



Safety and quality

Health and safety on the premises

Key points

- You must follow the law on Health and Safety at Work.
- You must maintain a hygienic and safe practice environment.
- You must ensure that a safe environment is provided to deliver care to your patients.
- You should comply with workplace safety policies and procedures.
- You should contribute to clinical audits.
- You should report any adverse incidents.

[This Guidance does not change what you must do under the law.](#)

Principles of health and safety

- B.1. You must be aware of, and work to, applicable health and safety legislation.
- B.2. You must ensure that a safe environment is provided to deliver care to your patients, and take appropriate action if this is not the case.¹
- B.3. You should refer to the guidance sections on Infection control, Research and audit, and Use and supply of drugs or medicines in optometric practice.

Practitioner responsibilities

- B.4. You must follow the law on Health and Safety at Work.^{2,3}
- B.5. You must follow the regulations on substances hazardous to health.^{4,5}
- B.6. If you are self-employed or a locum you should also comply with the practice's reasonable rules and instructions.
- B.7. You must report to your employer or other appropriate person any potential risk to patients, yourself or colleagues.⁶
- B.8. You must work safely and minimise risks to patients,⁷ including the use of hazard control and infection control. See sections on Infection control and Use and supply of drugs or medicines in optometric practice.

B.9. If you are an employee, your employer is responsible for reporting injuries and incidents.^{8,9} If you are self-employed the person in control of the premises (which may be you) should report such injuries or incidents. If the responsible person is not present at the time of the incident you should report it to them at the earliest opportunity.

B.10. You should report any adverse incidents. See section on Protecting patients, colleagues and others from harm.

B.11. You should contribute to workplace clinical audits. See section on Research and audit.

B.12. You should respond to requests from organisations monitoring public health.

B.13. You must act promptly if you think a patient is at risk as a result of:

- a. lack of care
- b. inadequate premises or equipment, or
- c. a colleague who may not be fit to practise.

See section on Protecting patients, colleagues and others from harm.

B.14. You should maintain your own immunisation and health. See section on Infection control.

B.15. You must take appropriate steps to minimise the risk of infection if you have a health condition that could pose a risk to a patient. See section on Infection control.

Useful information and links

Department of Health (2013) Health Technical Memorandum 05-01: Managing healthcare fire safety. 2nd ed. Available from: gov.uk/government/publications/managing-healthcare-fire-safety [Accessed 5 Dec 2019]

Health and Safety Executive (for England, Wales and Scotland) hse.gov.uk Including the Control of Substances Hazardous to Health available from: hse.gov.uk/coshh/index.htm and the Reporting of Injuries, Diseases and Dangerous Occurrences, available from: hse.gov.uk/riddor/ [Accessed 5 Dec 2019]

Health and Safety Executive Northern Ireland hseni.gov.uk

Royal Society for the Prevention of Accidents occupational safety advice and information. Available from: [rospsa.com/Occupational-Safety/Advice](https://www.rospsa.com/Occupational-Safety/Advice) [Accessed 5 Dec 2019]

¹ General Optical Council (2016) Standards of Practice for Optometrists and DeOe para 12.1 Available from: standards.optical.org [Accessed 5 Dec 2019]

² ee

³ General Optical Council (2016) Standards of Practice for Optometrists and Dispensing Opticians para 12.1.1 Available from: standards.optical.org [Accessed 5 Dec 2019]

⁴ The Control of Substances Hazardous to Health Regulations 2002, SI 2677.

⁵ General Optical Council (2016) Standards of Practice for Optometrists and Dispensing Opticians para 12.1.4 Available from: standards.optical.org [Accessed 5 Dec 2019]

⁶ General Optical Council (2016) Standards of Practice for Optometrists and Dispensing Opticians paras 11.3 and 11.5 Available from: standards.optical.org [Accessed 5 Dec 2019]

⁷ General Optical Council (2016) Standards of Practice for Optometrists and Dispensing Opticians para 12.1 Available from: standards.optical.org [Accessed 5 Dec 2019]

⁸ The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013, SI 1471

⁹ Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (Northern Ireland) 1997, SI 455

Infection control

Key points

- Infection control is concerned with two main areas. Firstly, transmission from person to person, and secondly, transmission via a contaminated object.
- You must ensure that a safe environment is provided to deliver care to your patients.
- You must follow appropriate infection controls including hand hygiene.
- You should keep up to date with immunisations.
- You must use and dispose of sharps safely.
- You should be aware of situations of increased concern, including patients with transmissible infections.
- You should use routine infection control precautions, including decontaminating equipment that regularly comes into contact with patients.
- You should know the measures to take in case of accident.
- You must dispose of waste safely.

[This Guidance does not change what you must do under the law.](#)

Introduction

B.16. Infection control is concerned with two main areas. Firstly, transmission from person to person, and secondly, transmission via a contaminated object, such as an ophthalmic device or piece of equipment, or via contaminated contact lens solution bottles or multi-dose eye drops that have been used on another patient. In addition, there are environmental hazards that arise from your disposal of waste.

