep a patient health record for each patient. **O. Reg. 749/94, s. 3.**

(2) The patient health record must include the following:

1. The name and address of the patient and the name of the member who provided the service.

2. The date of each visit of the patient.

3. The name and address of any referring health professional.

4. The patient's health and oculo-visual history.

5. The clinical procedures used.

6. The clinical findings obtained.

7. The diagnosis, when possible.

8. Every order made by the member for examinations, tests, consultations or treatments to be performed by any other person.

9. Particulars of every referral to or from another health professional.

10. Information about every delegation of a controlled act within the meaning of subsection 27 (2) of the Regulated Health Professions Act, 1991, delegated by the member.

11. Information about a procedure that was commenced but not completed, including reasons for non-completion.

12. A copy of every written consent to treatment. **O. Reg. 749/94, s. 3.**

(3) Every part of a patient health record must be dated and have a reference identifying the patient or the patient health record. **O. Reg. 749/94, s. 3.**

(4) Every entry in the patient health record must be dated and the person who made the entry must be readily identifiable. **O. Reg. 749/94, s. 3.**

(5) Every patient health record shall be retained for at least 10 years following,

(a) the patient's last visit; or

(b) if the patient was less than 18 years old at the time of his or her last visit, the day the patient became or would have become 18 years old. **O. Reg. 749/94, s. 3.**

11. (1) The following are acts of professional misconduct for the purposes of clause 51 (1) (c) of the Health Professions Procedural Code:

1. Allowing any person to examine a patient health record or giving a copy of a document or any information from a patient health record to any person except as required by law or as required or allowed by this section.

2. Failing to provide copies from a patient health record for which the member has primary responsibility, as required by this section. **O. Reg. 749/94, s. 3.**

(2) A member shall provide copies from a patient health record for which the member has primary responsibility to any of the following persons on request:

1. The patient.

2. A personal representative who is authorized by the patient to obtain copies from the record.

3. If the patient is dead, the patient's legal representative.

4. If the patient lacks capacity to give an authorization described in paragraph 2,

i. a committee of the patient appointed under the Mental Incompetency Act,

ii. a person to whom the patient is married,

iii. a person, with whom the patient is living in a conjugal relationship outside marriage, if the patient and the person,

A. have cohabited for at least one year,

B. are together the parents of a child, or

C. have together entered into a cohabitation agreement under section 53 of the Family Law Act,

iv. the patient's son or daughter,

v. the patient's parent. **O. Reg. 749/94, s. 3; O. Reg. 390/06, s. 1.**

(3) It is not an act of professional misconduct under paragraph 2 of subsection (1) for a member to refuse to provide copies from a patient health record until the member is paid a reasonable fee.

(4) A member may provide copies from a patient health record for which the member has primary responsibility to any person authorized by or on behalf of a person to whom the member is required to provide copies under subsection (2).

(5) A member may, for the purposes of providing health care, allow a health professional to examine the patient health record or give a health professional a copy of a document or any information from the record. **O. Reg. 749/94, s. 3.**

12. For record keeping required by this Part, a member may use computer, electronic or other equipment for recording, storing and retrieval of records if,

(a) the record keeping system provides ready access by an authorized investigator, inspector or assessor of the College, or the patient or the patient's representative to the records;

(b) ancillary equipment is readily available for the making of hard copies of the record at no expense to an authorized investigator, inspector or assessor of the College;

(c) the equipment or software being used is such that no amendment, correction, addition or deletion can be made to any record which obliterates the original record or does not show the date of the change. **O. Reg. 749/94, s. 3.**

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the Optometry Act)** includes the following act of professional misconduct:

27. If a member closes his or her office or retires from practice, failing to make reasonable efforts to make arrangements with a patient or his or her authorized representative to transfer the patient's records to,

i. the patient or his or her authorized representative,

ii. another member, if the patient or his or her authorized representative so requests, or

iii. another member, with notice to the patient that his or her records have been transferred to that other member.

Optometrists maintain the information contained within their records in trust, and in compliance with Ontario's Personal Health Information Protection Act (PHIPA).

Professional Standard

In addition to the regulatory requirements, the patient health record shall also:

- be legible and complete;
- be maintained in either English or French;
- include the date of birth;
- include proposal(s) for care and advice offered;
- include a description of the care rendered and recommendations for ongoing care;
- include details of all patient communication (both in person and electronic);
- be maintained to allow for easy identification and location of all documentation related to the provision of care;
- indicate deviations from usual care due to patient refusal or inability to cooperate; and
- make specific notation in the event that a test was performed or a question asked and the result was 'negative' or 'normal'.

Patient Access to Records

The right of patients to access the information in their record or direct that the information be transferred to another health care provider must not be limited in any manner, except as allowed by regulation. It is the right of patients to choose who provides care to them.

Relocation of a Patient Health Record

In situations where optometrists relocate their practice or entrust the custody of records to another optometrist in another location, optometrists entrusted with the maintenance of the records must make a reasonable attempt to inform patients of the location of the records.

Electronic Records

Members must produce complete financial records and patient health records (as defined by the regulation **(O. Reg. 119/94 Part IV, S.12)** upon request.

In addition to the regulatory requirements, optometrists are expected to utilize reasonable and reliable backup systems.

Where patient information is stored on mobile devices or offsite in an identifiable form, the information must be encrypted.

Last Reviewed: November 2018

First Published: September 2006
Revised: June 2012
June 2014

5.2 The Prescription

Description

A prescription is an order between an optometrist and a patient. A prescription is based upon the analysis of all available clinical information and subsequent diagnoses from optometric examination. Optometrists may issue two distinct types of prescriptions: **optical prescriptions,** which when combined with further appliance-specific information, enable the patient to obtain eyeglasses, contact lenses or subnormal vision devices; and **prescriptions for drugs,** which specify topical or oral drugs used to treat certain ocular diseases.

Regulatory Standard

The *Optometry Act, 1991(as amended 2007)* lists four authorized acts that can be performed by optometrists subject to the terms, conditions and limitations on their certificate of registration. Two of those acts are:

- Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eyeglasses. (1991, c. 35, s. 4".)
- Prescribing drugs designated in the regulations

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act, 1991)** includes the following acts of professional misconduct:

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescription for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

The Designated Drugs and Standards of Practice Regulation, **(O.Reg. 112/11 under the Optometry Act)** describes the following conditions under which optometrists may prescribe drugs:

Drugs that may be prescribed

1. For the purposes of paragraph 2.1 of section 4 of the Act, and subject to sections 2, 3 and 4 and Part II of this Regulation, a member may prescribe a drug set out under a category and sub-category heading in Schedule 1.

Limitation

2. Where a limitation or a route of administration is indicated in the sub-category heading set out in Schedule 1, a member shall only prescribe a drug listed under that sub-category in compliance with the limitation and in accordance with the route of administration specified.

Training required

3. No member may prescribe any drug unless he or she has successfully completed the relevant training in pharmacology that has been approved by the Council.

Recording

4. Every time a member prescribes a drug the member shall record the following in the patient's health record as that record is required to be kept under section 10 of Ontario Regulation 119/94 (General) made under the Act:

1. Details of the prescription, including the drug prescribed, dosage and route of administration.
2. Details of the counselling provided by the member to or on behalf of the patient respecting the use of the drug prescribed.

Non-prescription drugs

5. In the course of engaging in the practice of optometry, a member may prescribe any drug that may lawfully be purchased or acquired without a prescription.

Professional Standard

Optometrists issue a prescription only after establishing a professional relationship with the patient, completing an appropriate examination and obtaining a full understanding of the relevant aspects of the patient's needs, ocular health, refractive status and/or binocular condition. The prescribed therapy must be within the scope of practice of the optometrist and in the patient's best interest. Optometrists are responsible to counsel their patients in the use of any prescribed therapy and required follow-up. The prescription and appropriate counselling must be documented in the patient record. In the event that a patient experiences an adverse or unexpected response to the prescribed therapy, optometrists will provide additional diagnostic and/or counselling services and, if required, make appropriate modifications to the management plan.

***All* prescriptions** must contain information that:

- Clearly identifies the prescribing optometrist, including name (with degree and profession), address, telephone number, license (registration) number and signature;
- Clearly specifies the identity of the patient; and
- Specifies the date prescribed.

If optometrists determine that a prescribed therapy is required, a prescription **must** be provided as part of the assessment without additional charge, regardless of whether the examination is an insured or uninsured service.

Patients have the right to fill their prescriptions at the dispensary or pharmacy of their choice.

A. Optical Prescription

An optical prescription must also:

- Contain information that is used by a regulated professional to dispense eyeglasses, contact lenses or a subnormal vision device that will provide the required vision correction **(OPR 6.3)** for the patient; and
- Specify an expiry date.

