



# THE COLLEGE OF OPTOMETRISTS

## Learning outcomes for Professional Higher Certificate in Low Vision

### 1. Aim

This certificate is designed to improve knowledge and skills for optometrists to be able to provide an enhanced standard of low vision care. The Professional Higher Certificate:

- builds on the professional certificate in low vision
- is a College accredited certificate in low vision practice
- is a prerequisite to the College accredited Diploma qualification in low vision practice
- can contribute to further College accredited qualifications
- is worth 30-40 HE credits.

The Professional Higher Certificate will engender an understanding of the evidence base and will be reviewed regularly to take account of technological changes and new research.

### 2. Learning Outcomes

Following completion of the programme an optometrist should be able to demonstrate:

- a) a detailed knowledge of the causes and epidemiology of low vision in specialist groups of patients, see 3 a) below for list of specialist groups
- b) an awareness of the impact that key factors has on these specialist groups, including premature birth, ageing and cultural background
- c) an ability to assess and manage patients in these specialist groups
- d) a detailed knowledge of optical and non-optical devices and demonstrate an ability to prescribe a selection of these
- e) an understanding of the interaction of mental health and low vision
- f) an understanding of the evidence base for low vision rehabilitation.

- g) an ability to communicate effectively with patients, carers and fellow professionals
- h) an understanding of the legislation and guidelines underpinning low vision practice.

### **3. Indicative Content**

- a) The causes and epidemiology of low vision in people in the specialist groups listed below:
  - children and young people
  - transition to adulthood
  - people of working age
  - learning disabilities
  - dual sensory loss
  - neurological and cognitive impairment
  - non-organic sight loss
  - profound and multiple disabilities
  - black, minority and ethnic groups
  - profound sight loss
  - those undergoing treatment, for example people currently receiving therapy for retinal disease
  - cortical visual impairments.
  
- b) The impact of premature birth, ageing and cultural diversity on the groups listed in a) above.
  
- c) Assessment and management of specialist groups
  - assessing and managing people with low vision in some of the specialist groups listed in a) above, including adaptations to the assessment. See section 4 below for minimum numbers required for evidence.
  
- d) Optical and non-optical devices and their prescribing to include:
  - field expansion devices (including prisms, minifiers and mirror systems)
  - telescopes (including bioptics)
  - IT and electronic aids (including electronic magnifiers and adaptations to mainstream technology)

- tints
- lighting and environmental modification
- appropriate prescribing to minimise a risk of falling.

e) Interaction of mental health and low vision including:

- the epidemiology of depression, sleep disturbance, Charles Bonnet syndrome and non-organic sight loss in people with low vision
- identifying depression, sleep disturbance, Charles Bonnet syndrome and non-organic sight loss
- coping strategies for adjusting to sight loss
- the role of carers
- appropriately managing people with depression, sleep disturbance, Charles Bonnet syndrome and non-organic sight loss, including a detailed knowledge of referral to counselling services and medical intervention.

f) Evidence base for low vision rehabilitation including:

- the scope of professionals involved in the range of rehabilitation services .

g) Communicate effectively with patients, carers and fellow professionals:

- ability to work effectively with a large and complex team of professionals involved in the care of the specialist groups in (a) above
- ability to work effectively with family and others involved in the care of the specialist groups in (a) above.

h) Legislation and guidelines underpinning low vision practice:

- current legislation
- national and local guidance
- professional bodies and best practice guidelines.

#### **4. Teaching, learning and assessment strategies**

The programme should be of sufficient length to achieve the stated learning outcomes. Programme delivery may be achieved through a variety of learning strategies, for example. face-to-face instruction, distance learning or directed private study. However, these must be appropriate for the material or skill being taught. Assessments should be designed to provide valid and reliable judgements about a candidate's performance. Assessment criteria must be made explicit and be

appropriate for the competency they are designed to test. For example, competencies relating to a clinical skill should be assessed using an appropriate skills-based assessment. For each assessment, a marking scheme with the appropriate pass/fail criteria should be established.

Candidates should demonstrate skills such as critical thinking, problem solving and reflection.

To guide teaching strategy we distinguish between different levels of candidate competence in our learning outcomes:

- awareness – the candidate will be familiar with the item(s) in the learning outcome but is not required to demonstrate detailed understanding, knowledge or practical experience
- understanding – the candidate will be able to explain the key item(s) in the learning outcome but is not required to have practical experience
- detailed knowledge – the candidate will be able to demonstrate higher order thinking in most item(s) in the learning outcome
- ability – the candidate will have competence in a practical task acquired through skills based training or experience. Ability should incorporate higher order thinking.

The following should be incorporated:

- a practical element
- a log book of 50 patient episodes directly examined by the candidate; the patient episodes must be with a minimum of 20 patients; note that a patient episode is a patient visit; it is assumed that some patients will be seen on several occasions; with a maximum of one telephone consultation per patient
- a separate presentation of ten full case records, which cover at least five of the specialist groups described in section 3. a) above, of which six records will be sampled and assessed
- a peer review session.

Accreditation of prior learning (APL) may be awarded to candidates as appropriate. It should be noted that the APL must be specific to the units and certificates already held by candidates. APL can count for no more than one third of the programme.