Transmission from person to person

Routes for transmission

B.17. There are four main routes for transmission, these are:

- a. physical contact, which can spread:
 - ophthalmic infections, such as bacterial and adenoviral conjunctivitis
 - skin infections, for example staphylococcus, herpes simplex or fungi, and
 - enteric infections, for example viral gastroenteritis

Guidance for professional practice

b. airborne particles, including respiratory infections, for example tuberculosis:

- you are at a special risk of the transmission of airborne infection because of the proximity to the patient's nose and mouth
- potentially infectious respiratory aerosols are generated when an individual sneezes, coughs or talks. Particles over 5 microns in diameter do not normally travel more than 1m but smaller particles can travel longer distances and remain airborne for longer

c. contact with bodily fluids:

- you are at extremely low risk of transmitting blood-borne viruses, such as human immunodeficiency virus (HIV) and hepatitis B and C, in optometric practice
- tears can contain infectious agents (including these viruses, and others that are much more contagious, such as adenovirus) which may be transmitted to yourself or to other patients if your hands are not properly cleaned after the clinical examination
- all spillages of blood and body fluids should be cleaned up immediately using a product that contains a detergent and disinfectant. Do not use mops for this – use disposable paper towels and dispose of as clinical waste.¹⁰

d. use of sharps: the main risk of transmission is associated with invasive procedures in which injury, for example needlestick, could result in blood from the infected individual entering open tissues of another person. If you suffer an injury from a sharp which may be contaminated you should:

- gently encourage the wound to bleed, if possible whilst holding it under running water
- wash the wound using running water and plenty of soap
- dry the wound and cover it with a waterproof plaster or dressing
- seek urgent medical advice
- report the injury to your employer.^{11,12}

You should not suck the wound or scrub it while you are washing it.

B.18. You must use adequate infection control measures to avoid transmitting infections.¹³

Methods of preventing infection transmission from person to person

Hand hygiene

Guidance for professional practice

- B.19. You must decontaminate your hands regularly and thoroughly to prevent the spread of infection, see paras B.29-B.31.¹⁴ You can reduce the risk of transmitting infections such as methicillin-resistant *Staphylococcus aureus* (MRSA) or *Clostridium difficile* (*C.diff*) if you use fastidious hand hygiene.
- B.20. There are a number of organisms present in healthy skin: some are resident organisms (skin commensals) and are mostly harmless, although some are known to cause mild eye infections. You can reduce the number of skin commensals left on your skin by washing with an antiseptic detergent preparation, instead of soap and water.
- B.21. Other transient organisms can be deposited on the skin, including certain gram-negative bacteria which could lead to more serious corneal infections. You can remove most of these transient organisms by thoroughly washing with liquid soap and water.
- B.22. You must decontaminate your hands, as appropriate:
- a. before every episode of direct patient contact or care
 - b. after every episode of direct patient contact or care
 - c. after any exposure to body fluids (including tears)
 - d. after any other activity or contact with a patient's surroundings that could potentially result in hands becoming contaminated, and
 - e. after removal of gloves.
- B.23. You can use an antibacterial handrub between patients during a clinic session. Alcohol is not a cleaning agent so you should perform a proper handwash with soap and water at the beginning and completion of the clinic session, as well as after exposure to body fluids. Alternatively, you can wash your hands between patients.
- B.24. You should also decontaminate your hands:
- a. before (and after) contact lens insertion or removal
 - b. after going to the toilet
 - c. when hands are visibly dirty
 - d. before (and after) contact with ocular surfaces and adnexae
 - e. before (and after, if necessary) administering medication, for example eye drops, and

Guidance for professional practice

- f. after any possible microbial contamination, e.g. contact with body fluids, wounds, or clinical waste.

B.25. You should use the following handwashing technique for most procedures you perform in the clinical setting:

- a. wet hands under running water
- b. dispense liquid soap or antiseptic into cupped hand (bar soap should not be used)
- c. rub hands vigorously and thoroughly for 10–15 seconds without adding more water
- d. ensure all surfaces of the hands are covered
- e. rinse hands thoroughly under warm running water, and
- f. dry hands with a disposable paper towel. You should not use non-disposable towels.

See Annex 3 World Health Organization guidance on handrubbing and handwashing techniques.

B.26. Hand hygiene agents include:

- a. liquid soap
- b. antiseptic, and
- c. antibacterial (alcohol-based) handrubs.¹⁵

B.27. Handwashing with soap and water is effective in removing most transient microorganisms and is usually all you need to prevent infection. In clinical areas, you should:

- a. use liquid soap in disposable containers or containers that are washed and dried before refilling, and
- b. never top up the containers.

B.28. Antiseptic agents are effective in reducing both transient and resident microorganisms. Chlorhexidine (4%) preparations have a residual effect against transient organisms influencing the survival time on hand surfaces.¹⁶ You should use an antiseptic agent:

- a. before and after direct contact with patients in clinical settings, where there is an outbreak of antimicrobial resistant organisms (e.g. residential or nursing homes)

Guidance for professional practice

- b. where there is heavy microbial contamination, or
- c. before performing invasive procedures or minor operations.

B.29. Antibacterial (alcohol-based) handrubs rapidly destroy microorganisms on the skin surface. However, they are not a cleaning agent and you should not use them if hands are visibly dirty or contaminated with blood, bodily fluids or other potentially infectious agents. They are especially useful in situations where handwashing and drying facilities are inadequate e.g. domiciliary visits, or between patient contacts.

B.30. You should not use alcohol handrubs as a substitute for handwashing with soap and water, when these are available. You are strongly advised to wash your hands at the start and finish of a session. Alcohol handrubs are not effective against *Clostridium difficile* spores or norovirus (a cause of viral gastroenteritis) so you should use liquid soap and water in situations where there is potential for the spread of these organisms.