A spectacle prescription (prescription for eyeglasses) must be provided to the patient without request and without additional charge, regardless of whether the examination is an insured or uninsured service. Charges for additional copies of the prescription are at the discretion of the optometrist.

When optometrists have performed the necessary services to prescribe a specific appliance (e.g. contact lens), an appliance-specific prescription including the parameters of that appliance must be provided to the patient upon request. Optometrists may withhold this information pending payment for the related service.

B. Prescription for Drugs

A prescription for drugs must also contain:

- the drug name, dose, dose form;
- directions to the pharmacist such as quantity to be dispensed, refills allowed and an indication if **no** substitutions are permitted;
- directions to the patient; and
- the optometrist's **original** signature.

To provide timely care, it may be necessary to fax a prescription for drugs to a pharmacy. This fax must contain appropriate information verifying that it originates at the prescribing optometrist's office.

When it is necessary to verbally communicate a prescription for drugs to a pharmacy, the details must be fully documented in the patient record, including the name of the pharmacy and any staff members assisting in the calll.

Last Reviewed: December 2018

First Published: September 2007

Revised: April 2011
April 2014
September 2014
April 2015
January 2019

6. General Procedures

6.1 Anterior Segment Examination

Description

The anterior segment can be considered as the front third of the eye, encompassing the structures in front of (that is, anterior to) the vitreous humour, including, the lids and lashes, conjunctiva and sclera, cornea, anterior chamber, iris, and crystalline lens. The anterior segment examination consists of a thorough assessment of these structures to facilitate the diagnosis of diseases, disorders and dysfunctions of the eye and vision system. Information obtained from an anterior segment examination is part of the *required clinical information* **(OPR 4.2)**.

Regulatory Standard

The Professional Misconduct Regulation **(O. Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Optometrists must be proficient in and equipped for examining the anterior segment. The equipment customarily used for the assessment is the slit-lamp biomicroscope.

A complete anterior segment examination must include an inspection of the following anatomical areas:

- lids and lashes/adnexa;
- conjunctiva/sclera;
- cornea/tear film (and corneal thickness when indicated);
- anterior chamber and angle;
- iris; and
- crystalline lens.

All patients will receive an anterior segment examination as a part of initial and ongoing optometric care. Emphasis is given to the evaluation of the anterior

chamber angle prior to pupillary dilation and in patients with diagnosed or suspected glaucoma. The optometrist's decision regarding the frequency and extent of the examination and the specific techniques utilized will be influenced by a patient's signs, symptoms and risk factors.

An anterior segment examination is an essential component of all *contact lens assessments* **(OPR 6.5)**.

Last Reviewed: July 2022

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April 2014
September 2022

6.2 Posterior Segment Examination

Description

The posterior segment can be considered as the back two-thirds of the eye, encompassing the structures posterior to the crystalline lens, including the vitreous humour, optic nerve head, retina and choroid. The posterior segment examination consists of a thorough assessment of these structures to facilitate the diagnosis of diseases, disorders, and dysfunctions of the eye and visual system. Information obtained from a posterior segment examination is part of the *required clinical information*. **(OPR 4.2)**.

Examination Procedures

METHOD	CHARACTERISTICS
1 Direct Ophthalmoscopy	Maximum magnification Minimum field of view
2 Binocular Indirect Ophthalmoscopy	Maximal field of view Minimal magnification Scleral indentation view Minimal range of condensing lens, fixed objective lens
3 Monocular Indirect Ophthalmoscopy	Moderate field of view Moderate magnification
4 Slit Lamp / Biomicroscopy (slit lamp photography)	High magnification and a very bright light source permit better appreciation of the optic nerve, macula, retinal vessels and other posterior pole structures.
5 Fundus Photography / Fundus Autofluorescence	Moderate to wide field of view and magnification with a wide range of filters and recording media. Colour, black and white, film or digital recording.
6 Imaging Technologies	Include, but are not limited to: • optical coherence tomography (OCT) • confocal scanning laser ophthalmoscopy (SLO) • scanning laser polarimetry (GDx) • multi-spectral imaging • macular pigment optical density (MPOD) measurement

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or

should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Optometrists must be proficient, and *equipped* **(OPR 4.1)**, to examine the posterior segment.

A complete posterior segment examination must include an inspection of the following anatomical structures:

- vitreous humour
- optic nerve head
- macula and fovea
- retinal vasculature
- retinal grounds including, posterior pole, mid-periphery and where clinically indicated and/or possible, peripheral retina, and ora serrata.

All patients will receive a posterior segment examination as a part of initial and ongoing optometric care. An optometrist's decision about the frequency of examination, extent of view and methods of examination of the posterior segment, including the use of pharmacological pupillary dilation, will be influenced by a patient's signs, symptoms and risk factors.

Pharmacologic Dilation

Pharmacologic dilation **(OPR 4.4)** of the pupil is generally required for a thorough evaluation of the ocular media and posterior segment. Dilation can also facilitate examination of the anterior segment structures when certain conditions are present or suspected. The results of the initial dilated examination usually indicate the appropriate timing for subsequent pupillary dilation.

The following lists some of the situations/patient symptoms that indicate dilation is required (unless contraindicated) with the informed consent of the patient. These situations/patient symptoms include but are not limited to:

- symptoms of flashes of light (photopsia), onset of or a change in number or size of floaters;
- unexplained or sudden vision change, loss, or distortion (metamorphopsia);
- the use of medication that may affect ocular tissues (including but not limited to hydroxychloroquine, phenothiazine, long-term steroids);
- the presence of systemic disease that may affect ocular tissues (including but not limited to diabetes, hypertension);
- a history of significant ocular trauma, or ocular surgery that increases risk to the posterior segment;

- a history of moderate to high axial myopia;
- when a better appreciation of the fundus is required (including but not limited to choroidal nevus, optic nerve anomaly);
- when the ocular fundus is not clearly visible through an undilated pupil (including but not limited to cataract);
- when there is a known or suspected disease of:
  - the vitreous (including but not limited to vitreous hemorrhage);
  - the optic nerve (including but not limited to glaucoma);
  - the macula (including but not limited to age-related macular degeneration);
  - the peripheral retina (including but not limited to lattice degeneration);
  - the choroid (including but not limited to melanoma).

Optometrists choose the dilating agent after considering the extent of pupillary dilation desired, the patient's health history and clinical ocular characteristics, as well as the implications of expected side effects on the patient's activities and safety.

Last Reviewed: May 2017

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May 2012
February 2013
April 2014
June 2017

6.3 Refractive Assessment and Prescribing

Description

Assessing the patient's refractive error and, where required, *prescribing* **(OPR 5.2)** an optical correction is an integral part of optometric care. Assessment methods include objective and subjective techniques.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescripton for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

The process of obtaining *required clinical information* **(OPR 4.2)** includes determination of the refractive status and best-corrected visual acuities. When possible, objective and subjective refraction techniques are used to assess the refractive status of the eye, at the initial visit and as clinically indicated thereafter. *Cycloplegic refraction* is employed when clinically necessary. **(OPR 7.6)**

Refractive assessment alone does not provide sufficient information to allow an optometrist to issue an appropriate prescription for subnormal vision devices, contact lenses or eyeglasses.. The effects of ocular and systemic health conditions, binocular vision status and the occupational and avocational visual environment and demands must also be considered.

The College standard on *delegation and assignment* **(OPR 4.3)** and *collaboration* **(OPR 4.8)** must be followed when refractive data is obtained from a person to whom the procedure has been assigned, including another regulated health professional (RHP). Specifically, there must be direct supervision of the subjective refractive assessment when this procedure is assigned.

Last Reviewed: July 2017 First Published: May 2009

Revised: April 2014

6.4 Spectacle Therapy

Description

Optometrists are authorized to dispense spectacles for the treatment of disorders of refraction and/or sensory and oculomotor disorders and dysfunctions of the eye and vision system. The patient must present a valid prescription written by an optometrist or physician.

Regulatory Standard

Ophthalmic dispensing is defined as "the preparation, adaptation and delivery" of vision correction, and is a controlled act in Ontario authorized to optometrists, physicians and opticians:

- Prescribing or dispensing, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses **(Optometry Act, 1991, c.35,s.4)**.

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the Optometry Act, 1991)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which consent is required by law, without such a consent.

9. Making a misrepresentation with respect to a remedy, treatment or device.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescripton for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

29. Charging pr allowing a fee to be charged that is excessive or unreasonable in relation to the professional services performed.

30. Failing to issue a statement or receipt that itemizes an account for professional goods or services to the patient or a third party who is to pay, in whole or in part, for the goods or services provided to the patient.

33. Charging or accepting a fee, in whole or in part, before providing professional services to a patient unless

i. the fee relates to the cost of professional goods to be used in the course of performing the services, or,

ii. the member informs the patient, before he or she pays the fee, of the patient's right to choose not to pay the fee before the professional services are performed.

