Guidance for Professional Practice Changes 2026

Knowledge, skills and performance

Develop and maintain knowledge and skills

	Section/Number	Current	Proposed Change
1	Key Points	You must meet the GOC's requirements for continuing education and training (CET).	Replace CET with CPD
2	Key Points	The College encourages you to take responsibility for, and participate in, professional development beyond CET requirements.	Replace CET with CPD
3	Supporting the education and training of others		**Add:** **[Axx] You should support the education and training of others** **[Axx]** If you supervise a trainee, you have a responsibility for the quality of that supervision. You should: 1. be familiar with the GOC Education and Training Requirements (ETR) and the College's Optometric Practical Educator (OptPE) framework 2. ensure you have the time, environment, and patient mix to provide effective supervision 3. provide constructive feedback that supports the trainee's development

			4. 2ecognize when a trainee is struggling, and act early to support them Axx You must retain clinical responsibility for the patients seen under your supervision (see C220–C225). **[Axx]** Where you contribute to teaching or assessment more broadly, you should keep your educational knowledge and skills up to date alongside your clinical knowledge and skills.

The routine eye examination or sight test

	Section/Number	Current	Proposed Change
4	**A63**	You should examine patients at the most appropriate intervals, depending on their clinical needs. This applies to both private and NHS patients. You should consider each patient holistically when determining their clinical need, this should include factors such as whether a person is affected by dementia[26,27], cognitive impairment, whether they are at an increased risk of falls[27] and their general health.[28]	You should examine patients at the most appropriate intervals, depending on their clinical needs. This applies to both private and NHS patients. You should consider each patient holistically when determining their clinical need, this should include factors such as whether a person is affected by dementia[26,27], cognitive impairment, whether they are at an increased risk of falls[27] , learning disabilities and their general health.[28]
5	**New section to Clinical reasons for earlier recall**		Add: Axx Myopia management patients may need more frequent appointments for axial length and refractive review, but are not entitled to more frequent NHS sight tests simply because they are using myopia management. However, if they present with symptoms of refractive change, due to rapidly progressing myopia, they may access an NHS-funded eye sight test.

The needs led examination

	Section/Number	Current	Proposed Change
6	**A75**	A needs led examination is one where the patient does not need a sight test as defined in law (a statutory sight test) but has symptoms that would benefit from a clinical assessment and opinion. Examples would include minor eye conditions services (MECS), Eye Health Examination Wales (EHEW) or equivalent, follow-up appointments after a routine eye examination, assessment of patients for suspect glaucoma or ocular hypertension, or the co-management of a patient with another healthcare practitioner. See sections on Examining patents who present as an emergency and Examining patients with flashes and floaters.	A needs led examination is one where the patient does not need a sight test as defined in law (a statutory sight test) but has symptoms that would benefit from a clinical assessment and opinion. Examples would include minor eye conditions services (MECS~~), Eye Health Examination Wales (EHEW)~~WGOS2, NHS Scotland supplementary eye examination, PEARS or equivalent, follow-up appointments after a routine eye examination, assessment of patients for suspect glaucoma or ocular hypertension, or the co-management of a patient with another healthcare practitioner. See sections on Examining patents who present as an emergency and Examining patients with flashes and floaters.
7	**New section**		Add: Examination under commissioned urgent and emergency eye care pathways Axx In many areas a patient presenting to you as an emergency may be eligible for care under a locally or nationally commissioned pathway, such as a Community Urgent Eyecare Service (CUES), a Minor Eye Conditions Service (MECS), the Primary Eyecare Assessment and Referral Service (PEARS) in Northern Ireland, an NHS Scotland Supplementary Eye Examination, or the corresponding Welsh General Ophthalmic Services pathway. Axx Where such a pathway is available you should:

			1. consider whether the patient is eligible for the commissioned pathway and whether it is clinically appropriate 2. be clear with the patient about the service you are providing and what (if anything) it will cost them 3. work to the clinical standards set out in the applicable service specification. 4. record the consultation in a way that reflects the service under which it was delivered

Examining patients with a disability

	Section/Number	Current	Proposed Change
8	**New Section**		Examining Patients with deaf blindness or dual sensory loss Axx Dual sensory loss (deaf blindness) affects a substantial number of people in the UK, especially older adults. Patients with deaf blindness may use a range of communication methods, including deafblind manual alphabet, block alphabet, hands-on signing, or a personal communicator. You should: 1. ask the patient how they prefer to communicate, and adjust your approach accordingly 2. allow more time for the consultation and for communication support 3. offer information in alternative formats, in line with the NHS Accessible Information Standard (identify, record, flag, share, meet and review)

			4. be alert to the particular impact of any change in vision for a patient who relies on their remaining sense for information 5. be aware of local deafblind-specific support services and voluntary-sector resources, and signpost the patient as appropriate.

Assessing and managing children with myopia

	Section/Number	Current	Proposed Change
9	**A128**	When discussing myopia management, you should: a. explain the short- and long-term benefits and risks of all available interventions in a way that is readily understandable. This should include the possible outcomes of using traditional single vision optical corrections in comparison to the use of myopia management options, and the risks of no optical correction. b. ensure patients understand the anticipated treatment outcomes and manage their expectations. This should be based on the available level of evidence and, where possible, using relative and absolute risk examples, presented in a clear and impartial way. c. you should ensure your patients understand the likely length of treatment and required aftercare.	Add: d. not provide a myopia management appliance or therapeutic agent on the basis of an external prescription without first consulting the prescribing clinician.

10	**New Sections to Principles of managing children with myopia**		AXX You should be aware of the evidence around using axial length measures and the limitations of alternative methods to measure axial length AXX Where myopia management is outside your competence or not available in your setting, you should know where to refer.

Examining autistic patients

	Section/ Number	Current	Proposed Change
11	**New Section**		Relevant training and the Oliver McGowan Code of Practice Axx You should consider completing relevant training in the examination of autistic people. (The Oliver McGowan Code of Practice sets a statutory training requirement under section 181A of the Health and Social Care Act 2008 (as inserted by the Health and Care Act 2022).
12	**A185**		Replace: Some autistic people are very sensitive to light, so tell the patient when you need to shine a light into their eye and make sure they are comfortable with that. Be aware that pen lights may trigger seizures in some people With: Some autistic patients may find the testing room too bright, too noisy, or otherwise sensorily overwhelming. You should ask the patient about sensory sensitivities and make adjustments where possible.

Examining patients with specific learning difficulties

	Section/Number	Current	Proposed Change
13	**New Section**		Advertising and claims when examining patients with specific learning difficulties Axx. You must not claim, or imply, that an eye examination, coloured overlay, precision-tinted filter, tinted lens or any other optometric intervention diagnoses, treats or alleviates a specific learning difficulty (SpLD) such as dyslexia, dyspraxia or attention deficit disorder. The diagnosis, assessment and treatment of SpLDs are outside the scope of optometric practice. Foot note: Dyslexia can only be formally diagnosed by a certified assessor: either a psychologist specialising in SpLDs or a specialist teacher accredited by a recognised body such as the British Dyslexia Association. You should not describe any optometric service as a dyslexia assessment, dyslexia screening or dyslexia test. Confusing or compound terms such as 'visual dyslexia', 'dyslexia overlays', 'dyslexia eye tests' or 'dyslexia-friendly lenses' must not be used in any patient-facing material, including websites, social media, leaflets, in-practice signage, third-party listings and verbal communications. See A162 to A170 for clinical guidance on examining patients with SpLDs and the use of tints.