B.31. The standard for efficacy of hygienic handrubs uses a reference of 60% isopropyl alcohol. However, to be effective against staphylococci, including MRSA, handrubs must contain 70% of either ethyl or isopropyl alcohol.

B.32. If you use an unperfumed alcohol-based handrub prior to contact lens insertion it has been shown to have a negligible effect on ocular comfort, redness and lens wettability. You should ensure that the handrub has been allowed to dry on the hands as instructed by manufacturers (often 15 seconds).

Maintain the integrity of your skin

B.33. To maintain the integrity of your skin, you should:

- a. cover cuts and abrasions to skin with waterproof dressings (preferably coloured)
- b. dry skin properly with paper hand towels after washing, and
- c. use hand cream as appropriate; you should not share jars of hand cream with others.

Keep up to date with immunisation

B.34. You should keep up to date with immunisation, including:

- a. tetanus
- b. polio

Guidance for professional practice

- c. tuberculosis, and
- d. hepatitis B.

Minimise the risk of airborne infection

- B.35. You should minimise the risk of airborne infection by:¹⁷
- a. covering your nose and mouth and using a tissue whilst coughing or sneezing
 - b. disposing of used tissues in the nearest receptacle as soon as possible¹⁸
 - c. performing hand hygiene after coughing or sneezing
 - d. not working in clinical practice if you have an acute upper respiratory tract infection, such as the common cold, and
 - e. avoiding touching your mouth, eyes and nose unless you have performed hand hygiene.

Protective clothing

- B.36. Wear protective clothing:
- a. to protect against direct contact with body fluid, or
 - b. while handling and cleaning decontaminated equipment.

Masks

B.37. You do not have to use a mask, unless there is a serious respiratory risk involved. Ordinary surgical masks are not effective protection. In these cases, you should wear specialised respiratory protection.¹⁹

Gloves

- B.38. You should wear gloves where you consider there is a risk from:
- a. invasive procedures
 - b. contact with:
 - non-intact skin, or
 - mucous membranes

Guidance for professional practice

c. exposure to:

- blood
- bodily fluids, including tears
- secretions
- excretions
- sharp or contaminated instruments, or
- other contaminated material, for example dressings.

B.39. You should consider the following factors when deciding to wear gloves:

- a. whether the patient has an overt infection, such as ulcerative blepharitis, acute viral or bacterial conjunctivitis
- b. the degree of contact with bodily fluids or infected tissue, and
- c. the consequences of infection.

B.40. You do not have to wear gloves to:

- a. carry out a normal eye examination
- b. perform minor procedures where there is no likelihood of cross-inoculation with bodily fluids, or
- c. fit contact lenses.

B.41. You should practise thorough hand hygiene before wearing, and after removing, gloves, as they may not provide complete protection.

B.42. You must dispose appropriately of gloves that you believe are contaminated.

B.43. You can use non-sterile disposable examination gloves. However, if you undertake a procedure which requires a sterile environment you must use sterile surgical gloves. You must not use polythene gloves for clinical interventions. If you choose to use latex gloves you should be aware that these might cause allergic reactions such as asthma in sensitised individuals.^{20,21}

Appropriate sharp disposal

B.44. You must only use sharps where this is necessary.²²

B.45. If you need to use sharps you should use and dispose of them safely by:²³

Guidance for professional practice

- a. using equipment with safety devices, and
- b. using safe handling and disposal procedures.

B.46. You should follow the NICE guidance on sharps containers.¹⁴

Situations of increased concern – transmission from person to person

High-risk groups

B.47. High-risk groups include those patients with MRSA, *C.difficile*, tuberculosis (within the first two weeks of treatment), or pandemic influenza (where there is no vaccine available) and *Staphylococcus aureus*, which have caused particular concern in recent times.

B.48. *Staphylococcus aureus* is a bacterium that can reside on the skin, or can be found in the nose. About one third of healthy individuals carry *S. aureus*. MRSA is a less common variant of *S. aureus* which may be resistant to many antibiotics, making it more difficult to treat than normal strains of the bacterium. MRSA may be a problem in many hospitals and, although the risk of serious infection with MRSA is lower in the community, it still exists and this organism is increasingly seen in community health care units, such as nursing homes. MRSA does not cross intact skin.

B.49. There is little risk of infection for healthy clinical staff; however, infection control is important to avoid transmission to vulnerable people.

MRSA in the community

B.50. MRSA detected in the community may be the result of:

- a. patients discharged from hospital with MRSA
- b. nursing home residents who have acquired MRSA
- c. MRSA transmitted to non-hospitalised patients, or other individuals, from MRSA patients, or
- d. MRSA arising naturally in the community.

B.51. If you examine a patient with a known transmissible infection, you should:

- a. increase the effectiveness of your hand hygiene by:
 - keeping nails short, clean and free of nail varnish, and by avoiding artificial nails

Guidance for professional practice

- avoiding wearing jewellery, especially rings with ridges or stones, and
 - avoiding wearing wristwatches, and
- b. keep in mind NHS policy on clinician attire by:
- wearing short sleeves or rolling up long sleeves, and
 - not wearing a tie.

Transmission via an inert agent

B.52. Transmission via an inert agent can be from a contaminated object, such as an ophthalmic device or piece of equipment, or via contaminated contact lens solution bottles or multi-dose eye drops that have been used on another patient.