Professional Standard

Optometrists providing spectacle therapy must satisfy all Regulatory and Professional Standards, regardless of whether or not technology (including the internet) is used as a tool to facilitate the provision of spectacle therapy to patients.

The provision of spectacle therapy involves:

- **Reviewing with the patient any relevant environmental, occupational, avocational, and/or physical factors affecting spectacle wear:** If this review is not performed in-person, optometrists should include a precaution for patients that in-person reviews are recommended for individuals with special needs or atypical facial and/or postural features. If optometrists choose specific patient factors by which to limit their internet dispensing services, including, but not limited to, a specific age range, this should be disclosed on the website where patients can easily find it.
- **Reviewing the details of the prescription:** Optometrists are responsible for confirming the validity and/or veracity of prescriptions. Prescriptions provided using the internet must be provided in a secure manner and collected in an unaltered form (pdf/image). All prescriptions must contain information that clearly identifies the prescriber (including name, address, telephone number and signature), and specifies the identity of the patient and the date prescribed **(OPR 5.2 The Prescription)**. All prescriptions must include an expiry date.
- **Advising the patient regarding appropriate ophthalmic materials:** In the event that this is not performed in-person, patients must be given clear directions on how to contact the office/optometrist with any questions they may have.
- **Taking appropriate measurements (including but not limited to interpupillary distance and segment height) to ensure proper function of the spectacles:** If computer applications are used (in-office or remotely) to determine dispensing measurements, optometrists must be satisfied that the application determines these measurements with equal accuracy to traditional in-person measurements, including the production of supportable evidence should this matter come to the attention of the College.
- **Confirming the suitability of the order and arranging for the fabrication of the spectacles**
- **Verifying the accuracy of the completed spectacles to ensure that they meet required tolerances**
- **Fitting or adjusting the spectacles to the patient:** Optometrists providing spectacle therapy will possess the equipment required to fit and adjust spectacles. In-person fitting and adjusting of spectacles provides a

final verification and mitigates risk of harm by confirming that patients leave the clinic with spectacles that have been properly verified, fit and adjusted. Further, it establishes a patient/practitioner relationship in circumstances where patients are new to the clinic and spectacle therapy was initiated through the optometrist's website. That being said, patients have the right to agree to, or decline the performance of any procedure, including in-person fitting and adjustment of spectacles. When patients require or request delivery of prescription eyeglasses prior to in-person fitting, optometrists must use their professional judgment in determining whether this is appropriate, with consideration to factors including, but not limited to, the age of the patient, the degree of ametropia and/or anisometropia, and prescribed multifocality or prism.

- **Counselling the patient on aspects of spectacle wear including, but not limited to: the use, expectations, limitations, customary adaptation period and maintenance requirements of the spectacles:** This may be done in person or virtually.

The principle of informed consent applies to spectacle therapy whether the service is provided in-person or virtually. Optometrists use professional judgement in determining when consent must be specifically documented in the patient record. While implied consent can be assumed to apply to the in-person provision of spectacle therapy, the same cannot be said for virtual encounters, when express written documentation of informed consent is preferable.

Additional Considerations

Patients experiencing unexpected difficulty adapting to new spectacles should be counselled to seek re-examination by the prescriber to assess the appropriateness of the prescription. Optometrists dispensing appliances based on a prescription from another practitioner are expected to ensure that this has been filled appropriately, however they are not responsible for the efficacy or accuracy of that practitioner's prescription.

Delegation: Optometrists who delegate elements of spectacle dispensing (for example, the fitting and adjusting of spectacles) to staff who are not authorized to independently perform the controlled act, must be present in the same physical location and able to intervene, unless another optometrist is present to provide appropriate delegation **(OPR 4.3 Delegation and Assignment)**.

Most Responsible Dispenser: In collaborative or multi-optometrist practices, where multiple optometrists may participate in dispensing spectacles to an individual patient, the College considers that the last optometrist to provide care, or "touch the patient", typically the optometrist fitting or adjusting the spectacles, is the most responsible dispenser. This optometrist is responsible for all preceding steps in the dispensing process, as well as the performance of the spectacles and any potential risk of harm to the patient. Similarly, where optometrists practice in working arrangements with opticians, the most responsible dispenser is the last regulated professional to provide care to the patient.

Jurisdiction: Ontario-based optometrists providing care to patients in other jurisdictions (provinces/states) may need to be registered in those jurisdictions and should consult with the appropriate regulatory authorities. Optometrists participating in any aspect of ophthalmic dispensing in Ontario must be registered with the College of Optometrists of Ontario.

The Patient Record: Internet prescriptions and orders must be maintained in the patient record **(OPR 5.1 The Patient Record)**.

Internet Sites: Where the internet is used in the provision of spectacle therapy, websites utilized by member optometrists must:

- comply with College advertising guidelines and relevant paragraphs in the Professional Misconduct regulation **(O. Reg. 119/94, Part I under the Optometry Act)**;
- identify the website as belonging to or referring to a member registered with the College of Optometrists of Ontario;
- collect and record patient information in a private and secure manner respecting patient confidentiality;
- identify the physical location of the clinic/dispensary, including address and city/town, and the hours of operation of the clinic; and
- include the telephone number to contact the clinic/dispensary.

Conflicts of Interest: Under the Optometry Act (O. Reg. 119/94, Part II Conflict of Interest p. 3.(2)(h)), optometrists are prohibited from sharing fees with other than another Ontario-registered optometrist or physician. Optometrists providing spectacle therapy in working arrangements with corporations must not share fees, and must practice as an independent contractor as outlined under the Optometry Act (O. Reg. 119/94, Part II Conflict of Interest p. 4.(5)).

Expired Prescriptions: Optometrists must use professional judgment in determining whether it is appropriate to provide spectacle therapy to patients presenting expired prescriptions. Optometrists must advise patients of any appreciated risks and obtain their informed consent before dispensing their expired prescriptions.

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September 2014
October 2015
September 2019

6.5 Contact Lens Therapy

Description

Optometrists are authorized to prescribe and dispense contact lenses for the treatment of:

- disorders of refraction, and/or sensory and oculomotor dysfunctions of the eye and vision system, and/or
- diseases/disorders affecting ocular health, and/or
- anatomical, structural and/or cosmetic concerns

The provision of this service to patients involves an initial assessment to determine suitability of patients for contact lens therapy, a determination of the parameters of a contact lens appropriate for patients, and ongoing monitoring of the efficacy of treatment. Contact lenses are classified by Health Canada as a medical device, not a consumer commodity, and should be treated accordingly.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescripton for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Initial Contact Lens Fitting

Before contact lens fittings, optometrists obtain required clinical information **(OPR 4.2)** to determine the suitability of patients for contact lens wear. Special emphasis is given to the analysis of:

- the health of the cornea, conjunctiva, lids, tarsal and bulbar conjunctiva, and the integrity of the tear layer;

- corneal curvature;
- refractive status and visual acuity;
- the effects that contact lens wear may have on the function of the accommodative, oculo-motor and sensory systems; and
- relevant environmental, occupational, avocational, emotional and systemic health factors affecting contact lens wear.

To allow patients to make informed decisions about proceeding with treatment, optometrists provide information about the advantages, risks, limitations, and costs of contact lens wear and on the prognosis for successful treatment. Patients may choose to proceed with the contact lens fitting by their optometrist, or may obtain a copy of the spectacle prescription to be used for contact lens fitting by other qualified practitioners.

In fitting contact lenses, optometrists will determine, by diagnostic fitting or calculation, lenses that are appropriate for their patients. The initial lenses are evaluated on a patient's eyes and subsequent modifications of the lens parameters are made as required.

Instructions are provided to patients with respect to:

- hygiene;
- lens insertion and removal;
- use of specific lens care products;
- recommended wearing times and replacement schedules;
- normal and abnormal adaptive symptoms;
- contraindications to lens use;
- progress evaluations; and
- appropriate instructions on how and when to access emergency care **(OPR 4.6)**.

Patients are examined during the adaptation period to assess lens performance, adaptation and compliance.

Once optometrists are satisfied that the adaptation process is complete, and that the parameters of the contact lenses are correct, a contact lens prescription can be finalized. Optometrists are entitled to remuneration for all professional services involved in the determination of these prescriptions. At this point, patients have the option of obtaining contact lenses from their optometrist, or requesting a copy of the contact lens prescription in order to obtain contact lenses elsewhere.

Continuing Care

Optometrists provide continuing care to established contact lens patients. In providing continuing care, optometrists:

- maintain a history concerning:
  - the specifications, age and wearing schedule of current contact lenses;
  - the current lens care regime;
  - any adverse reactions associated with contact lens wear; and

    - any health or medication changes.