Examining patients with dementia or other acquired cognitive impairment

	Section/Number	Current	Proposed Change
14	**Key Points**		Add: Axx You should be aware that vision loss is a recognised risk factor for the prevention and progression of dementia [New reference]
15	**New Section**		Capacity fluctuation and supported decision-making Axx Patients with dementia or acquired cognitive impairment may have capacity that fluctuates with time of day, environment, or the complexity of the decision. You should: 1. assess capacity for each decision at the time it needs to be made 2. consider whether adjusting the time, setting or method of communication might support the patient to make their own decision 3. involve family members, carers or advocates where the patient lacks capacity, having regard to the Mental Capacity Act 2005 (England and Wales), the Adults with Incapacity (Scotland) Act 2000, or the Mental Capacity Act (Northern Ireland) 2016 1. (LINK to relevant GfPP section on capacity)

The domiciliary eye examination

	Section/Number	Current	Proposed Change
16	**A225**	When carrying out eye examinations in a domiciliary setting you should: a. ensure that a relative or carer is present, where possible b. carry out whatever tests are possible to determine the patient's needs for vision care for both sight and health. The format and content of the eye examination will be determined by your	Add new section a: Ensure that, when working in the home of a patient or other community setting, the environment is safe and appropriate for the delivery of care And new section k:

		professional judgement and the legal requirements c. consider whether it is appropriate to offer low vision assessment and advice, visual counselling for elderly people and advice on illumination. You should tell the patient and their relative or carer about any additional costs before you provide extra services d. accommodate the special needs of the patient, bearing in mind difficulties in communication caused through physical, sensory or mental disabilities e. be flexible about the approaches you use, which will depend on the environment f. be equipped with suitable portable equipment to ensure you can deliver the best possible optometric care to the patient in the circumstances. This should include: o Amsler grid o dispensing equipment and a range of spectacle frames o distance and near ocular-muscle balance tests, plus suitable targets and occluder o focimeter o a full range of diagnostic drugs o illuminated test chart o means to examine the external eye, including an appropriate method if you are using diagnostic stains o near chart o ophthalmoscope o picture tests, as appropriate, for patients with learning disabilities	You should endeavour to complete all relevant examinations, but this may not always be possible. In this case you should: • act in the patient's best interests • record precisely what was and was not completed • explain the limitations of the assessment to your patient • ensure appropriate follow-up, safety netting or referral if required.

		○ retinoscope ○ some means of assessing visual fields other than confrontation ○ tonometer ○ trial case and trial frame g. be readily identifiable to the patient, and provide them or their relative or carer with information about how you can be contacted for continuing care h. ensure the visit is not seen as a one-off but as part of the provision of continuing care for the patient i. be aware of additional local services that might be appropriate for the patient.[91]	

Examining patients with diabetes mellitus

	Section/ Number	Current	Proposed Change
17	**A241**	**You should ask the patient if they are being screened for retinopathy in an NHS diabetic eye screening programme. If they are, you should ask when they last had a screening. You should clarify, as far as possible, who is responsible for the overall care and clinical management of the patient.**	**You should ask the patient if they are being screened for retinopathy in an NHS diabetic eye screening programme in their nation of residence. If they are, you should ask when they last had a screening. You should clarify, as far as possible, who is responsible for the overall care and clinical management of the patient.**
18	**A244**	**If patients are in an NHS diabetic eye screening programme, recall should be the same as for patients who do not have diabetes. (This applies for patients who have 6, 12 or 24 month diabetic eye screening reviews.) Younger people and people of black**	**If patients are in an NHS diabetic eye screening programme, recall should be the same as for patients who do not have diabetes~~. (This applies for patients who have 6, 12 or 24 month diabetic eye screening reviews.) Younger people and~~**

		and Asian ethnicities are affected by sight-threatening diabetic retinopathy more than other groups, you should use your professional judgement to determine the most appropriate sight test interval based on your patient's clinical needs and risk factors[94].	~~people of black and Asian ethnicities are affected by sight-threatening diabetic retinopathy more than other groups, you should use your professional judgement to determine the most appropriate sight test interval based on your patient's clinical needs and risk factors~~ Younger people, people of Black or South Asian ethnicity, and people living in areas of higher socioeconomic deprivation are affected by sight-threatening diabetic retinopathy more than other groups. You should use your professional judgement to determine the most appropriate sight test interval based on your patient's clinical needs and risk factor
19	**A246**	**In England, the NHS diabetic eye screening programme service specification no 22 is commissioned by NHS England;[95] in Wales it is the Diabetic Retinopathy Screening Service for Wales (DRSSW);[96] in Northern Ireland it is the Diabetic Retinopathy Screening Programme (DRSP);[97] and in Scotland it is the Scottish Diabetic Retinopathy Screening (DRS) collaborative.**	

Examining patients at risk of glaucoma

	Section/Number	Current	Proposed Change
20	**A254**	You will identify the majority of patients who are at risk from chronic open angle glaucoma during a routine eye examination. They are principally patients with one or more of the following: a. optic disc features suggestive of glaucoma b. loss of peripheral vision c. high IOP.	Change to: a. optic disc features suggestive of glaucoma b. retinal nerve fibre layer features suggestive of glaucoma c. presence of a visual field defect d. high IOP.

21	**A267**	Optic nerve head imaging, including photography and OCT, may be helpful for the assessment and detection of abnormal structural changes to the optic nerve head. You should stay up to date with the evidence and be cautious about management decisions based on imaging alone.	Remove: You should stay up to date with the evidence and be cautious about management decisions based on imaging alone.
22	**A270**	In England, unless clinical circumstances indicate that urgent or emergency referral is indicated, patients should have referral filtering before they are referred to the HES. For these non-urgent patients, you should only refer without referral filtering if there are no such local arrangements. Referral filtering is where the patient has additional tests done. These may be repeat measures, referral refinement or enhanced case finding.[106] In Scotland you should follow SIGN guidelines.	Change to: Unless clinical circumstances indicate that urgent or emergency referral is indicated, patients should have referral filtering before they are referred to the HES. For these non-urgent patients, you should only refer without referral filtering if there are no such local arrangements. Referral filtering is wher e the patient has additional tests done. These may be repeat measures, referral refinement or enhanced case finding.
23	**New Section to Referral and organisation of care**		Add: <u>Axx In Scotland you should follow SIGN guidelines.</u> <u>Axx In Wales you should follow WGOS guidelines.</u> <u>Axx In Northern Ireland, you should follow HSC guidelines.</u> <u>Axx You should include the minimum required dataset for the nation you practice with each referral, and provide a brief explanation where information is not available.</u> <u>Axx You should stay up to date with the evidence and should not make a referral based on imaging alone from a single episode. If you have access to imaging, you should look for evidence of change to the optic nerve head or retinal nerve fibre layer.</u>

			Axx If clinically significant imaging has been captured, it should be included in the referral, either as an image (JPEG or PDF) or preferably as a shareable image file.
24	**Community Services**	Community services	Change community services to Community glaucoma pathway And add: **Axx** Community glaucoma services are now commissioned in many areas across England, Wales, Scotland and Northern Ireland, allowing patients to receive glaucoma triage and monitoring in primary care. **Axx** If you work in a community glaucoma pathway, you should: 1. work to the applicable national or local clinical standards, 2. Understand your role within the pathway and the scope of your responsibilities, including when to refer back to secondary care 3. keep clear records of the care you have provided and of information shared with other pathway colleagues 4. ensure there is an appropriate level of clinical governance and audit 5. ensure all members of your team you supervise have received appropriate training. (See section on supervision and delegation.)

Examining patients who present with flashes and floaters

	Section/Number	**Current**	**Proposed Change**

25	**A289**	If you suspect a retinal break or tear, you should, as a minimum: a. take a detailed history and symptoms, looking for particular risk factors b. examine the anterior vitreous to look for pigment cells c. perform a dilated fundal examination, using an indirect viewing technique d. give appropriate advice to the patient, which you back up with written information.	Change b to: examine the anterior vitreous to look for pigment and/ or blood cells
26	**A292**	The majority of patients presenting with flashes and/or floaters will not have a retinal detachment. If you do not feel competent to manage a patient presenting with flashes and/or floaters, you should refer them to an appropriate colleague. Emergency referrals include: a. retinal detachment b. pigment in the anterior vitreous (tobacco dust) c. vitreous, retinal or pre-retinal haemorrhage d. lattice degeneration or retinal break, with symptoms.	Change b to: pigment in the vitreous (Shafer's Sign/tobacco dust)
27	**A294**	Most cases of floaters are due to posterior vitreous detachment (PVD) or vitreous degeneration. You can manage a patient in your practice if you confirm they have a PVD after dilated ocular examination and: a. vision is unchanged b. no retinal tear or detachment is present c. no pigment is present in the anterior vitreous d. the patient is well informed about what symptoms to expect if the retina does break or detach subsequently e. you issue the patient with written information to support your diagnosis and advice.	Change c to: no pigment or blood cells are present in the vitreous add d: no vitreous pre-retinal or retinal haemhorrhage is present