List of agents that may harbour infection

B.53. The agents that may harbour infection are:

- a. contact lenses, contact lens cases and other paraphernalia
- b. ophthalmic devices such as:
- tonometer heads
 - pachymeters, and
 - diagnostic lenses that come into contact with the ocular surface, such as: gonioscopes, fundus lenses, three-mirror lenses and lenses used in conjunction with laser therapy, and
- c. the environment: bacteria may contaminate flat surfaces if they become airborne. Bacteria that are shed into the environment may survive for long periods in dust. Flat surfaces act as reservoirs for *S. aureus*, including MRSA, and contamination will transfer easily to hands when such surfaces are touched. Contamination on hands and/or gloves may be similarly transferred by contact with equipment, switches, phones, computer keyboards, door handles, light switches etc.

Methods of preventing infection transmission via an inert agent

Guidance for professional practice

B.54. You should use the following routine infection control precautions:

- a. maintain good hand hygiene,¹⁴ see paras B.19-B.32
- b. decontaminate equipment after use, see paras B.55-B.79
- c. disinfect used linen, and
- d. decontaminate the environment:
 - keep it clean and free from dust, and
 - disinfect spills of body fluid.

Principles of cleaning, sterilisation and disinfection

B.55. You should decontaminate equipment that regularly comes into contact with patients, including:

- a. trial frames
- b. chin and forehead rests
- c. refractor heads
- d. handheld occluders
- e. rulers
- f. tonometer heads
- g. gonioscopes and other diagnostic lenses, and
- h. contact lenses.

B.56. You should decontaminate equipment in all situations where you or your patients are at risk of any known transmissible infection, including settings such as:

- a. nursing homes
- b. schools, or
- c. workplaces.

Guidance for professional practice

- B.57. There are three levels of decontamination. You should use the one that is most appropriate for the item being decontaminated. The three levels are:
- a. cleaning to remove organic or inorganic debris. This may be done with detergents or ultrasonic cleaning
 - b. disinfecting to reduce viable microorganisms with heat or chemicals, or
 - c. sterilising to kill or remove all microorganisms, including spores. This is not normally required in optometric practice.
- B.58. You must clean the items first.
- B.59. Not all equipment needs to be sterile before being used and you should:
- a. clean equipment which does not come into close contact with mucous membranes or sterile body areas, e.g. trial frames and refractor heads
 - b. clean surfaces in the consulting room, unless contaminated with body fluids, see d below
 - c. disinfect equipment which comes into close contact with intact mucous membranes
 - d. 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), and
 - e. sterilise equipment introduced into a sterile body area or in contact with a break in the skin or mucous membrane.
- B.60. You should have access to a hand basin in, or near, the consulting room.

Levels of decontamination

B.61. Agents recommended for cleaning and disinfection procedures:

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

Agent	Preparation	Examples of use
Chlorhexidine 5% in 70% isopropyl alcohol ²⁴	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% ^{24,24,163}	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)	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)	under normal usage, these agents are disinfectants, and not sterilants	disinfection of body fluid 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)

B.62. Items must be clean before progressing to disinfection or sterilisation.

The re-use of contact lenses and ophthalmic devices

B.63. If an instrument has been used on a patient it must be disinfected or sterilised.

B.64. There is a remote theoretical risk, identified by the Department of Health (DH), of transmitting prion proteins, which are associated with transmissible spongiform

Guidance for professional practice

encephalopathies (TSEs) and are implicated in Creutzfeldt-Jakob Disease (CJD) and variant CJD (vCJD), through re-useable ophthalmic devices and trial contact lenses. However, there is no evidence that this has occurred,²⁵ and this risk has been questioned.²⁶ The anterior eye has been designated as low risk.²⁵

- B.65. You should follow the advice of your local infection control team if available. If this is not available:
- a. You should use single patient use lenses and devices contacting the surface of the eye where practicable.
 - b. You should not re-use a lens or device that is intended by the manufacturer for single use.
 - c. 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, and
 - apply appropriate disinfection/contamination procedures. These should include the use of sodium hypochlorite solution where possible, see para B.61.²⁵

Definitions of contact lenses

- B.66. You should note these definitions of contact lenses:
- a. trial contact lens: a lens that is used to assess fitting, following which it is either disposed of by the clinician or dispensed to the patient. Currently the majority of contact lens patients are fitted with single patient use lenses of various types
 - b. special complex lens: a lens used by the clinician to assess performance of the design on the eye, which may be necessary where there is disease or abnormality of the lid, cornea or ocular surface. These lenses may be re-used.
- B.67. The above definitions can apply to the following categories of lenses:
- a. hydrogel lenses
 - b. silicone hydrogel lenses
 - c. hybrid lenses, and
 - d. rigid lenses, including:
 - corneal

Guidance for professional practice

- sclera
- scleral shells, and
- ocular prostheses.

B.68. Special complex lenses may be of any type. If you use these lenses you ~~must~~should ~~carry out appropriate disinfection.:~~

~~a. use them only within your premises and they must be under your control or that of another clinician at all times~~

~~b. carry out appropriate decontamination~~

~~c. keep full records to show the usage of each lens, and~~

~~inform the patient of the risks and benefits associated with contact lens fitting. See section on Fitting contact lenses.~~

Definitions of ophthalmic devices

B.69. An ophthalmic device is any instrument which comes into contact with the ocular surface, including:

- a. tonometer
- b. contact pachymeter
- c. gonioscope, or
- d. other lens to aid diagnosis of disease.

B.70. Where it is practicable you should use single use devices, such as disposable tonometer heads or tips.