- assess patients to determine if they are achieving acceptable:
    - lens appearance and fit;
    - wearing time;
    - comfort with lenses in place;
    - corneal clarity and integrity;
    - conjunctival and lid appearance;
    - tear characteristics;
    - over-refraction for best visual acuity;
    - spectacle acuity; and
    - compliance with recommendations on lens handling, lens care, lens replacement and wearing times.
- identify any problems and counsel patients as necessary.
- provide and implement management plans for any problems identified, making recommendations for further care.

Replacement Contact Lens Services

When providing replacement contact lens services, optometrists are responsible for:

- determining the currency of clinical information and providing diagnostic services as required;
- determining the need for alteration of previous lens specifications and makes adjustments accordingly;
- advising patients as to the need for and extent of continuing care;
- confirming the parameters of contact lenses as ordered; and
- providing follow-up services as needed.

The College standards on Delegation and Assignment **(OPR 4.3)** and Collaboration **(OPR 4.8)** must be followed when any procedures are assigned, including to another regulated health professional (RHP).

Internet Sites

Where the internet is used in the provision of contact lens therapy, websites must:

- comply with College advertising guidelines and relevant paragraphs in the Professional Misconduct regulation (O. Reg. 119/94, Part I under the Optometry Act);
- identify the website as belonging to or referring to a member registered with the College of Optometrists of Ontario;
- collect and record patient information in a private and secure manner respecting patient confidentiality;

- identify the physical location of the clinic/dispensary, including address and city/town, and the hours of operation of the clinic; and
- include the telephone number to contact the clinic/dispensary.

The College standards on Delegation and Assignment **(OPR 4.3)** and Collaboration (OPR 4.8) must be followed when any procedures are assigned, including to another regulated health professional (RHP).

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June 2018

6.6 Low Vision Assessment and Therapy

Description

Patients are considered to be visually impaired when there is a measurable loss of vision, including but not limited to visual acuity, contrast sensitivity, and visual field.

Patients are considered to have low vision when their visual impairment results in a reduction in best-corrected visual acuity or visual field that is inadequate for their activities of daily living.[1,2,3]

Patients with low vision may benefit from a low vision evaluation. This includes review of ocular and general (systemic) health conditions, identification of patient-defined goals, extended evaluation of visual function, prescription of and training in the use of various optical and/or non-optical low vision aids and/or rehabilitation strategies directed towards previously-defined patient-defined goals, and counseling and education.

The need for a low vision evaluation will generally be determined as the result of an exploration of patient-reported limitations and goals, and will be informed by specific clinical findings from a comprehensive optometric examination **(see OPR 4.2 - Required Clinical Information)**.

Other reasons for conducting a low vision evaluation include but are not limited to referral from another practitioner or direct referral from a patient or family member. Repeat or ongoing examinations may be required to determine the response to the rehabilitation plan or to monitor the status of patients with low vision.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescripton for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

24. Failing to make or maintain records in accordance with Part IV.

Professional Standard

A low vision examination generally will include the following components:

- a comprehensive patient history that explores:
  - personal ocular and general health history (including medications);
  - family ocular and general health history;
  - personal social history, including patient-identified impact of visual impairment (specific limitations in activities of daily living and goals (vocational/educational/avocational requirements));
  - personal perspective regarding stability of vision;
  - current access to services;
  - current devices and usage/satisfaction;
- consideration of common issues that affect people with low vision;
- a review of the results of the patient's most recent optometric examination, and re-assessment, as necessary;
- patient education regarding visual status, treatment options, and prognosis;
- assessment of rehabilitation options that includes discussion and/or demonstration of potential optical, non-optical, and electronic aids and devices, lighting requirements, environmental modifications, and adaptive strategies;
- creation of a rehabilitation plan individualized for the patient's needs;
- referral to other professionals/service providers, as indicated;
- generation of a report to individuals in the patient's circle of care, when indicated; and
- appropriate follow-up, arranged as needed, to assess the effectiveness of the rehabilitation plan and to monitor the visual condition and needs.

1. Leat SJ, Legge G, Bullimore M. What is low vision - a re-evaluation of definitions. Optom. Vis. Sci. 1999; 76:198-210.
2. THE ICF: AN OVERVIEW **https://www.cdc.gov/nchs/data/icd/icfoverview_finalforwho10sept.pdf**
3. Strong G Jutai J, Plotkin A, Bevers P. Competitive enablement: a consumer -oriented approach to device selection in device-assisted vision rehabilitation. Aging Disability & Independence. 2008; 175-195.

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April 2019

6.7 Binocular Vision Assessment and Therapy

Description

Binocular vision is defined as the ability to maintain visual focus on an object with both eyes, creating a single visual image. Binocular vision enables good depth perception and allows clear, comfortable vision to be maintained throughout visual activities. Optometrists diagnose and treat both congenital and acquired disorders of binocular vision. Clinically, binocular vision is assessed through investigation of the oculomotor and sensory systems.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health related purpose in a situation in which a consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

The initial binocular vision assessment includes:

- appropriate case history;
- refraction and determination of best-corrected visual acuities, including use of cycloplegic **(OPR 7.6)** agents, when indicated;
- assessment of ocular alignment and comitancy;
- assessment of ocular motility;
- assessment of saccadic and pursuit function;
- assessment of vergence function;
- assessment of accommodative function;
- assessment of sensory function;
- identification of postural adaptations, including anomalous head posture, if present,
- assessment of nystagmus, if present;
- consideration of etiology (congenital versus acquired disorders).

The initial binocular vision assessment includes distance and nearpoint testing in primary gaze, at minimum. Follow-up evaluations may be limited to re-assessment of pertinent areas of binocular function.

Management of binocular vision disorders includes:

- refractive and prismatic corrections;
- full or partial occlusion;
- amblyopia **(OPR 7.12)** therapy;
- vision therapy;
- periodic monitoring of the condition;
- collaboration with other service providers involved, including educators, occupational and physical therapists, physicians, neurologists, etc.; and/or
- tertiary care referral **(OPR 4.5)**, including but not limited to surgery and/or imaging, when indicated.

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Revised: April 2014
June 2015
January 2016
January 2019

6.8 Visual Field Assessment

Description

Assessment of the field of vision is an essential part of evaluation of the oculo-visual system. Assessment strategies used may be either screening or detailed (threshold) in nature, utilizing manual or computerized instruments and can assess patients' central and/or peripheral field of vision. Visual field assessment is used in the diagnosis and monitoring of conditions of the eye and vision system including, but not limited to, glaucoma, neurological and retinal disease, and to fulfil third party reporting requirements. Information obtained from visual field assessment and analysis is part of the patient health record **(OPR 5.1)** and must be retained.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct.

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or health-related purpose in a situation in which a consent is required by law, without such consent

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice for the profession.

Professional Standard

The required clinical information **(OPR 4.2)** includes the results and analysis of visual field assessment when indicated by patient signs, symptoms or history. The nature of the signs, symptoms or history will determine the test strategy used and the frequency of re-assessment.

Indications for visual field assessment include, but are not limited to:

- assessment of visual disability
- assessment of patients' ability to operate a motor vehicle
- unexplained headaches
- unexplained photopsia or other visual disturbances
- use of medications with potential neuro-ophthalmic or retinal toxicity
- eyelid or anterior segment anomalies that may affect the visual field

- some retinal diseases and abnormalities
- glaucoma or risk factors for glaucoma
- diseases of the optic nerve and visual pathway
- neurological disease

Visual field screening provides a rapid assessment of the sensitivity and/or extent of the visual field to determine if a more detailed evaluation of the visual field is required. Screening strategies include, but are not limited to:

- confrontation methods
- amsler grid
- tangent screen and arc perimeter methods
- automated techniques specifically designed for screening

When a more detailed evaluation is required, it is appropriate to utilize techniques including but not limited to:

- Goldmann perimetry (kinetic and/or static)
- automated threshold perimetry

If optometrists do not have the required instrumentation, arrangements must be in place whereby the appropriate testing will be performed elsewhere in a timely fashion. For guidance, see **OPR 4.8 Collaboration and Shared Care.**

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September 2022

7. Specific Diseases, Disorders and Procedures

7.1 Patients with Age-related Macular Degeneration

Description

Age-related Macular Degeneration (AMD) is an acquired retinal disorder that affects central visual function. Nonexudative AMD, also known as "dry" AMD, results in a gradual, progressive loss of central visual functioning, whereas patients with exudative AMD, also known as "wet" AMD, notice a more profound and rapid decrease in central visual functioning.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg.119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the Regulated Health Professions Act, 1991 when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

In addition to required clinical information, the evaluation of patients with retinal changes suggestive of AMD, or patients suspected of having AMD, includes:

- patient history of any symptoms associated with AMD; and
- ocular examination including the following:
  - measurement of best corrected monocular visual acuity, distance and near;
  - additional assessment of macular function (for example Amsler grid testing); and
  - posterior segment examination with pupilary dilation **(OPR 6.2)**.