Examining patients who drive

	Section/Number	Current	Proposed Change
28	**A305**	If you decide to notify the DVLA or DVA you should: a. notify the appropriate authority (DVLA or DVA) in writing, and, if appropriate, provide evidence of clinical findings (see useful information below) b. notify the patient c. make a note on the patient record d. consider whether to notify other healthcare professionals, such as the patient's GP.	Add e If driving is relevant to the patient's occupation, you should advise them to inform their employer

Examining patients who work with display screen equipment or computers

	Section/Number	Current	Proposed Change
29	**A312**	Display screen equipment (DSE) is a device or piece of equipment that has an alphanumeric or graphic display screen. It includes conventional display screens and laptops, touchscreens and other similar devices.	**Display screen equipment (DSE) is a device or piece of equipment that has an alphanumeric or graphic display screen. ~~It includes conventional display screens and laptops, touchscreens and other similar devices~~. It includes conventional display screens and laptops, smartphones, tablets, and other similar devices.**
30	**A313**	The Health and Safety (Display Screen Equipment) Regulations 1992 apply to workers who use DSE daily, for more than an hour or more at a time.[1]	**~~The Health and Safety (Display Screen Equipment) Regulations 1992 apply to workers who use DSE daily, for more than an hour or more at a time.~~[1] The Health and Safety (Display Screen Equipment) Regulations 1992 apply in Great Britain to workers who use DSE daily, for more than an hour at a time. [In Northern Ireland, equivalent provisions apply under the Health and Safety (Display Screen Equipment)**

			Regulations (Northern Ireland) 1992 (SR 1992/513), enforced by the Health and Safety Executive for Northern Ireland (HSENI). The Regulations apply equally to home, hybrid and office-based workers.
31	**New Section**		***Advice for DSE users*** **AXX. You should give all DSE users brief, evidence-based advice on simple measures that can reduce the symptoms of digital eye strain. These include taking regular screen breaks, conscious complete blinking, and the use of ocular lubricants where indicated.[121]** **AXX. You should advise patients to take short, frequent breaks from prolonged near screen work. You should also encourage patients to take longer breaks away from the screen where possible, and to alternate near and distance tasks across the working day.** Where practicable, patients should be encouraged to set sensible limits on their overall daily screen time, including non-occupational use, and to build genuine screen-free periods into their day.** **Footnote** ****One widely used framework is the "20-20-20 rule" – every 20 minutes, look at something at least 20 feet (approximately six metres) away for at least 20 seconds. The specific numerical thresholds within the rule reflect clinical consensus rather than definitive trial evidence,[122] but recent studies suggest that structured screen-break reminders can produce short-term improvement in self-reported digital eye strain and dry eye symptoms.[123]**

Contact lens equipment

	Section/Number	Current	Proposed Change
32	**Key points**	You should have all equipment verified and calibrated regularly	Add: You should have all equipment verified and calibrated regularly and decontaminated appropriately

Fitting contact lenses

	Section/Number	Current	Proposed Change
33	**A382**	**Y**ou should: a. determine and advise on the length of the fitting period. This should be long enough for you to be satisfied that the patient has adapted to the contact lenses and that there is unlikely to be any change in the patient's ocular health. This will be when you decide that the patient does not need any contact lens check-ups, other than those scheduled routinely. The fitting period will usually be less than three months This can vary, depending on: ○ contact lens type and modality of wear ○ how quickly the patient adapts to the contact lenses ○ the likelihood of a change in the patient's ocular health ○ other clinical findings	Add new a: Be satisfied they are able to insert and remove the contact lenses safely

		b. tell the patient if the fitting will take longer than expected and record the reasons for this on the patient record.	

Use and supply of drugs or medicines in optometric practice

	Section/Number	Current	Proposed Change
34	**New section to supply of drugs in optometric practice**		Add <u>Axx The POMs that are mentioned in paragraph A476 may be used off-label for purposes outside their licensed indication. However, off-label use should only be considered only when such use is clearly justified and supported by best clinical practice, such as the CMGs.</u>

Communication, partnership and teamwork

Consent

	Section/Number	Current	Proposed Change
35	**New section**		**<u>Consent where the patient is in vulnerable circumstances</u>** **<u>Cxx</u>** <u>Patients may be in vulnerable circumstances for many reasons, including physical or mental health conditions, cognitive or sensory impairments, limited health literacy, language or communication needs, or a difficult set of life events. Vulnerability may be permanent, temporary or episodic, and it is often the combination of the patient's</u>

			circumstances and the nature of the care you are providing that creates vulnerability, rather than the patient's circumstances alone. **Cxx** Where a patient has capacity but is in vulnerable circumstances, you should: 1. take additional time to explain the nature and purpose of the examination, treatment or supply, and any material risks and reasonable alternatives 2. consider what reasonable adjustments to your communication are required under the Equality Act 2010, and whether additional adjustments beyond those required by the Act are needed to respond to the patient's circumstances 3. be alert to signs that the patient feels pressured, rushed or unable to ask questions, and address these openly 4. consider whether the patient would benefit from a trusted friend, family member, advocate or interpreter being present, with the patient's consent 5. record in the patient's notes the steps you have taken to support their decision-making. **Cxx** You should have regard to the GOC supplementary guidance on the care of patients in vulnerable circumstances. See also the sections on Partnership with patients, Confidentiality, Examining patients with learning disabilities, Examining autistic patients, Examining patients with dementia or other acquired cognitive impairment, and The domiciliary eye examination.

Confidentiality

	Section/Number	Current	Proposed Change
36	**New section to principles of patient confidentiality**		Principles of patient confidentiality add: **Cxx** Patient health information is 'special category' personal data under UK GDPR. You must identify a lawful basis for processing such data under Article 6 and a further lawful condition under Article 9. Where you rely on explicit consent, that consent must be informed and freely given, and the patient must be told how you will use their information. **Cxx** You should apply the Caldicott Principles to your handling of patient information. The eight Principles are: (a) justify the purpose; (b) use confidential information only when necessary; (c) use the minimum information necessary; (d) access on a need-to-know basis; (e) understand your responsibilities; (f) comply with the law; (g) the duty to share information can be as important as the duty to protect it; and (h) inform patients and service users about how their confidential information is used.

Dealing with complaints

	Section/Number	Current	Proposed Change
37	**New section**		**Add:** **The professional duty of candour** **Cxx** You have a professional duty to be open and honest with patients when something goes wrong with their treatment or

			care which has caused, or could cause, harm or distress. This is known as the duty of candour and applies to all registrants, regardless of whether the patient makes a complaint. **Cxx** Where something has gone wrong, you should: 1. tell the patient what has happened, in a way they can understand 2. offer an appropriate apology 3. explain, as far as you are able at the time, the short and longer-term effects of what has happened 4. describe what can be done to put things right where this is possible 5. record what has happened, what you have told the patient, and what action you are taking. **Cxx** An apology is not an admission of liability. You should apologise whenever a patient has experienced harm, distress or inconvenience, whether or not you believe you are personally at fault. **Cxx** In England, services regulated by the Care Quality Commission are additionally subject to the statutory duty of candour under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Equivalent duties apply in Scotland, Wales and Northern Ireland. You should be aware of the duty as it applies to your setting.

Social Media and online behaviour

	Section/Number	**Current**	**Proposed Change**
38	**New section**		Generating online content

			Cxx Where you use artificial intelligence tools to generate or assist in generating content that is published online in your name or your practice's name (including but not limited to text posts, clinical explanations, images, video, or synthetic voices), you should: 1. review the content before publication and take personal responsibility for its accuracy, balance and appropriateness 2. not publish AI-generated content that misrepresents your clinical findings, your qualifications, or the views of your patients or colleagues 3. consider whether a reasonable viewer would be materially misled if they were unaware the content had been generated or substantially assisted by AI 4. disclose the use of AI where that would be material to the reader's understanding 5. comply with the applicable data protection obligations where the content draws on patient information. Cxx You should not publish AI-generated images or likenesses of identifiable patients without explicit, informed consent. You should not use AI tools to create or circulate content depicting colleagues in ways that could humiliate, intimidate or harass them. See also Maintaining boundaries and Working with colleagues.