B.71. Some devices are not able to withstand certain forms of disinfection~~contamination~~; in these cases you should use your professional judgement, bearing in mind that undetected disease may have sight- or life-threatening consequences.

B.72. You must explain to the patient the risks and benefits of re-using a device.

How to ~~disinfect~~decontaminate

B.73. The following advice reduces the potential risk of iatrogenic transmission of CJD/vCJD via contact devices.

Guidance for professional practice

- B.74. You should not use alcohol wipes alone to ~~disinfect~~~~contaminate~~ contact devices as they are ineffective against many organisms, and may fix prion proteins to the surface of the instrument.²⁵
- B.75. Prion proteins adhere strongly to materials including smooth surfaces. You should ensure that the device is thoroughly cleaned to remove adhered debris as the potential for the transmission of cellular and proteinaceous debris via tonometer prisms has been demonstrated.^{27,28}
- B.76. You ~~should~~~~must~~ 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 para B.78-B.79.
- B.77. You should use 1% sodium hypochlorite solution to ~~disinfect~~ ~~econtaminate~~. The concentration advised has been reduced to a level which is:²⁵
- a. appropriate for inactivating infectious agents such as bacteria and viruses, and
 - b. less harmful to the eye than stronger concentrations if it accidentally comes into contact with it.
- B.78. You need the following equipment for ~~disinfection~~~~econtamination~~ of contact lenses or ophthalmic devices:
- a. water for irrigation BP, or sterile normal saline
 - b. cleaning solution, such as liquid soap or detergent, and
 - c. sodium hypochlorite solution 1% (10,000 ppm of available chlorine).
- B.79. You should follow this process to ~~disinfect~~~~contaminate~~ contact lenses or an ophthalmic device:

Step	ACDP TSE WG, 2011 recommendation ²⁵	Notes
When to disinfect contaminate	immediately after use	immediately disinfect contaminate 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 econtaminated .
Do not dry	do not allow to dry	
Rinse	in water for irrigation BP/sterile normal saline for at least 30 sec	

Step	ACDP TSE WG, 2011 recommendation ²⁵	Notes
Clean	rubbing with liquid soap or detergent	thoroughly clean the item (including by rubbing) to remove cellular debris and adherent protein
Disinfect/contaminate	using sodium hypochlorite 1% (10,000 ppm of available chlorine) for 10 min	disinfect/contaminate 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

Measures to take in case of accident

B.80. Chlorine can be toxic to the eye, but if you follow the disinfection/contamination guidelines correctly there is no situation in which sodium hypochlorite solution comes into contact with a patient's eye. However, if this does occur, you should follow this process:

- a. irrigate the affected eye immediately with copious quantities of sterile normal saline solution or water
- b. check the ocular surface for epithelial damage using fluorescein
- c. examine the anterior segment for inflammation
- d. check intraocular pressure
- e. if there are no clinically significant signs, advise the patient to re-attend the practice if they experience any problems with their eyes, otherwise you should re-examine them at the normal interval
- f. if there are clinically significant signs, you should re-examine the patient the following day or refer them to the Hospital Eye Service, as appropriate
- g. record any adverse incident centrally, in your practice's system or in the practice Accident Book, and

Guidance for professional practice

- h. if you feel it is appropriate, report the incident to the National Reporting and Learning System which is anonymous and helps lessons to be learnt from adverse incidents.²⁹

Storage and handling

B.81. You are not required to label sodium hypochlorite 1% solution as harmful or irritant under the COSHH regulations.³⁰ You should follow appropriate measures for safe storage, access and handling.

Contamination via contact lens solutions and medicine bottles

B.82. You should carefully maintain all contact lens care products and medicines used during examination and discard any prior to their expiry date.

B.83. You should:

- a. be aware that multi-dose containers can be a source of infection
- b. be aware that varying levels of contamination exist in plastic bottles containing contact lens solutions, and
- c. note when these bottles are opened and discard them according to manufacturer's guidelines, which vary depending on the product and its use.

B.84. You should:

- a. keep the dropper tip free from contamination
- b. replace the lid on the container immediately after use as all solutions are susceptible to contamination during the time that caps are removed, and
- c. dispose of solutions immediately if you suspect contamination.

B.85. Use single use drug delivery systems, where possible.

Situations of increased concern – transmission via a contaminated object

High-risk groups

B.86. Patient groups that have been identified as being at greater than normal risk of developing transmissible spongiform encephalopathies (TSE) include: [Error!](#)
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Guidance for professional practice

- a. patients with a family history of CJD or other prion disease
- b. recipients of pituitary derived hormones such as human growth hormone or gonadotrophins
- c. patients who have had surgery on the brain or spinal cord, or
- d. patients who have, since 1980, received more than 50 units of blood or have received blood or blood components on more than 20 occasions.

Examining a patient in a high-risk group

- B.87. Before carrying out any procedure that might involve the re-use of a contact lens or ophthalmic device you should, as far as possible, question the patient to establish if they fall into any of the above high-risk groups. If the patient is in a high-risk group you must only use items intended for single patient use. If this is not possible you should consider referring the patient to the Hospital Eye Service.
- B.88. If you use a re-usable item in an emergency with a patient in one of the above high-risk groups you should discard it immediately after use.
- B.89. If you examine a patient with a known transmissible infection, you should:
- a. cover cuts and abrasions to skin with waterproof dressings (preferably coloured)¹⁴
 - b. carry out hand hygiene before and after each patient contact and before and after leaving their home or care home, see paras B.19-B.32, and
 - c. follow the guidance in paras B.51.a and B.51.b.