The management of patients with AMD includes:

- continued assessment for differential diagnosis;
- monitoring patients at a frequency that is dependent on the risk of progression of the disease;

- educating patients to be aware of symptoms such as decreased vision, scotomata and dysmorphopsia by monocular assessment;
- educating patients on the potential benefits of the use of supplements (vitamins, antioxidants) where clinically indicated;
- educating patients on the benefit of lifestyle changes (use of UV protection, cessation of smoking) where indicated;
- instructing patients on the importance of monitoring for the onset of new symptoms between in-office assessments, and to return immediately for assessment should they be noted; and
- making a timely referral **(OPR 4.5)** for treatment assessment for patients suspected of having choroidal neovascularization (CNV), particularly given the advent of anti-vascular endothelial growth factor (anti-VEGF) treatments that may afford an improvement in central vision.

In developing a treatment plan, consideration should be given to the patient's visual demands and abilities.

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January 2018

7.2 Patients with Glaucoma

Description

Glaucoma* is a clinical term referring to a spectrum of conditions resulting in damage to the optic nerve and progressive reduction in sensitivity within the field of vision. Patients with glaucoma or patients with significant risks of having glaucoma (hereafter referred to as "glaucoma suspects" for consistency with current professional literature) are commonly encountered in optometric practice. Early diagnosis and therapy may reduce the rate of progression of this disease.

When glaucoma develops without an identifiable cause, it is termed primary.1 Primary open angle glaucoma is the most common form of this disease and may be managed by optometrists with therapeutic qualifications. Glaucoma with an identifiable cause is termed secondary.

Regulatory Standard

The Optometry Act, 1991 states that in the course of engaging in the practice of optometry optometrists are authorized, subject to terms, conditions and limitations imposed on his or her certificate of registration, to perform the following controlled act:

2.1 Prescribing drugs designated in the regulations.

The Designated Drugs and Standards of Practice Regulation **(O. Reg. 112/11 under the Optometry Act)** describes the following conditions under which an optometrist may prescribe drugs for the treatment of glaucoma:

PART II

STANDARDS OF PRACTICE — GLAUCOMA

Prescribing of antiglaucoma agents

6. It is a standard of practice of the profession that in treating glaucoma a member may only prescribe a drug set out under the category of "Antiglaucoma Agents" in Schedule 1.

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* Glaucoma is a clinical term referring to a variety of conditions with the common feature of an optic neuropathy (i.e. glaucomatous optic neuropathy [GON]) characterized by a distinctive loss of retinal nerve fibres and optic nerve changes. GON can develop under a number of circumstances with varying contributions by several known and as yet unidentified risk factors. The clinical term glaucoma is sometimes used when 1 risk factor, elevated intraocular pressure (IOP) is very extreme and GON is impending but not yet present (i.e. acute glaucoma). Glaucoma is often pluralized to reflect the variety of clinical presentations of this optic neuropathy. (Canadian Ophthalmological Society)2. rev:20170123

Open-angle glaucoma

7. 1) Subject to subsection (2) and to section 8, it is a standard of practice of the profession that a member may only treat a patient with glaucoma where the patient has primary open-angle glaucoma the treatment of which is not complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment.

2) It is a standard of practice of the profession that a member may only treat a patient having open-angle glaucoma, the treatment of which is complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment, in collaboration with a physician with whom the member has established a co-management model of care for that patient and who is,

(a) certified by the Royal College of Physicians and Surgeons of Canada as a specialist in ophthalmology; or

(b) formally recognized in writing by the College of Physicians and Surgeons of Ontario as a specialist in ophthalmology.

Referral to physician or hospital

8. (1) Subject to subsections (2) and (3), it is a standard of practice of the profession that a member shall immediately refer a patient having a form of glaucoma other than primary open angle glaucoma to a physician or to a hospital.

(2)It is a standard of practice of the profession that a member may initiate treatment for a patient having angle-closure glaucoma only in an emergency and where no physician is available to treat the patient.

(3) It is a standard of practice of the profession that a member shall immediately refer any patient being treated in accordance with subsection (2) to a physician or hospital once the emergency no longer exists or once a physician becomes available, whichever comes first.

(4) In this section,"hospital" means a hospital within the meaning of the Public Hospitals Act.

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the Optometry Act)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Optometrists must be knowledgeable and competent in the diagnosis and management of glaucoma.

The examination of patients with either glaucoma, or a suspicion of developing glaucoma, must include an appropriate assessment of any patient-specific risk factors. The core considerations for the diagnosis and management of glaucoma include:

- case history with attention to risk factors for glaucoma
- biomicroscopic examination of the anterior segment and anterior chamber angle
- measurement of the intraocular pressure
- evaluation and description of the optic nerve head through dilated pupils **(OPR 6.2)**
- gonioscopy*
- investigation of threshold visual fields*; and
- measurement of central corneal thickness, when clinically indicated.

*These tests may not be required if the patient's signs and/or symptoms indicate a referral to a secondary or tertiary eye care provider for the continuing diagnosis and/or management of glaucoma.

Members are expected to use instrumentation and techniques consistent with current professional standards of practice.

Management Options

For patients with glaucoma or glaucoma suspects, options include:

1. follow-up examinations at suitable intervals

2. drug therapy when indicated:

   a. by referral to an ophthalmologist,

   b. by an optometrist with authority to prescribe drugs for the treatment of primary open angle glaucoma

   c. by an optometrist with authority to prescribe drugs in collaboration **(OPR 4.8)** with an ophthalmologist for the treatment of primary open angle glaucoma when complicated by a concurrent medical condition or potentially interacting pharmacological treatment;

d. by referral to a physician or hospital, for secondary glaucomas

e. the immediate application of drugs in an emergency situation, such as angle-closure glaucoma, where no physician is available, then, immediately refer the patient to a physician or hospital once the emergency no longer exists or once a physician becomes available, whichever comes first.

Optometrists must discuss the appropriate option(s) with the patient and obtain informed consent.

The management plan must be clearly documented in the *patient health record* **(OPR 5.1)**

In summary:

Optometrists with authority to prescribe drugs are required to refer patients with primary open angle glaucoma to an ophthalmologist if the treatment is complicated by either a concurrent medical condition or a potentially interacting pharmacological treatment. Treatment may be provided in collaboration with an ophthalmologist with whom the member has established a co-management model of care for that patient.

Optometrists are required to refer patients with secondary glaucoma to a physician or hospital.

Last Reviewed: October 2017

First published: March 2011
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April 2014
January 2018

7.3 Patients with Cataract

Description

The practice of optometry includes the diagnosis, care and, when appropriate, referral of patients with cataract. Optometrists also work in collaborative arrangements **(OPR 4.8)** providing preoperative and postoperative care to patients requiring cataract surgery.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

7. Engaging in the practice of the profession while in a conflict of interest as described in Part II.

9. Making a misrepresentation with respect to a remedy, treatment or device.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

19. Performing a controlled act that the member is not authorized to perform.

Professional Standard

When providing care to patients with cataract, optometrists will:

- have the required knowledge, skill and judgement to diagnose and appropriately manage patients with cataract;
- utilize appropriate instrumentation and techniques to diagnose cataract and identify any ocular or systemic conditions that may complicate the surgical procedure or limit the postsurgical visual outcome. As a minimum, these techniques would include the taking of a thorough ocular and systemic history (including medications) as well as refraction, slit lamp examination and funduscopic examination;
- counsel patients regarding their visual status and recommend surgical referral when appropriate;
- arrange *referral* **(OPR 4.5)** as required;
- disclose to patients any financial interest in a surgical centre to which patients are referred;

- comply with the College standards on collaboration/shared care when providing preoperative and/or postoperative care to patients **(OPR 4.8)**; and
- comply with College standards on delegation when performing a controlled act that is outside the scope of practice of optometry. **(OPR 4.3)**

Last Reviewed: June 2017

First Published: June 2010

Revised: April 2014

September 2017

7.4 Patients with Diabetes

Description

Diabetes mellitus (DM) is a very common systemic condition that can have numerous ocular manifestations. While retinopathy and macular edema pose the greatest long-term threat to vision for most patients with diabetes, optometrists should also be alert to the development of many other possible complications ranging from transient fluctuations in refractive error and dysfunctions of accommodation and colour vision, to abnormalities in the cornea, iris, retina, lens, vitreous, and optic nerve. Also, neuro ophthalmic conditions/anomalies may arise from neuropathies affecting cranial nerves.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Due to the high prevalence of ocular manifestations of diabetes and the increasing incidence of retinopathy as the duration of the disease increases, all patients with diabetes require periodic assessment of the eye and vision system. Patients are advised as to the appropriate frequency of such assessments, depending on factors such as the duration of the disease, the nature of the condition (e.g. Type I versus Type II), the quality of blood glucose control, and the clinical findings. The normal complement of required clinical information **(OPR 4.2)** is updated regularly with particular emphasis on a detailed case history and thorough anterior and posterior segment examination with pharmacological pupil dilation. Any abnormalities found are carefully documented in the patient record.