Maintaining boundaries

	Section/Number	Current	Proposed Changes

39	**New Section**		**Workplace culture, colleague boundaries, and employer responsibilities** **Cxx** You must not engage in conduct of a sexual nature with colleagues that is unwanted, and you must not create or contribute to an intimidating, degrading, humiliating or offensive environment for any colleague. This applies to communications and behaviours in person, online, and in any other setting connected to your professional activity. **Cxx** If you own, manage or lead a practice you should: 1. take reasonable steps to prevent sexual harassment of employees, as required by the preventative duty under the Equality Act 2010 (inserted by the Worker Protection (Amendment of Equality Act 2010) Act 2023 and in force from 26 October 2024) 2. ensure all staff know how to raise concerns about the behaviour of colleagues, and that concerns can be raised safely 3. respond promptly and proportionately to concerns raised 4. have regard to Part 2 of the GOC supplementary guidance on maintaining appropriate sexual boundaries, which addresses the responsibilities of optical businesses 5. consider how the working environment supports registrants to maintain appropriate boundaries with patients, including in lone-working and domiciliary settings. **Cxx** You should support colleagues who raise concerns in good faith and should not retaliate against, or tolerate retaliation against, those who do so. See also the sections on Raising concerns and Working with colleagues.

Working with colleagues

	Section/Number	Current	Proposed Change
40	**Title**	Collaborative care pathways	Change to: Collaborative and shared care pathways
41	**C237**	When delivering care as part of a locally agreed pathway there should be overarching clinical governance processes for ensuring all clinicians have the appropriate level of clinical competence and decision-making ability for any given patient risk level.	Remove C237
42	**New section to Collaborative care pathways**		Collaborative care pathways add: **Cxx** Many patients are now cared for across more than one setting and more than one profession, through locally or nationally commissioned pathways. Examples include community urgent eye care pathways, community glaucoma pathways, post-operative cataract review, community-based medical retina or low vision services, and shared-care pathways between primary optometry and hospital ophthalmology. **Cxx** If you work in such a pathway, you should: 1. understand your role within the pathway and the scope of your responsibilities 2. work within the nationally or locally agreed clinical standards (including, where relevant, the LOCSU/CCEHC Clinical Standard Specification for

			community minor and urgent eye care and the GIRFT Best Practice Guidance for Glaucoma Services) 3. communicate promptly and clearly with colleagues in the pathway, including when you have assessed, managed or discharged a patient 4. keep clear records of the care you have provided and of information shared with other pathway colleagues, having regard to UK GDPR and the Data Protection Act 2018 as amended by the Data (Use and Access) Act 2025 5. raise concerns if the pathway is operating in a way that is unsafe for patients or is inconsistent with the agreed clinical standards. **Cxx** Where you refer a patient into, or discharge a patient from, a collaborative care pathway, you should ensure that the patient understands the pathway, the role of each clinician involved, and where they should seek help if their condition worsens. See the section on Partnership with patients.

Safety and Quality

Health and safety on the premises

	Section/Number	Current	Proposed Change
43	**Key Points**		Add: You should be familiar with, and use, the clinical governance and risk management structures and processes in any organisation that you work for or are contracted to

44	**Principles of health and safety**		Add: Bxx You should be familiar with, and use, the clinical governance and risk management structures and processes in any organisation that you work for or are contracted to
45	**B15**	You should maintain your own immunisation and health. See section on Infection control.	You should maintain your own health and immunisation against common serious communicable diseases (unless contra-indicated) ~~and health~~. See section on Infection control.
46	**New Section**		**Managing risks posed by your health** Bxx You should avoid seeking medical care from a family member or anyone you work closely with. If you are registered with a general practitioner this should be someone outside your family and your workplace. Bxx You should try to take care of your own health and wellbeing, recognising if you may not be fit for work. You should seek independent professional advice about your fitness for work, rather than relying on your own assessment. Bxx You must consult a suitably qualified professional and follow their advice about any changes to your practice they consider necessary if: 1. you know or suspect that you have a serious condition that you could pass on to patients 2. your judgement or performance could be affected by a condition or its treatment. 1. You must not rely on your own assessment of the risk to patients.

Infection Control

	Section/Number	Current	Proposed Changes
47	B61	You must clean the items first.	You must clean the items first before disinfection or sterilisation.
48	B62c	disinfect equipment which comes into contact with intact mucous membranes, or becomes contaminated with blood and other bodily fluids, using a chlorine-releasing disinfectant such as sodium hypochlorite 1% (10,000 ppm of available chlorine)	**Appropriately disinfect reusable equipment (e.g. contact devices, see Re-using contact lenses and ophthalmic devices below) which comes into contact with intact mucous membranes~~, or becomes contaminated with blood and other bodily fluids, using a chlorinereleasing disinfectant such as sodium hypochlorite 1% (10,000 ppm of available chlorine)~~**
49	B62d	disinfect surfaces in the consulting room if contaminated with body fluids, using a chlorine-releasing disinfectant such as sodium hypochlorite 1% (10,000 ppm of available chlorine)	**Disinfect surfaces and reusable equipment in the consulting room if contaminated with body fluids or blood, using a chlorine-releasing disinfectant such as sodium hypochlorite 1% (10,000 ppm of available chlorine)**
50	B64	See Below	See Below
51	B67a	You should use single patient use lenses and devices that contact the surface of the eye where practicable.	You should use single patient use lenses and devices that contact the surface of the eye where practicable or the use of disposable covers where possible and does not impact on the quality of care.
52	B67c	When single use lenses and devices are not practicable, you should: balance the benefits that patients receive from contact lenses and ophthalmic devices against the transmission of disease apply appropriate disinfection procedures. These should include the use of sodium hypochlorite solution where possible, see section on Levels of decontamination.	When single use lenses and devices are not practicable, you should: balance the benefits that patients receive from contact lenses and ophthalmic devices against the transmission of disease apply appropriate disinfection procedures to ensure the risk of infection transmission is reduced to a minimum practical level. ~~These should include the use of sodium hypochlorite solution where possible~~, see section on Levels of decontamination.

54	**New Section to Re- using contact lenses and ophthalmic devices**		Add: **BXX** You should use an appropriate agent to disinfect reusable equipment and contact devices. You should ensure the product is: a. appropriate for inactivating infectious agents such as bacteria and viruses b. Minimises risk of harm to the eye should it accidentally come into contact with it. **BXX** You should not use agents or procedures capable of binding proteins to surfaces e.g. isopropyl alcohol, glutaraldehyde or autoclaving, unless you appropriately decontaminate contact devices first (see BXX below)
54	**B72**	Where it is practicable, you should use single use devices, such as disposable tonometer heads or tips.	Remove
55	**B73**	Some devices are not able to withstand certain forms of disinfection. In these cases, you should use your professional judgement, bearing in mind that undetected disease may have sight- or life-threatening consequences.	Remove
56	**Title: How to disinfect equipment**	How to disinfect equipment	**How to minimise the risk of CJD/vCJD in eye care practice disinfect equipment**
57	**B75**	The following advice reduces the potential risk of iatrogenic transmission of CJD/vCJD via contact devices.	**The following advice reduces the potential risk of iatrogenic transmission of CJD/vCJD via re-usable contact devices that make contact with the ocular surface. This is a balance between routinely performing potentially expensive and/or impractical disinfection**

			procedures for a theoretical risk of CJD/vCJD transmission which may be difficult to operationalise versus not exposing patients unnecessarily and avoidably to a potentially life-threatening disease. However, there is real and significant risk of transmission of more common infections from adenovirus and bacteria, which does require regular and effective decontamination procedures. Thus, an approach of risk reduction rather than risk elimination for prion proteins is recommended for the majority of patients as outlined below.
58	**New section to: How to disinfect equipment**		**BXX** **Where it is practicable, you should use single use contact d evices, such as disposable tonometer heads or tips or the use of disposable covers where possible and does not impact on the quality of care.**
59	**B76**	You should not use alcohol wipes alone to disinfect contact devices as they are ineffective against many organisms, and may fix prion proteins to the surface of the instrument.	**You should not use alcohol wipes alone to disinfect contact devices as they are ineffective against many organisms, and may fix prion proteins to the surface of the instrument which may not be removable with further decontamination procedures.**
60	**B78**	You should not use agents or procedures capable of binding proteins to surfaces e.g. isopropyl alcohol, glutaraldehyde or autoclaving, unless you decontaminate devices first, following the process outlined in paragraphs below.	**Remove**
61	**B79**	You should use 1% sodium hypochlorite solution to disinfect equipment. This concentration is: a. appropriate for inactivating infectious agents such as bacteria and viruses b. less harmful to the eye than stronger concentrations, should it accidentally come into contact with it.	**Remove**