Safe disposal of waste

- B.90. You must take all reasonable steps to deal appropriately with controlled, clinical and offensive waste, including both non-hazardous and hazardous waste.^{31,32,33,34}
- B.91. Controlled waste is defined as waste from households, industry or commerce.
- B.92. Clinical waste means waste from a healthcare activity, and waste of a similar nature from a non-healthcare activity, that:³⁵
- a. contains viable microorganisms or their toxins which are known or reliably believed to cause disease in humans or other living organisms
 - b. contains or is contaminated with a medicine that contains a biologically active pharmaceutical agent, or

Guidance for professional practice

- c. is a sharp, or a body fluid or other biological material (including human and animal tissue) containing or contaminated with a dangerous substance within the meaning of Council Directive 67/548/EEC on the approximation of laws, regulations and administrative provisions relating to the classification, packaging and labelling of dangerous substances.

B.93. Offensive waste means waste that:³⁶

- a. is not clinical waste
- b. contains body fluids, secretions or excretions, and
- c. falls within code 18-01-04, 18-02-03 or 20-01-99 in Schedule 1 to –
 - the List of Wastes (England) Regulations 2005, in relation to England,³⁷ or
 - the List of Wastes (Wales) Regulations 2005, in relation to Wales.³⁸

Useful information and links

Department of Health and Social Care (2013): Prevention and control of infection in care homes. Available from: gov.uk/government/publications/infection-prevention-and-control-in-care-homes-information-resource-published [Accessed 12 Dec 2019]

Environmental management: Waste. Available from: gov.uk/topic/environmental-management/waste [Accessed 5 Dec 2019]

NetRegs. Environmental guidance for your business in Northern Ireland and Scotland. [Available from: netregs.org.uk](http://netregs.org.uk) [Accessed 5 Dec 2019]

National Institute of Health and Care Excellence (2017): Healthcare-associated infections: prevention and control in primary and community care CG139. Available from: nice.org.uk/guidance/CG139 [Accessed 12 Dec 2019] and interactive flowchart, available from: pathways.nice.org.uk/pathways/prevention-and-control-of-healthcare-associated-infections#path=view%3A/pathways/prevention-and-control-of-healthcare-associated-infections/prevention-and-control-of-healthcare-associated-infections-in-primary-and-community-care.xml&content=view-index [Accessed 12 Dec 2019]

Royal College of Ophthalmologists (2016) Ophthalmic instrument decontamination. Available from: rcophth.ac.uk/wp-content/uploads/2014/12/Ophthalmic-Instrument-Decontamination.pdf [Accessed 5 Dec 2019]

SEPA, NIEA, CNC and EA (2015) Guidance on the classification and assessment of waste. Available from: sepa.org.uk/media/162490/waste-classification-technical-guidance-wm3.pdf [Accessed 5 Dec 2019]

University of Leicester (2009) Washing your hands with alcohol rub. Video, available from: [youtube.com/watch?v=Gems7BFCqTE](https://www.youtube.com/watch?v=Gems7BFCqTE) [Accessed 5 Dec 2019]

¹⁰ Health Protection Agency/Public Health Agency NI (2017) Guidance on infection control in schools and other childcare settings. Available from: publichealth.hscni.net/sites/default/files/Guidance_on_infection_control_in%20schools_poster.pdf [Accessed 5 Dec 2019]

¹¹ [nhs.gov.uk/healthservices/needlesticks/index.htm](https://www.nhs.gov.uk/healthservices/needlesticks/index.htm) [Accessed 5 Dec 2019]

¹² [nhs.uk/common-health-questions/accidents-first-aid-and-treatments/what-should-i-do-if-i-injure-myself-with-a-used-needle/](https://www.nhs.uk/common-health-questions/accidents-first-aid-and-treatments/what-should-i-do-if-i-injure-myself-with-a-used-needle/) [Accessed 5 Dec 2019]

¹³ General Optical Council (2016) Standards of Practice for Optometrists and Dispensing Opticians para 12.1 Available from: standards.optical.org [Accessed 5 Dec 2019]

¹⁴ National Institute for Health and Care Excellence (2017) Healthcare-associated infections: prevention and control in primary and community care. Clinical Guideline 139. Available from: [nice.org.uk/guidance/cg139](https://www.nice.org.uk/guidance/cg139) [Accessed 5 Dec 2019]

¹⁵ British Standards Institute (2013) Chemical disinfectants and antiseptics. Hygienic handrub. Test method and requirements (phase 2/step 2). BS EN 1500:2013
College members can access British Standards Online via the College website college-optometrists.org/the-college/library-and-information-services/online-databases-and-reports.html [Accessed 5 Dec 2019]

¹⁶ Chlorhexidine is known to induce hypersensitivity, including generalised allergic reactions and anaphylactic shock. The prevalence of chlorhexidine hypersensitivity is unknown but is likely to be very rare. For further information see MHRA (2012) Chlorhexidine: reminder of potential for hypersensitivity Available from: [gov.uk/drug-safety-update/chlorhexidine-reminder-of-potential-for-hypersensitivity](https://www.gov.uk/drug-safety-update/chlorhexidine-reminder-of-potential-for-hypersensitivity) [Accessed 5 Dec 2019].