Optometrists should be familiar with the classification and current management standards for the various stages of diabetic retinopathy. *Referral* **(OPR 4.5)** to an appropriate healthcare professional is required when indicated.

Last Reviewed: December 2018

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April 2014

June 2015

January 2019

7.5 Patients with Systemic Hypertension

Description

A number of ocular diseases are directly or indirectly associated with systemic hypertension. Hypertensive retinopathy is the most common direct ocular consequence, while hypertensive choroidopathy and optic neuropathy are less common sequelae. Hypertension is a risk factor for the development of retinal artery and vein occlusions and extraocular muscle palsies, and can increase the risk and severity of age-related macular degeneration, diabetic retinopathy, and glaucoma (the latter may also be affected by the aggressive treatment of systemic hypertension). A collaborative approach with medicine is needed for the management of patients with systemic hypertension who have ocular complications.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

The frequency of assessments of the eye and vision system depends on factors such as the history and status of the condition, the clinical findings, and the presence of other cardiovascular risk factors, most commonly dyslipidemia and diabetes. Any abnormalities found are documented and the patient's primary healthcare practitioner (such as family physician, or nurse practitioner) is advised as necessary of any findings that may pose a threat to the patient's ocular or systemic health.

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June 2014

January 2019

7.6 Cycloplegic Refraction

Description

Objective and subjective refraction done under cycloplegia can provide useful information in situations where sustained accommodative effort is suspected to be contributing to symptoms or obscuring a full diagnosis of the clinical problem.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Cycloplegic refraction is indicated on the initial assessment of children and young adults, including but not limited to those:

- with suspected clinically significant latent hyperopia;
- with unexplained reduced visual acuity;
- with suspected amblyopia; or
- who are at risk of developing amblyopia secondary to accommodative esotropia or asymmetric refractive error.

Cycloplecic refraction is repeated when clinically indicated.

When *using cycloplegic agents* **(OPR 4.4)**, optometrists will:

- be familiar with the properties of any cycloplegic agents they use;
- counsel patients appropriately regarding the expected effects and anticipated duration of action of the agent; and
- consider the presence of any significant contraindications to the use of a cycloplegic agent prior to instillation (e.g., narrow anterior chamber angle, past history of angle closure attacks or other adverse reactions or hypersensitivities to similar agents, etc.).

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February 2015

January 2019

7.7 Dilation and Irrigation of the Naso-Lacrimal Ducts

Description

Dilation and irrigation of the naso-lacrimal ducts may be used as diagnostic or treatment procedures. These procedures temporarily enlarge the punctal opening to the canaliculi for insertion of occlusion devices and/or the irrigation of material from the canaliculi and the naso-lacrimal ducts and/or to maintain complete patency of the system.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

Members providing this service must be competent in performing this technique and have a thorough understanding of the anatomical features and fluid dynamics of the lacrimal system to determine the location of an obstruction.

- dilation and irrigation of the naso-lacrimal ducts will follow a diagnostic process to determine if the procedure is warranted.
- appropriate infection controls must be used.

Last Reviewed: September 2017

First Published: September 2006

Revised: April 2014

7.8 Shared Care in Refractive Surgery

Description

The term 'Refractive Surgery' (RS) is a general term for the various forms of surgery used to correct refractive errors of the eye. This includes techniques that use lasers and other forms of electromagnetic energy, implantable lenses and devices, and incisional techniques. Optometrists provide preoperative and postoperative care to RS patients both in their offices and within surgical centres.

Refractive surgery is one of the situations in which optometrists often participate in a shared care relationship **(OPR 4.8)** with another healthcare practitioner. Shared care arrangements are intended to assist in the delivery of effective, efficient, high quality patient care. This standard and guideline addresses the sharing of responsibilities, the communication of patient information, and the financial arrangements within shared care situations.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

7. Engaging in the practice of the profession while in a conflict of interest as described in Part II.

9. Making a misrepresentation with respect to a remedy, treatment or device.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

16. Performing a controlled act that the member is not authorized to perform.

Conflict of Interest **(O. Reg. 119/94 Part II under the Optometry Act)** includes the following conflicts of interest:

3. (1) A member shall not engage in the practice of the profession while the member is in a conflict of interest. **O. Reg. 24/14, s. 1.**

(2) A member is in a conflict of interest where the member,

(a) Has a personal or financial interest that influences or is likely to influence the exercise of the member's professional expertise or judgment in respect of the treatment or referral of a patient;

(d) accepts a benefit that is related to the member referring a patient to any other person;

(h) shares fees related to the practice of the profession with any person other than,

(i) another member, or

(ii) a member of the College of Physicians and Surgeons of Ontario engaged in the practice of medicine. **O. Reg. 24/14, s. 1.**

Professional Standard

Optometrists providing care to patients pursuing RS will:

- maintain current knowledge of surgical procedures and competence in delivering the various types of preoperative and postoperative procedures in which they participate;
- acquire the normal complement of required clinical information **(OPR 4.2)**;
- identify preoperative ocular health, binocular, refractive or systemic conditions that may complicate the surgical procedure or limit the postsurgical outcome;
- inform patients of the various risks and benefits of the procedure, their options for care providers and all associated fees;
- make a referral **(OPR 4.5)** to an ophthalmic surgeon that includes relevant history and clinical findings;
- follow postoperative protocols indicated by refractive surgeons;
- disclose to patients any financial interest in a surgical centre to which the optometrist refers the patient; and
- comply with the College standards on collaboration/shared care **(OPR 4.8)** and delegation **(OPR 4.3)**.

Last Reviewed: February 2014 First Published: September 2006

Revised: June 2014

7.9 Patients with Learning Disorders

Description

Learning disorders are genetic, congenital, developmental and/or acquired factors that affect the acquisition, organization, retention, understanding or use of gross motor, fine motor, auditory, verbal, or visual information. Optometrists play a role in investigating whether visual signs and symptoms could be a contributing factor for a patient with a suspected or recognized learning disorder(s).

By assessing and managing vision problems associated with a learning disorder, optometrists act as members of a multidisciplinary team that may also include one or more of the following professionals:

- another optometrist who is proficient in visual information processing (visual perception) evaluation;
- educator;
- psychologist;
- physician;
- occupational therapist;
- audiologist; and/or
- speech-language pathologist.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation which a consent is required by law, without such a consent.

9. Making a misrepresentation with respect to a remedy, treatment or device.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

29. Charging or allowing a fee to be charged that is excessive or unreasonable in relation to the professional services performed.

Professional Standard

All patients with a suspected or recognized learning disorder require initial and periodic assessment of the eye and vision system. The frequency of such assessments depends on factors such as the history and clinical findings, and the visual demands of the patient's academic /vocational circumstances.

In addition to required clinical information **(OPR 4.2)**, the care of patients with a suspected or recognized learning disorder(s) includes:

- Case history questions related to, but not limited to, pregnancy and birth of the patient, reading level, and performance in school;
- Baseline assessment of distance and near visual acuity for patients with sufficient letter recognition and verbal communication;
- Refractive assessment **(OPR 6.3)** and cycloplegic refraction as indicated **(OPR 7.6)**;
- Binocular vision assessment **(OPR 6.7)**;
- Counselling patients regarding options for further investigation and/or consultation with another professional as indicated; and
- Referral for treatment including optometric vision therapy (OVT) to manage diagnosed conditions related to binocular vision and visual function as indicated **(OPR 6.7)**.

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December 2022

7.10 Orthokeratology

Description

Orthokeratology (Ortho-K) involves the wearing of specially designed rigid gas permeable (RGP) contact lenses, generally overnight, to progressively and temporarily alter the curvature of the cornea. This procedure may be offered by optometrists as an option for vision correction (most commonly myopia and/or astigmatism), and for myopia control in children.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation which a consent is required by law, without such a consent.

8. Failing to reveal the exact nature of a secret remedy or treatment used by the member following a patient's request to do so.

9. Making a misrepresentation with respect to a remedy, treatment or device.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescription for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

15. Delegating a controlled act in contravention of the Act, the Regulated Health Professions Act, 1991 or the regulations under either of those Acts.

22. Publishing or using, or knowingly permitting the publication or use of an advertisement or announcement or information that promotes or relates to the provision of professional services by a member to the public, whether in a document, business card, business sign, website, or any other format, which,

i. is false or deceptive, whether by reason of inclusion or of omission of

information,

ii. suggests that the member is a specialist or is specially educated, trained or qualified other than where the reference is to an educatioal acheivement and the reference has been approved by Council.

v. is not factual, objectively verifiable or readily comprehensible to the persons to whom it is directed.