62	**B81**	You should follow this process to disinfect contact lenses or an ophthalmic device:	**~~You should follow this~~ The ACDP TSE WG (2011) recommends the following process to disinfect contact lenses or an ophthalmic device:**
63	**B81 Table**	See below	**See below**
64	**New section to How to disinfect equipment**		**BXX However, some devices are not able to withstand certain forms of disinfection, such as sodium hypochlorite, unless made from PMMA, glass or non-ferrous materials. Thus, where possible, you should follow the manufacturer's instructions for decontamination for each specific device.** **BXX Sodium hypochlorite solution has other potential disadvantages:** **a. it needs to be manually diluted to the correct concentration (1%) and at least a volume of 50mL** **b. it may be corrosive and cause damage to the device** **c. direct contact to the ocular surface and skin can cause irritation or harm.** **BXX In line with ophthalmic instrument decontamination recommendations from the Royal College of Ophthalmologists, The College therefore supports the following approach for decontaminating reusable contact devices:** **SEE NEW TABLE BELOW** **BXX You should consider involvement of local infection prevention control teams and risk assess all contact procedures carried out in the practice to ensure decontamination processes are appropriate.**

Current B64

Agent	Preparation	Examples of use
Liquid soap	as supplied	handwash
Chlorhexidine gluconate 4% skin cleanser	500 ml bottles with pump dispenser eg Hibiscrub	antiseptic handwash
Chlorhexidine 5% in 70% isopropyl alcohol [202]	500 ml bottles with pump dispenser eg Hibisol	antiseptic hand disinfectant for use before aseptic procedures or after handling contaminated materials
Alcohol-based hand sanitizer	as supplied, usually in bottles with pump dispenser eg Purell (contains 63% ethyl alcohol)	routine handrub
Detergent	general purpose detergent or detergent impregnated wipes eg Cutan multisurface wipes	cleaning of hard surfaces
Isopropyl alcohol 70%	Isopropyl alcohol of a concentration of 70% has been shown to be effective against SARS-CoV-2, MRSA and staphylococcus infection. Alternative wipes may be used if they carry the CE or UKCA mark, and are used according to the manufacturer's instructions. For example, impregnated swabs eg mediswabs or wipes eg mediwipes	disinfection of hard surfaces, chin rests etc. (not suitable for use with medical devices that come into contact with the surface of the eye)
Hypochlorite solution 0.1% (1,000 ppm available chlorine)	available from pharmacies eg Milton or own brand sterilising solution (dilute to concentration required) under normal usage, these agents are disinfectants, and not sterilants	general disinfection (ensure that items are thoroughly rinsed in sterile saline or distilled water after using hypochlorite)
Hypochlorite solution 1%		disinfection of body fluid spills and decontamination of trial contact lenses, diagnostic contact lenses, tonometer heads

Agent	Preparation	Examples of use
(10,000 ppm available chlorine)		and other devices that come into contact with the surface of the eye (ensure that items are thoroughly rinsed in sterile saline or distilled water after using hypochlorite)

Proposed Changes B64

Agent	Preparation	Examples of use
Chlorhexidine 5% in 70% isopropyl alcohol [202]	500 ml bottles with pump dispenser eg Hibisol	antiseptic hand disinfectant for use before aseptic procedures or after handling contaminated materials
Alcohol-based hand sanitizer	as supplied, usually in bottles with pump dispenser eg Purell (contains 63% ethyl alcohol)	routine handrub
Detergent	general purpose detergent or detergent impregnated wipes eg Cutan multisurface wipes	Regular cleaning of hard surfaces and equipment, including when visibly soiled

Isopropyl alcohol 70%	Isopropyl alcohol of a concentration of 70% has been shown to be effective against SARS-CoV-2, MRSA and staphylococcus infection. Alternative wipes may be used if they carry the CE or UKCA mark, and are used according to the manufacturer's instructions. For example, impregnated swabs eg mediswabs or wipes eg mediwipes	disinfection of hard surfaces, chin rests etc. (not suitable for use with medical devices that come into contact with the surface of the eye). Surfaces must be left to air dry or dried with tissue or non-shedding clean cloth between patients
Hypochlorite solution 0.1% (1,000 ppm available chlorine)	available from pharmacies eg Milton or own brand sterilising solution (dilute to concentration required) under normal usage, these agents are disinfectants, and not sterilants	general disinfection (ensure that items are thoroughly rinsed in sterile saline or distilled water after using hypochlorite)
Hypochlorite solution 1% (10,000 ppm available chlorine)		disinfection of body fluid and blood spills ~~and decontamination of trial contact lenses, diagnostic contact lenses, tonometer heads and other devices that come into contact with the surface of the eye (ensure that items are thoroughly rinsed in sterile saline or distilled water after using hypochlorite)~~

Current B81 Table

Step	ACDP TSE WG, 2011 recommendation[203]	Notes
Timing	immediately after use	immediately disinfect the item, and if this is not possible, keep it in a container of water for irrigation BP or sterile normal saline, until it can be disinfected.
Do not dry	do not allow to dry	
Rinse	in water for irrigation BP/sterile normal saline for at least 30 sec	
Clean	rubbing with liquid soap or detergent	thoroughly clean the item (including by rubbing) to remove cellular debris and adherent protein
Disinfect	using sodium hypochlorite 1% (10,000 ppm of available chlorine) for 10 min	disinfect it by using sodium hypochlorite
Rinse	in water for irrigation BP/sterile normal saline for at least 10 min with 3 changes of water/saline	thoroughly rinse off the sodium hypochlorite, which is toxic to the eye, before re-use
Dry	shake off excess, dry with tissue, re-use immediately or store dry	return the item to its dedicated case, if it has one
Further steps	if necessary, since hypochlorite is not effective against all spores or cysts	follow with conventional disinfection

Proposed Changes to B81 table

Step	ACDP TSE WG, 2011 recommendation[20] [3]	Notes
Timing	immediately after use	immediately decontaminate ~~disinfect~~ the item, and if this is not possible, keep it in a container of water for irrigation BP or s terile normal saline, until it can be cleaned ~~disinfected.~~
Do not dry	do not allow to dry	
Rinse	in water for irrigation BP/sterile normal saline for at least 30 sec	
Clean	rubbing with liquid soap or detergent	thoroughly clean the item (including by rubbing) to remove cellular debris and adherent protein
Disinfect	using sodium hypochlorite 1% (10,000 ppm of available chlorine) for 10 min	disinfect it by using sodium hypochlorite
Rinse	in water for irrigation BP/sterile normal saline for at least 10 min with 3 changes of water/saline	thoroughly rinse off the sodium hypochlorite, whic h is toxic to the eye, before re-use
Dry	shake off excess, dry with tissue, re-use immediately or store dry	return the item to its dedicated case, if it has one

Further steps	**if necessary, since hypochlorite is not effective against all spores or cysts**	**follow with conventional disinfection**

New Proposed table to How to disinfect equipment

Step	**Recommendation**	**Notes**
Timing	**Immediately after use**	**Immediately decontaminate the item, and if this is not possible, keep it in a container of sterile water or saline, until it can be cleaned**
Do not dry	**Do not allow device to dry after use**	
Clean	**Clean by rubbing with detergent, liquid soap or neutral detergent wipes for at least 20 seconds**	
Rinse	**Rinse with sterile water or saline and shake off excess**	
Dry	**Dry with clean non-linting/shedding tissue. Device can be re-used immediately or store dry**	**Return the item to its dedicated case, if it has one**
Further steps	**If used on a known or suspected infected patient, it must be disinfected using the steps listed under B81**	**The device may need to be sterilised**

Protecting patients, colleagues and others from harm

	Section/Number	Current	Proposed Changes
65	**Raising concerns**		Add: Bxx if you are unable to resolve the issue, or if the issue is so serious as to merit immediate referral, you should consider escalating your concerns to a speaking up guardian within your organisation, local optical committee or employer, speaking to someone within your local NHS trust, or a prescribed person or organisation (including the GOC and/or the police)