¹⁷ NHS Choices. *Catch it, Bin it, Kill it*. Available from: www.gov.uk/government/news/catch-it-bin-it-kill-it-campaign-to-help-reduce-flu-infections [Accessed 5 Dec 2019]

¹⁸ Health and Safety Executive: Pandemic Flu – Workplace guidance. Available from: [hse.gov.uk/biosafety/diseases/pandflu.htm](https://www.hse.gov.uk/biosafety/diseases/pandflu.htm) [Accessed 5 Dec 2019]

¹⁹ Pratt RJ, Pellowe CM, Wilson JA et al (2007) Epic2: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. *Journal of Hospital Infection* 65(S1) S1-S61, but see page S22

²⁰ NHS Plus, Royal College of Physicians, Faculty of Occupational Medicine (2008) Latex allergy: occupational aspects of management. A national guideline. Available from: [rcplondon.ac.uk/guidelines-policy/latex-allergy-occupational-aspects-management-2008](https://www.rcplondon.ac.uk/guidelines-policy/latex-allergy-occupational-aspects-management-2008) [Accessed 5 Dec 2019]

²¹ Health and Safety Executive. *Latex allergies*. Available from: [hse.gov.uk/skin/employ/latex.htm](https://www.hse.gov.uk/skin/employ/latex.htm) [Accessed 5 Dec 2019]

²² The Health and Safety (Sharp Instruments in Healthcare) Regulations SI 645 of 2013.

²³ Health and Safety Executive (2013) Health and Safety (Sharp Instruments in Healthcare) Regulations 2013: Guidance for employers and employees Available from: [hse.gov.uk/pubns/hsis7.pdf](https://www.hse.gov.uk/pubns/hsis7.pdf) [Accessed 5 Dec 2019]

²⁴ Coia JE, Duckworth GJ, Edwards DI et al (2006) Guidelines for the control and prevention of methicillin-resistant *Staphylococcus aureus* (MRSA) in healthcare facilities. *Journal of Hospital Infection* 63 Suppl 1:S1-44

²⁵ Managing CJD/vCJD risk in ophthalmology Annex L In: Department of Health. Advisory Committee on Dangerous Pathogens Transmissible Spongiform Encephalopathy (ACDP TSE) Risk Management Subgroup (2011) Guidance on prevention of CJD and vCJD. Available from: [gov.uk/government/uploads/system/uploads/attachment_data/file/209770/Annex_L_-_Managing_CJD_vCJD_risk_in_ophthalmology.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209770/Annex_L_-_Managing_CJD_vCJD_risk_in_ophthalmology.pdf) [Accessed 5 Dec 2019]

²⁶ Buckley R (2010) Decontamination. *Optometry in Practice* 11(1), 25-29

²⁷ For cellular debris: Lim R, Dhillion B, Kurian KM et al (2003) Retention of corneal epithelial cells following Goldmann tonometry: implications for CJD risk. *British Journal of Ophthalmology* 87(5), 583-586

²⁸ For proteinaceous debris: Amin SZ, Smith L, Luthert PJ et al (2003) Minimising the risk of prion transmission by contact tonometry. *British Journal of Ophthalmology* 87(11), 1360-1362

²⁹ National Reporting and Learning System (NRLS), available from: nrls.npsa.nhs.uk/report-a-patient-safety-incident/about-reporting-patient-safety-incidents/

³⁰ The Control of Substances Hazardous to Health Regulations 2002 SI 2677. Available from legislation.gov.uk/ukksi/2002/2677/regulation/7/made

³¹ Environmental Protection Act, 1990. Available from: legislation.gov.uk/ukpga/1990/43/contents

³² College of Optometrists (2014) Guidance on the disposal of waste. Available from: college-optometrists.org/en/utilities/document-summary.cfm/docid/4E9BEE2D-12AF-4E0C-80D90ACCF0B6DE00 [College members only] [Accessed 12 Dec 2019]

³³ Scottish Environment Protection Agency (SEPA). Clinical waste. Available from : sepa.org.uk/waste/waste_regulation/clinical_waste.aspx [Accessed 12 Dec 2019]

³⁴ Northern Ireland Department of Agriculture, Environment and Rural Affairs. Waste. Available from: daera-ni.gov.uk/topics/waste [Accessed 12 Dec 2019]

³⁵ Controlled Waste Regulations 2012 SI 588. Available from: legislation.gov.uk/ukksi/2012/811/contents

³⁶ Classify different types of waste. Available from: gov.uk/how-to-classify-different-types-of-waste/healthcare-and-related-wastes [Accessed 12 Dec 2019]

³⁷ The List of Wastes (England) Regulations 2005 SI 895. Available from legislation.gov.uk/ukksi/2005/895/contents

³⁸ The List of Wastes (Wales) Regulations 2005 SI 1820. Available from: legislation.gov.uk/wsi/2005/1820/contents/made

Protecting patients, colleagues and others from harm

Key points

- You must raise concerns about patient care and safety, including any practitioner's fitness to practise.
- Raising a concern is also known as whistleblowing.
- In some circumstances you are protected in law when you raise a concern.
- You should act quickly.
- You should keep a record of any concerns.
- You must protect patient confidentiality.
- You should record adverse incidents centrally, for example in your practice's system or in the practice Accident Book.
- You should report near misses involving NHS-funded patients in England and Wales to the National Reporting and Learning System and to the equivalent bodies in the other UK countries.

[This Guidance does not change what you must do under the law.](#)

Raising concerns

B.94. You must act quickly to protect patients from risks posed by colleagues. The safety of patients must come first. If you have serious concerns about any practitioner's fitness to practise you should raise this with them first if you feel able to.