Professional Standard

Optometrists performing Ortho-K must be competent in the fitting of RGP contact lenses and follow the contact lens standards outlined in section 6.5 of the OPR. They must stay abreast of developments in Ortho-K technologies, and consult peer-reviewed literature and professionally developed practice guidelines.

Optometrists must present a realistic prognosis when offering Ortho-K, especially as it pertains to the amount of myopia reduction and/or the realistic myopia management prognosis for patients **(OPR 7.14)**. The risks, as well as benefits, of corneal reshaping procedures and overnight contact lens wear must be explained to prospective patients and these individuals must be carefully monitored, both through the initial wear phase as well as the retainer wear phase. In addition, patients must be counseled to be compliant with lens care, wearing schedule instructions, and follow-up assessments.

The full complement of required clinical information may not be necessary when providing specific assessments or consultation services for referring optometrists, physicians or nurse practitioners. In such cases, optometrists will determine what is clinically necessary based on the reason for presentation. **(OPR 4.2)**

Optometrists accepting referrals for Ortho-K must review the results of the referring practitioner's optometric and/or medical examination(s), and assess, or re-assess the referred patient, should any additional clinical information or clarification be necessary.

Preliminary and ongoing examination follows the standards articulated in Contact Lens Therapy **(OPR 6.5)**, and also includes:

- refraction and visual acuities (unaided and best corrected)
- corneal topography measurements (pre-treatment, during follow-up until refractive stability is achieved, and thereafter at the discretion of the practitioner)

Consent

Optometrists must obtain informed consent from patients, including information regarding the fitting method, concerns and precautions of overnight contact lens wear, realistic expectations, the pre-and post-fitting appointment obligations, the itemized costs involved, the warranty/exchange of material policies, and what to do in the event of an emergency. If patients are incapable of providing consent

(i.e. young children undergoing Ortho-K for myopia management), consent must be obtained from their substitute decision-makers (usually a parent or guardian in the previous example).

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December 2021

December 2022

7.11 Patients With Dry Eye Disease

Description

Dry eye disease (DED) is a complex disorder, as noted in the contemporary definition articulated by the Tear Film and Ocular Surface Society Dry Eye Workshop II (TFOS DEWS II)[1] in 2017:

> *'Dry eye is a multifactorial disease of the ocular surface characterized by a loss of homeostasis of the tear film, and accompanied by ocular symptoms, in which tear film instability and hyperosmolarity, ocular surface inflammation and damage, and neurosensory abnormalities play etiological roles.'*

Although DED can be broadly categorized as aqueous deficient dry eye (ADDE, secondary to inadequate tear production primarily due to lacrimal gland insufficiency) or evaporative dry eye (EDE, secondary to excessive tear evaporation primarily due to meibomian gland dysfunction (MGD)), these conditions exist on a continuum and are not mutually exclusive. In fact, patients typically present with mixed-mechanism disease. Regardless of etiology, the common endpoints of DED include tear film instability, hyperosmolarity, and inflammation leading to variable signs and symptoms that are frequently discordant (that is, one may exist in the absence of the other), and may be episodic or chronic.

A number of tests to diagnose and establish the severity of DED are available. Like signs and symptoms, the results of these tests are often dissonant, but inform patient-specific management strategies aimed at re-establishing tear film and ocular surface homeostasis.

A detailed discussion of diagnosis and management of DED is beyond the scope of this document: a brief synopsis is provided under Professional Standard (below), and the reader is referred to the TFOS DEWS II Report for its comprehensive review **(https://www.tearfilm.org/dettreports-tfos_dews_ii_report/32_30/eng/)**.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation which a consent is required by law, without such a consent.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the *Regulated Health Professions Act, 1991* when the member recognizes

or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

Professional Standard

The DED assessment begins with the case history, with special attention to risk factors including but not limited to older age, female sex, general health conditions (including but not limited to connective tissue and autoimmune disease), topical and systemic medications (including but not limited to antihistamines, antidepressants, diuretics, and preservatives accompanying topical medications), environment, and occupational/avocational demands (including but not limited to computer use and contact lens wear).

Patients are questioned regarding symptoms suggestive of DED: the use of a validated questionnaire may be helpful.

Optometrists must perform a clinical examination of the anterior segment of the eye **(OPR 6.1)**, with special attention to eyelid anatomy and health, the blink mechanism, meibomian gland integrity and function, and the integrity of the precorneal tear film and cornea itself. The presence of reduced tear break-up time, elevated or interocular asymmetry in tear osmolarity, or ocular surface staining are signs of the loss of homeostasis that characterizes DED. Optometrists recognize that signs and symptoms of DED are often discordant and that no single diagnostic test can be relied upon to the exclusion of others.

Treatment of DED aims to restore homeostasis of the tear film and ocular surface. It involves a staged, step-wise approach that includes but is not limited to:

- education about DED, and its management and prognosis;
- recommending modification of the patient's environment (including but not limited to increasing humidity, reducing air movement, and encouraging frequent breaks from prolonged use of digital devices), and considering alternative topical and/or systemic medications when feasible;
- use of non-prescription lubricating agents (artificial tears) of varying viscosities (solutions, emulsions, gels, and ointments) and/or osmolarities, including consideration of preserved versus non-preserved products (including autologous serum tears) and the component of the natural tear layer deemed most deficient;
- encouraging and providing instruction for proper eyelid hygiene (both in-office and home-based treatment of meibomian gland dysfunction may be considered);
- recommending the use of oral OTC products (including but not limited to polyunsaturated (omega-3) fatty acid supplements);

- employing mechanisms to promote retention of natural and artificial tears (including but not limited to the use of punctal occlusion (only when concurrent inflammation is under control), or moisture goggles);
- judicious use of topical and/or systemic prescription medications (including but not limited to topical anti-inflammatory and antibiotic agents, and oral antibiotics with anti-inflammatory properties (tetracyclines and macrolides)) within the parameters established by Ontario Regulation 112/11 – Designated Drugs and Standards of Practice **(OPR 4.4);**
- the use of therapeutic contact lenses (including but not limited to the use of bandage soft or scleral contact lenses) or amniotic membranes.

Depending upon the severity of DED and its response to treatment, referral **(OPR 4.5)** to another regulated health professional for further assessment and medical and/or surgical intervention may be necessary.

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[1]Craig JP, et al. TFOS DEWS II Report Executive Summary. The Ocular Surface 2017;15:802-12.

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July 2019

7.12 Patients With Amblyopia

Description

Amblyopia is clinically defined as best corrected visual acuity worse than or equal to 20/30 in one eye or both eyes and/or interocular difference of 2 lines or more in visual acuity, without disease or structural abnormality of the eye(s) or visual pathway(s). It is caused by an interruption of visual sensory stimulation (due to strabismus (an eye turn), uncorrected refractive error, or visual deprivation) occurring early in life during the visual-sensitive period. The level of interruption determines the reduction in acuity and subsequent suppression of the weaker eye: this is variable, and depends on the cause of the interruption. Children and adults with amblyopia commonly experience reduced vision and impaired eye co-ordination that may impact academic, recreational, and occupational accomplishments.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

8. Failing to reveal the exact nature of a secret remedy or treatment used by member following a patient's request to do so.

9. Making a misrepresentation with respect to a remedy, treatment or device.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the Regulated Health Professions Act, 1991 when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

29. Charging or allowing a fee to be charged that is excessive or unreasonable in relation to the professional services performed.

Professional Standard

Diagnostic evaluation of new patients with, or suspected of having, amblyopia incorporates:

- comprehensive case history including:
  - prior eye conditions, diseases and treatments (medical and/or surgical)
  - family history of amblyopia, strabismus and other eye conditions
  - developmental history and/or abnormalities such as, but not limited to, term of pregnancy, birth weight, and pre-/peri-natal history (including maternal use of alcohol, tobacco or drugs during pregnancy),
- measurement of uncorrected visual acuity
- refraction (both with and without cycloplegia) and measurement of best-corrected visual acuity **(OPR 7.6)**
- assessment of ocular motility and alignment
- dilated anterior and posterior segment examinations **(OPR 6.1 and OPR 6.2)**

Given that amblyopia is considered a diagnosis of exclusion, additional investigations are performed as needed to rule out other causes of reduced vision.