Safeguarding children and adults at risk

	Section/Number	Current	Proposed Changes
66	**Title**	Safeguarding children and adults at risk	Safeguarding vulnerable children and adults
67	**Safeguarding children and adults at risk**	Safeguarding children and adults at risk	Safeguarding vulnerable children and adults

Maintaining Trust

Honesty and Integrity

	Section/Number	Current	Proposed Changes
68	**Principle**		Add: Dxx: You must make sure that your conduct justifies patients' trust in you and the public's trust in your profession. Dxx: You must always be honest about your experience, qualifications, and current role. You should introduce yourself to patients and explain your role in their care. Dxx: If a patient, colleague, or anyone else you have contact with in your professional role asks for your registered name and/or GOMC reference number, you must give this information to them.
69	**Colleagues**		Add: Dxx If the patient takes their prescription elsewhere, and there is an anomaly or complaint of non-tolerance, they should return to the dispensing practice. As the prescriber, you are responsible for the prescription itself but it is the responsibility of the dispensing practice to resolve any

			non-tolerance issues and if necessary to issue a new dispense. Footnote This does not mean, however, that the dispensing practice should be responsible for incorrect spectacles resulting from a prescription error, but the general rule is that it is up to the dispensing practice to resolve any non-tolerance issues.
70	**Integrity and conflicts of interest**		Add: Dxx You should not write, commission, publish, or pay for reviews of your professional services in any way that misleads the public. You must not post fake reviews, write reviews under a false identity, suppress genuine negative reviews, or offer incentives in exchange for a review without disclosing the incentive. **Dxx** Marketing and advertising about your clinical practice — including testimonials, before-and-after images, and claims about clinical outcomes — must be honest, accurate, and capable of being substantiated. **Dxx** You must not publish, commission, or pay for reviews of your professional services in a way that misleads the public. In particular, you must not post fake

			reviews, write reviews under a false identity, suppress genuine reviews, or offer incentives in exchange for a review without disclosing the incentive. **Dxx** Marketing and advertising about your clinical practice — including testimonials, before-and-after images, and claims about clinical outcomes — must be honest, accurate, and capable of being substantiated. You should follow the Committee of Advertising Practice (CAP)
71	**New section**		Use of professional titles **Dxx** The titles "optometrist", "ophthalmic optician", "optician", and "dispensing optician" are protected in law under the Opticians Act 1989. You must not use, or allow to be used, any of these titles in connection with your practice unless you are appropriately registered with the General Optical Council. **Dxx** Other descriptors that you may add to your registered title — for example "senior", "lead", "consultant", "principal", “fellow”, or "resident" — are not themselves protected in law. You should only use such descriptors where they accurately describe your role and you can justify their use. You must not use any descriptor in a way that misleads patients

			or the public about your seniority, your role within a practice, or your standing within the profession. See **Professional** GOC Standard 16.4. **Dxx** Where you describe yourself by reference to a clinical area of practice — for example as a "glaucoma optometrist", "neuro-optometrist", "behavioural optometrist", or similar you should be clear about the qualifications, training and experience that support that description, and be ready to explain it on request. You should not use a clinical descriptor in a way that implies a regulated specialty or sub-specialty where none exists or that implies medical specialty status. (See GOC Standards 5, 6 and 16, and the section on Develop and maintain knowledge and skills.)

Annexes

Annex 1 Equipment list for the routine eye examination

	Section/Number	Current	Proposed Change
72	**Title**	Annex 1 Equipment list for the routine eye examination	Annex 1 Equipment list for the routine eye examination or sight test
73	**The following equipment is suggested**	The following equipment is	The following equipment is

	for the routine eye examination	suggested for the routine eye examination	suggested for the routine eye examination or sight test

Annex 2 Ophthalmic Abbreviations

	Section/Number	Current	Proposed Change
74	**Eye examination terms**	See Table Below	See Table Below
75	**Clinical condition terms**	See Table Below	See Table Below
76	**Contact lens terms**	See Table Below	See Table Below
77	**Visual field and retinal structural terms (relating to perimetry and OCT)**	See Table Below	See Table Below
78	**Pharmacy and drug terms**	See table below	See Table below

Eye Examination Terms Current Table

AC	**Anterior chamber**	**L/R**	**L hyperphoria**
AC 4/4	**grade 4 Anterior chamber angle**	**LSOT**	**Left esotropia**
AC 3/4	**grade 3 Anterior chamber angle**	**LVA**	**Low vision aid**

AC 2/4	**grade 2 Anterior chamber angle**	**MDU**	**Mallett distance unit**
AC 1/4	**grade 1 Anterior chamber angle**	**MNU**	**Mallett near unit**
AC 0/4	**grade 0 Anterior chamber angle (closed)**	**M.Wing**	**Maddox Wing**
AC/A	**Accommodative convergence/ accommodation ratio**	**MR**	**Maddox Rod**
Acc	**Accommodation**	**NCT**	**Non-contact tonometer**
Ad	**Advised**	**ND**	**Neutral density filter**
Add	**Addition**	**NPL**	**No perception of light**
AIT	**After-image transfer**	**NPC**	**Near point of convergence or no previous correction**
ALT	**Alternating**	**NRC**	**Normal retinal correspondence**

ALT SOT	**Alternating esotropia**	**NV**	**Near vision**
ALT XOT	**Alternating exotropia**	**NWT**	**Normal wearing time**
ARC	**Anomalous retinal correspondence**	**o symptoms**	**Zero symptoms**
A/V	**Arteriole/Venue ratio**	**ϕ**	**Horizontal orthophoria**
BE	**Both eyes**	**θ**	**Vertical orthophoria**
BIO	**Binocular indirect ophthalmoscopy**	**⊕**	**Horizontal & vertical orthophoria**
BSV	**Binocular single vision**	**OCs**	**Optical centres**
BV	**Binocular vision**	**Occ.**	**Occupation**
BVD	**Back vertex distance**	**OH**	**Ocular history**
BVP	**Back vertex power**	**OMB**	**Oculo motor or muscle balance**
CD	**Centration distance**	**ONH**	**Optic nerve head**

C/D	**Cup/disc ratio**	**Oph**	**Ophthalmoscopy**
CF	**Count fingers vision – state distance**	**PD**	**Pupillary distance**
CT	**Cover test**	**PERRLA**	**Pupils equal, round, reactive to light and accommodation**
CCT	**Central corneal thickness**	**Sx**	**Symptoms**
c/u	**Check-up**	**PH**	**Pinhole**
CW	**Close work**	**PL**	**Perception of light**
Δ	**Prism dioptre**	**POH**	**Previous ocular history**
D	**Dioptres**	**PPA**	**Peripapillary atrophy**
DC	**Dioptres cylinder**	**Px**	**Patient**
DNA	**Did not attend**	**RAPD**	**Relative afferent pupillary defect**

DOB	**Date of birth**	**RE**	**Right eye**
DS	**Dioptres sphere**	**Ret.**	**Retinoscopy**
DV	**Distance vision**	**RHyperT**	**Right Hypertropia**
DVD	**Dissociated vertical divergence**	**RHypoT**	**Right Hypotropia**
EF	**Eccentric fixation**	**RNFL**	**Retinal nerve fibre layer**
Ext	**External (eye)**	**RPE**	**Retinal pigment epithelium**
FB	**Foreign body**	**RSOT**	**Right Esotropia**
FD	**Fixation disparity**	**Rx**	**Prescription**
FF	**Foveal fixation**	**SLE**	**Slit lamp examination**
FOH	**Family ocular history**	**SLM**	**Slit lamp microscope**
F/U	**Follow up appointment**	**SOP/ESOP**	**Esophoria**

GH	**General health**	**SOT/ESOT**	**Esotropia**
G(M)P	**General (medical) practitioner**	**Supp.**	**Suppression**
HA	**Headaches**	**V**	**Vision (unaided)**
HARC	**Harmonious abnormal retinal correspondence**	**VA**	**Visual acuity (corrected)**
HM	**Hand motion vision – state distance**	**VAL**	**Left visual acuity**
Hx	**History**	**VAR**	**Right visual acuity**
IOL	**Intra-ocular lens implant**	**VDU**	**Visual display unit**
IOP	**Intra-ocular pressure**	**VF**	**Visual field**
ISNT	**Inferior, Superior, Nasal, Temporal (rule used to assess optic disc appearance)**	**VPS**	**Variable prism stereoscope**

K	**Keratometry**	**WD**	**Working distance**
LE	**Left eye**	**X/12**	**X months**
LHyperT	**Left hypertropia**	**X/52**	**X weeks**
LHypoT	**Left hypotropia**	**X/7**	**X days**
LOs	**Lenticular opacities**	**XOP/EXOP**	**Exophoria**
L/R FD	**L/R fixation disparity**	**XOT/EXOT**	**Exotropia**

Eye Examination Terms Proposed Changes

AC	**Anterior chamber**	**L/R**	**L hyperphoria**
AC 4/4	**grade 4 Anterior chamber angle**	**LSOT**	**Left esotropia**
AC 3/4	**grade 3 Anterior chamber angle**	**LVA**	**Low vision aid**
AC 2/4	**grade 2 Anterior chamber angle**	**MDU**	**Mallett distance unit**

AC 1/4	grade 1 Anterior chamber angle	MNU	Mallett near unit
AC 0/4	grade 0 Anterior chamber angle (closed)	M.Wing	Maddox Wing
AC/A	Accommodative convergence/ accommodation ratio	MR	Maddox Rod; Medial rectus
ACT	Alternating cover test		
Acc	Accommodation	NCT	Non-contact tonometer
Ad	Advised	ND	Neutral density filter
		NIPH	No improvement (with) pinhole
Add	Addition	NPL/NLP	No perception of light/No light perception
AIT	After-image transfer	NPC	Near point of convergence or no previous correction
AL	Axial length		
ALT	Alternating	NRC	Normal retinal correspondence
ALT SOT	Alternating esotropia	NV	Near vision
ALT XOT	Alternating exotropia	NWT	Normal wearing time

ARC	Anomalous retinal correspondence	o symptoms	Zero symptoms
A/V	Arteriole/Venue ratio	ϕ	Horizontal orthophoria
BC(D/N)VA	Best corrected distance/near visual acuity		
BE	Both eyes	θ	Vertical orthophoria
BIO	Binocular indirect ophthalmoscopy	⊕	Horizontal & vertical orthophoria
BSV	Binocular single vision	OCs	Optical centres
BV	Binocular vision	Occ.	Occupation
BVD	Back vertex distance	OH	Ocular history
BVP	Back vertex power	OMB	Oculo motor or muscle balance
CD	Centration distance	ONH	Optic nerve head
C/D	Cup/disc ratio	Oph	Ophthalmoscopy
CF	Count fingers vision – state distance	PD	Pupillary distance
CL	Contact lens		
CT	Cover test	PERRLA	Pupils equal, round, reactive to light and accommodation

		PT	Part time
		Δ	Prism dioptres
CCT	Central corneal thickness	Sx	Symptoms
		SO	Superior oblique
		SR	Superior rectus
c/u	Check-up	PH	Pinhole
CW	Close work	PL	Perception of light
Δ	Prism dioptre	POH	Previous ocular history
D	Dioptres	PPA	Peripapillary atrophy
DC	Dioptres cylinder	Px	Patient
DD	Disc diameter		
DNA	Did not attend	RAPD	Relative afferent pupillary defect
DOB	Date of birth	RE	Right eye
DS	Dioptres sphere	Ret.	Retinoscopy
DV	Distance vision	RHyperT	Right Hypertropia
DVD	Dissociated vertical divergence	RHypoT	Right Hypotropia
Dx	Diagnosis		
EF	Eccentric fixation	RNFL	Retinal nerve fibre layer

Ext	External (eye)	RPE	Retinal pigment epithelium
FB	Foreign body	RSOT	Right Esotropia
FD	Fixation disparity	Rx	Prescription
FF	Foveal fixation	SLE	Slit lamp examination
FOH	Family ocular history	SLM	Slit lamp microscope
		SLT	Selective laser trabeculoplasty
FT	Full time		
F/U	Follow up appointment	SOP/ESOP	Esophoria
GH	General health	SOT/ESOT	Esotropia
G(M)P	General (medical) practitioner	Supp.	Suppression
		Tx	Treatment
		UL	Upper lid
HA	Headaches	V	Vision (unaided)
HARC	Harmonious abnormal retinal correspondence	VA	Visual acuity (corrected)
HBP	High blood pressure		
HM	Hand motion vision – state distance	VAL	Left visual acuity

Hx	History	VAR	Right visual acuity
ICL	Intraocular contact lens		
ICR	Intrastromal corneal ring		
IO	Inferior oblique		
IOL	Intra-ocular lens implant	VDU	Visual display unit
IOP	Intra-ocular pressure	VF	Visual field
ISNT	Inferior, Superior, Nasal, Temporal (rule used to assess optic disc appearance)	VPS	Variable prism stereoscope
IR	Inferior rectus		
K	Keratometry	WD	Working distance
KC	keratoconus		
LE	Left eye	X/12	X months
		X/24	X hours
LHyperT	Left hypertropia	X/52	X weeks
LHypoT	Left hypotropia	X/7	X days
LL	Lower lid		
LOs	Lenticular opacities	XOP/EXOP	Exophoria
LR	Lateral rectus		

L/R FD	**L/R fixation disparity**	**XOT/EXOT**	**Exotropia**

Clinical condition terms Current Table

AMD/ARMD	**Age related macular degeneration**	**MS**	**Multiple sclerosis**
ACG/CAG	**Angle closure glaucoma**	**NIDDM**	**Non-insulin dependent diabetes mellitus**
BDR	**Background diabetic retinopathy**	**NRR**	**Neuro retinal rim**
BP	**Blood pressure**	**NS**	**Nuclear sclerosis**
BRAO	**Branch retinal artery occlusion**	**NTG**	**Normal tension glaucoma**
BRVO	**Branch retinal vein occlusion**	**PDR**	**Proliferative diabetic retinopathy**
CAG	**Closed angle glaucoma**	**PDT**	**Photodynamic therapy**
Cat	**Cataract**	**PK**	**Penetrating keratoplasty**

CLAPC	**Contact lens associated papillary conjunctivitis**	**POAG**	**Primary open angle glaucoma**
CLARE	**Contact lens associated red eye**	**PPDR**	**Preproliferative diabetic retinopathy**
CLPU	**Contact lens associated peripheral ulcer**	**PRA**	**Pan retinal ablation**
CNS	**Central nervous system**	**PRK**	**Photorefractive keratectomy**
CRAO	**Central retinal artery occlusion**	**PRP**	**Pan retinal photocoagulation**
CRVO	**Central retinal vein occlusion**	**PSCC**	**Posterior sub-capsular cataract**
CVA	**Cerebrovascular accident**	**PVD**	**Posterior vitreous detachment**
DR	**Diabetic retinopathy**	**RD**	**Retinal detachment**
ESR	**Erythrocyte sedimentation rate**	**RK**	**Radial keratotomy**

GPC	**Giant papillary conjunctivitis**	**RP**	**Retinitis Pigmentosa**
IDDM	**Insulin dependent diabetes mellitus**	**SEAL**	**Superior epithelial arcuate lesion**
IRMA	**Intra-retinal microvascular abnormality**	**SLK**	**Superior limbic keratoconjunctivitis**
KCS	**Keratoconjunctivitis sicca**	**SPK**	**Superficial punctate keratitis**
KP	**Keratic precipitates**	**SPEE**	**Superficial punctate epithelial erosions**
LASEK	**Laser epithelial keratomileusis**	**TIA**	**Transient ischaemic attack**
LASIK	**Laser in situ keratomileusis**	**T1 diab**	**Type 1 diabetes**
LTG	**Low tension glaucoma**	**T2 diab**	**Type 2 diabetes**
MI	**Myocardial infarction**	**SLT**	**Selective laser trabeculoplasty**

LPI	Laser peripheral iridotomy		

Clinical condition terms proposed table

AAC	Acute angle closure		
AMD/ARMD	Age related macular degeneration	MS	Multiple sclerosis
~~ACG/CAG~~	~~Angle closure glaucoma~~	NIDDM	Non-insulin dependent diabetes mellitus
BDR	Background diabetic retinopathy	NRR	Neuro retinal rim
BP	Blood pressure	NS	Nuclear sclerosis
BRAO	Branch retinal artery occlusion	NTG	Normal tension glaucoma
		PAS	Peripheral anterior synechiae
		PACG	Primary angle closure glaucoma
		PCMO	Pseudophakic cystoid macular odemea