Treatment for amblyopia involves:

- consideration of prognostic factors (including but not limited to patient age, cause of amblyopia, and degree of amblyopia) and patient education regarding realistic goals, limitations and estimated time frame of available treatment options
- optical correction, including the use of iseikonic lenses and contact lenses, as required
- occlusion treatment or pharmacological penalization, as indicated
- referral for binocular vision assessment and/or optometric vision therapy for monocular and binocular visual function, as required
- referral **(OPR 4.5)** for surgical correction of associated conditions (such as strabismus, ptosis, etc.), as indicated
- patient education regarding the impact of amblyopia on eligibility for specific occupations
- patient education on the importance of, and providing a prescription for, protective eyewear, as indicated due to the increased risk of eye injury

Continuing care of established patients previously diagnosed with amblyopia is done at appropriate intervals. Patients involved in active amblyopia therapy are seen frequently, to assess progress and modify treatment as needed, while others are seen regularly, as indicated. Continuing care includes:

- history concerning any changes in vision or visual function and patient adherence to prescribed treatment
- re-assessment of best-corrected visual acuity and binocular status

- re-assessment of ocular health status with special attention to the ongoing health of the non-amblyopic eye
- modification of the treatment plan, as indicated, to improve the effectiveness of treatment and/or to better meet patient needs and expectations

Optometrists must stay abreast of developments in evidence-based treatment for amblyopia and ensure that their patients have access to such treatment where clinically beneficial.

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7.13 Patients With Uveitis

Description

Uveitis is an inflammatory condition of the eye that is classified by

i. anatomy (based on the part of the eye primarily affected) as anterior, intermediate, posterior, or panuveitic,

ii. laterality (unilateral or bilateral), and

iii. duration: acute when the condition lasts less than two months, chronic when it lasts longer than two months, or as recurrent when repeated episodes are separated by several months of inactivity.

Anterior uveitis, also known as **iridocyclitis** or **iritis**, is inflammation of the iris and ciliary body. As many as 90% of uveitis cases are anterior in location.

Intermediate uveitis, also known as **pars planitis**, is inflammation of the vitreous cavity (vitritis) sometimes with snowbanking, or deposition of inflammatory material on the pars plana.

Posterior uveitis, is limited to inflammation in the posterior segment. Most of the posterior uveitis presents as a retinitis (inflammation of retina) or choroiditis (inflammation of the choroid) and can be further classified as focal or multifocal.

Panuveitis is inflammation of the entire uveal tract involving both the anterior segment (iris and ciliary body) and the posterior segment (choroid).

These conditions may occur as a single episode, subsiding spontaneously or with proper treatment, or may become chronic or recurrent in nature.

The practice of optometry includes the diagnosis, treatment and/or, when appropriate, referral of patients with uveitis.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

7. Engaging in the practice of the profession while in a conflict of interest as described in Part II.

8. Failing to reveal the exact nature of a secret remedy or treatment used by the member following a patient's request to do so.

9. Making a misrepresentation with respect to a remedy, treatment or device.

10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the Regulated Health Professions Act, 1991 when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

16. Performing a controlled act that the member is not authorized to perform.

Professional Standard

When providing care to patients with uveitis, optometrists will:

- have the required knowledge, skill and judgment to appropriately diagnose, treat and/or refer patients with uveitis
- utilize appropriate instrumentation and techniques to diagnose uveitis and identify any ocular or systemic conditions that may complicate the condition. As a minimum, this would include:
  - a thorough ocular, systemic and medication history
  - visual acuity
  - pupil reflexes
  - anterior segment examination **(OPR 6.1)**
  - tonometry
  - posterior segment examination with pharmacologic dilation at first visit of each occurrence and subsequently as indicated - **(OPR 6.2)**
- provide treatment options that include but are not limited to:
  1. topical corticosteroids to reduce inflammation
  2. topical cycloplegics to relieve pain, prevent iris adhesion to the anterior lens capsule (synechiae), and prevent protein leakage from inflamed blood vessels (flare)
  3. topical non-steroidal anti-inflammatory drugs (NSAIDs) to reduce inflammation leading to macular edema that may accompany uveitis
  4. topical intraocular pressure (IOP) lowering medications to reduce elevated IOPs
  5. over-the-counter oral analgesics to reduce pain

- arrange follow-up every 1-7 days until resolution and then as deemed appropriate to monitor for recurrence
- counsel patients regarding the serious nature of uveitis, stress compliance with the therapeutic regimen and follow-up appointments, and discuss potential side effects of long term corticosteroid use
- recommend referral **(OPR 4.5)** when appropriate, including initiating communication with the patient's primary care physician or another health care provider for evaluation and treatment if a systemic etiology is suspected (for example: when the condition is chronic, recurrent or bilateral, non-responsive to aggressive treatment, is accompanied by clinical signs or symptoms characteristic of systemic disease (including but not limited to: joint or lower back pain; respiratory, genitourinary or digestive difficulties; preceding or accompanying fever, malaise or skin rash) or involvesw the choroid as posterior uveitis), or when recalcitrant cases of uveitis require oral steroids or prescription analgesics where topical steroids or over-the-counter analgesics have produced little response

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7.14 Myopia Management

Description

Myopia, also known as nearsightedness, is a refractive condition, categorized as axial, refractive, or secondary. Myopia typically presents as low (SE ≤ -0.50D and > -6.00 D) and may progress to high (SE ≤ -6.00D) over time.

The risk factors for myopic progression include:

a. Family history: A child with 1 or 2 myopic parents has a greater chance of being myopic compared to a child with no family history of myopia.

b. Refractive error: Children presenting with less hyperopia than age appropriate are at a higher risk for developing myopia

c. Ethnicity: Asian ethnicity has been linked to an increased risk for onset and progression.

Regulatory Standard

The Professional Misconduct Regulation **(O.Reg. 119/94 Part I under the *Optometry Act*)** includes the following acts of professional misconduct:

2. Exceeding the scope of practice of the profession.

3. Doing anything to a patient for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health-related purpose in a situation in which a consent is required by law, without such a consent.

7. Engaging in the practice of the profession while in a conflict of interest as described in Part II.

8. Failing to reveal the exact nature of a secret remedy or treatment used by the member following a patient's request to do so.

9. Making a misrepresentation with respect to a remedy, treatment or device10. Treating or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond his or her experience or competence.

11. Failing to refer a patient to another professional whose profession is regulated under the Regulated Health Professions Act, 1991 when the member recognizes or should recognize a condition of the eye or vision system that appears to require such referral.

12. Failing, without reasonable cause, to provide a patient with a written, signed and dated prescription for subnormal vision devices, contact lenses or eye glasses after the patient's eyes have been assessed by the member and where such a prescription is clinically indicated.

13. Recommending or providing unnecessary diagnostic or treatment services.

14. Failing to maintain the standards of practice of the profession.

15. Delegating a controlled act in contravention of the Act, the Regulated Health Professions Act, 1991 or the regulations under either of those Acts.

22. Publishing or using, or knowingly permitting the publication or use of an advertisement or announcement or information that promotes or relates to the provision of professional services by a member to the public, whether in a document, business card, business sign, website, or any other format, which,

i. is false or deceptive, whether by reason of inclusion or of omission of information,

ii. suggests that the member is a specialist or is specially educated, trained or qualified other than where the reference is to an educational achievement and the reference has been approved by Council.

v. is not factual, objectively verifiable or readily comprehensible to the persons to whom it is directed

29. Charging or allowing a fee to be charged that is excessive or unreasonable in relation to the professional services performed.

Professional Standard

Optometrists who choose to consider interventions that slow the progression of myopia (known as 'myopia control' or 'myopia management') should be competent and must monitor patients at appropriate intervals. Necessary testing is dependent on the form of treatment; however, practitioners should consider axial length measurements as a definitive way of monitoring treatment efficacy over time.

Treatment options for the management of myopia include:

- **Specialty contact lenses that alter the corneal shape** including orthokeratology **(OPR 7.10)**:
  - Optometrists performing myopia management with these lenses must be competent in the fitting of contact lenses and follow the contact lens standards outlined in **OPR 6.5** and **7.10**.
- **Specialty contact lenses** including soft lenses:
  - Optometrists performing myopia management with these lenses must be competent in the fitting of contact lenses and follow the contact lens standards outlined in **OPR 6.5**.
- **Specialty spectacle lenses**:
  - Optometrists performing myopia management with specialty spectacle lenses must follow regulatory standards outlined in **OPR 5.2** (A).
- **Pharmaceutical treatment:**
  - Optometrists performing myopia management with pharmaceutical agents must follow standards outlined in **OPR 4.4**. Patients should be screened for potential contraindications of the pharmaceutical agent and aware of the potential side effects associated with the drug.

With all forms of management, a realistic prognosis should be presented to patients, especially those with high myopia. Risks, benefits, itemized costs, and alternatives should be outlined, and informed consent should be obtained by the patient and/or when required the parent/guardian prior to proceeding.

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[1] Flitcroft DI, He M, Jonas JB, et al. IMI - Defining and Classifying Myopia: A Proposed Set of Standards for Clinical and Epidemiologic Studies. Invest Ophthalmol Vis Sci. 2019;60(3):M20-M30. doi:10.1167/iovs.18-25957

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