		PACS	Primary angle closure suspect (Plus or minus indicating risk score)
BRVO	Branch retinal vein occlusion	PDR	Proliferative diabetic retinopathy
CAG	Closed angle glaucoma	PDT	Photodynamic therapy
Cat	Cataract	PK	Penetrating keratoplasty
CLAPC	Contact lens associated papillary conjunctivitis	POAG	Primary open angle glaucoma
CLARE	Contact lens associated red eye	PPDR	Preproliferative diabetic retinopathy
CLPU	Contact lens associated peripheral ulcer	PRA	Pan retinal ablation
CNS	Central nervous system	PRK	Photorefractive keratectomy
CRAO	Central retinal artery occlusion	PRP	Pan retinal photocoagulation
CRVO	Central retinal vein occlusion	PSCC	Posterior sub-capsular cataract
CVA	Cerebrovascular accident	PVD	Posterior vitreous detachment
DR	Diabetic retinopathy	RD	Retinal detachment

ESR	Erythrocyte sedimentation rate	RK	Radial keratotomy
GPC	Giant papillary conjunctivitis	RP	Retinitis Pigmentosa
IDDM	Insulin dependent diabetes mellitus	SEAL	Superior epithelial arcuate lesion
IRMA	Intra-retinal microvascular abnormality	SLK	Superior limbic keratoconjunctivitis
ITC	Irido-trabecular contact		
KCS	Keratoconjunctivitis sicca	SPK	Superficial punctate keratitis
KP	Keratic precipitates	SPEE	Superficial punctate epithelial erosions
		STFB	Sub-tarsal foreign body
LASEK	Laser epithelial keratomileusis	TIA	Transient ischaemic attack
LASIK	Laser in situ keratomileusis	T1 diab	Type 1 diabetes
LTG	Low tension glaucoma	T2 diab	Type 2 diabetes
MI	Myocardial infarction	SLT	Selective laser trabeculoplasty
LPI	Laser peripheral iridotomy		

Contact lens terms current table

BC	**Base curve**	**OS/OD**	**Overall size/overall diameter**
BOZD	**Back optic zone diameter**	**OZD**	**Optic zone diameter**
BOZR	**Back optic zone radius**	**PMMA**	**Polymethyl methacrylate**
BVP	**Back vertex power**	**RGP/RCL**	**Rigid gas permeable/rigid corneal lens**
CLAPC	**Contact lens associated papillary conjunctivitis**	**SCL**	**Soft contact lens**
CLARE	**Contact lens associated red eye**	**SiH/SiHy**	**Silicone hydrogel**
CLPU	**Contact lens associated peripheral ulcer**	**SEAL**	**Superior epithelial arcuate lesion**

Dk	**Unit of permeability**	**SLK**	**Superior limbic keratoconjunctivitis**
DW	**Daily wear**	**SPK**	**Superficial punctate keratitis**
EW	**Extended wear**	**SPEE**	**Superficial punctate epithelial erosions**
FOZD	**Front optic zone diameter**	**TBUT**	**Tear break up time**
FVP	**Front vertex power**	**Tc**	**Centre thickness**
HEMA	**Hydroxyethyl methacrylate**	**Td**	**Total diameter**
HT	**Handling tint**	**Te**	**Edge thickness**
HVID	**Horizontal visible iris diameter**	**TWT/WTT**	**Today wearing time**
K	**Keratometry**	**VPA**	**Vertical palpebral aperture**

MWT	Maximum wearing time	WT	Wearing time

Contact lens terms proposed changes

ALL	Anterior limiting lamina (Bowman's membrane)		
BCL	Bandage contact lens		
BC	Base curve	OS/OD	Overall size/overall diameter
BOZD	Back optic zone diameter	OZD	Optic zone diameter
BOZR	Back optic zone radius	PMMA	Polymethyl methacrylate
BVP	Back vertex power	RGP/RCL	Rigid gas permeable/rigid corneal lens
CIE	Corneal infiltrative event		
CLAPC	Contact lens associated papillary conjunctivitis	SCL	Soft contact lens
CLARE	Contact lens associated red eye	SiH/SiHy	Silicone hydrogel

CLPU	**Contact lens associated peripheral ulcer**	**SEAL**	**Superior epithelial arcuate lesion**
Dk	**Unit of permeability**	**SLK**	**Superior limbic keratoconjunctivitis**
DW	**Daily wear**	**SPK**	**Superficial punctate keratitis**
EW	**Extended wear**	**SPEE**	**Superficial punctate epithelial erosions**
FOZD	**Front optic zone diameter**	**TBUT**	**Tear break up time**
FVP	**Front vertex power**	**Tc**	**Centre thickness**
HEMA	**Hydroxyethyl methacrylate**	**Td**	**Total diameter**
HT	**Handling tint**	**Te**	**Edge thickness**
HVID	**Horizontal visible iris diameter**	**TWT/WTT**	**Today wearing time**
K	**Keratometry**	**VPA**	**Vertical palpebral aperture**
MWT	**Maximum wearing time**	**WT**	**Wearing time**
MCL	**Medical contact lens (e.g. bandage, rehabilitative, or**		

	therapeutic contact lenses)		

Visual field and retinal structural terms (relating to perimetry and OCT) Current Table

BM	**Bruch's membrane**	**PED**	**Pigment epithelial detachment**
dB	**Decibel**	**PSD**	**Pattern standard deviation**
EZ	**Ellipsoid zone**	**RPE**	**Retinal pigment epithelium**
GCL	**Ganglion cell layer**	**RNFL**	**Retinal nerve fibre layer**
IPL	**Inner plexiform layer**	**STQ**	**Superior temporal quadrant**
ILM	**Internal limiting membrane**	**MD**	**Mean deviation**
ITQ	**Inferior temporal quadrat**	**VMT/VT**	**vitreomacular traction/vitreous traction**
NIQ	**Nasal inferior quadrant**		
OD	**Ocular dexter (right eye)**		
OS	**Ocular sinister (left eye)**		

OPL	Outer plexiform layer		
ONL	Outer nuclear layer		

Visual field and retinal structural terms (relating to perimetry and OCT) Proposed Changes

BM	Bruch's membrane	PED	Pigment epithelial detachment
		PH	Posterior hyaloid
CMO	Cystoid macular oedema		
dB	Decibel	PSD	Pattern standard deviation
DMO	Diabetic macular oedema		
ELM	External limiting membrane		
ERM	Epiretinal membrane		
EZ	Ellipsoid zone	RPE	Retinal pigment epithelium
FTMH	Full thickness macular hole		
GCL	Ganglion cell layer	RNFL	Retinal nerve fibre layer
INL	Inner nuclear layer		
		SRF	Subretinal fluid
IPL	Inner plexiform layer	STQ	Superior temporal quadrant
ILM	Internal limiting membrane	MD	Mean deviation

IRF	Intraretinal fluid		
ITQ	Inferior temporal quadrat	VMT/VT	vitreomacular traction/vitreous traction
LMH	Lamellar macular hole		
NIQ	Nasal inferior quadrant		
OD	Ocular dexter (right eye)		
OS	Ocular sinister (left eye)		
OPL	Outer plexiform layer		
ONL	Outer nuclear layer		

Pharmacy and drug terms current table

A.d.	As directed	otc	Over the counter (bought medication)
b.d/b.i.d.	Twice a day	P	Pharmacy (drug)
GSL	General sales list	POM	Prescription only medicine
Gutt/g	Guttae (drops)	p.r.n.	When required

Meds	Medications	q.d.s./q.i.d.	Four times a day
Nocte	At night	Rx	Prescription
Occ	Ointment	t.d.s./t.i.d.	Three times a day
o.d	Once a day		

Pharmacy and drug terms proposed changes

A.d.	As directed	otc	Over the counter (bought medication)
b.d/b.i.d.	Twice a day	P	Pharmacy (only ~~drug~~) medicine
GSL	General sales list	POM	Prescription only medicine
Gutt/g	Guttae (drops)	p.r.n.	When required
Meds	Medications	q.d.s./q.i.d.	Four times a day
mg	milligrams		
ml/mL	millilitre		
Nocte	At night	Rx	Prescription
Occ	Ointment	t.d.s./t.i.d.	Three times a day
o.d	Once a day		