B.95. If necessary you should escalate your concerns to an appropriate person.³⁹ This could be the colleague's line manager, employer, or person in a Primary Care Organisation or hospital. If you remain concerned you should consult the relevant professional, representative or regulatory body.

B.96. Raising a concern is different from making a complaint. If you make a complaint, you might be asked for evidence to prove your case. When you raise a concern, you should not be expected to prove the issue you are concerned about, although you do need to have a reasonable belief that wrongdoing is happening, has taken place in the past, or is likely to happen in the future. If you are not sure whether you should act, ask yourself:

- a. what might the outcome be in the short- or longer-term if I do not raise my concern? And
- b. how could I justify why I did not raise the concern?

See section on Working with colleagues.

B.97. Examples of what you should report include:

Guidance for professional practice

- a. very poor treatment
- b. failure to gain patient consent to treatment
- c. cross-infection problems, for example use of dirty equipment
- d. sexual assault or abuse. See section on Maintaining boundaries
- e. practising under the influence of drink or drugs
- f. fraud or theft, or
- g. inadequate malpractice insurance.

B.98. You should:

- a. act quickly, and
- b. keep a record of the concerns you have raised, and actions you have taken. The record should be as detailed as possible, and not influenced by personal feelings or opinions. [The record should be verifiable or auditable, and you should keep a time line record of any communications.](#)

B.99. You must protect patient confidentiality. See section on Confidentiality.

B.100. In certain circumstances, you are protected in law from harassment or bullying when you raise a concern. This is known as 'protected disclosure'.^{40,41} [If you are making what you believe to be a protected disclosure you should make it clear to the person you are making the disclosure to that you believe the disclosure to be protected, and your reasons for this.](#)

B.101. In order to receive the protections of the Public Interest Disclosure Act you must follow your employer's policy, if it is a reasonable one. If you feel that your employer's policy is not reasonable then please contact your professional or representative body, or you can contact Public Concern at Work.⁴²

B.102. You should be able to raise your concern confidentially, so your name is not revealed unless this is required by law. When you raise your concern you need to make it clear if you are doing so confidentially. This is different from raising a concern anonymously, when you refuse to give your name.

Adverse incidents and near misses

B.103. An adverse incident is where harm has occurred, and a near miss is where harm could have occurred.

Guidance for professional practice

B.104. If an adverse incident occurs you should ~~take the following steps; this is what is meant by duty of candour:~~

- a. apologise to the patient
- b. explain what has happened, and
- c. explain any remedial action.

This is what is meant by the duty of candour.

B.105. If necessary, you should also:

- a. investigate the adverse incident
- b. take the appropriate action, and
- c. keep a written record.

B.106. You should record any adverse incident somewhere central to the practice, for example in your practice's system or in the practice Accident Book. This applies even if it was not due to any fault of the practice or practitioner.

B.107. If a near miss occurs, you should learn from it and you should reassure the patient if you think it caused them concern.

B.108. You should report any near misses or adverse clinical incidents involving patients receiving NHS funded care:

- a. in England and Wales to the National Reporting and Learning System (NRLS). This does not collect any patient or practitioner identifiable information⁴³
- b. in Scotland to your local health board, and
- c. in Northern Ireland to the Northern Ireland Adverse Incident Centre.⁴⁴

B.109. If the adverse incident was due to a drug or medical device you should report this to the Medicines and Healthcare Products Regulatory Agency, as appropriate.^{45,46} See sections on Infection and Use and supply of drugs or medicines in optometric practice.

Useful information and links

British Medical Association. Raising concerns. Available from:
bma.org.uk/advice/employment/raising-concerns [Accessed 12 Dec 2019]

Guidance for professional practice

Care Quality Commission. Raising a concern with CQC. A quick guide for health and care staff about whistleblowing. Available from: cqc.org.uk/sites/default/files/20160108_Whistleblowing_quick_guide_final_update.pdf [Accessed 12 Dec 2019]

General Optical Council (2019) Standards for Optical Businesses, Standard 1.1 standards.optical.org/the-standards/ [Accessed 12 Dec 2019]

General Optical Council (2016) Raising concerns with the GOC (whistleblowing) *policy*. Available from: optical.org/en/Investigating_complaints/raising-concerns.cfm [Accessed 12 Dec 2017]

National Advisory Group on the Safety of Patients in England (2013) A promise to learn – a commitment to act. Improving the safety of patients in England. Available from: gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf [Accessed 12 Dec 2019]

NHS Improvement. Patient safety. Available from: improvement.nhs.uk/improvement-hub/patient-safety/ [Accessed 12 Dec 2019]

NHS Improvement (2016) Freedom to speak up: raising concerns policy for the NHS Available from: improvement.nhs.uk/resources/freedom-to-speak-up-whistleblowing-policy-for-the-nhs/ [Accessed 12 Dec 2019]

NHS Scotland Confidential Alert Line 0800 008 6112 gov.scot/Topics/Health/NHS-Workforce/Employee-Experience/NHS-staff-alert-line [Accessed 12 Dec 2019]

Public Concern at Work www.pcaw.org.uk [Accessed 12 Dec 2019]

Public Health Wales (2013) All Wales Raising Concerns (Whistleblowing) Policy Available from: [www2.nphs.wales.nhs.uk:8080/phwpapersdocs.nsf/\(\\$all\)/765d60ff0c871fe280257be1005828f4/\\$file/27%2011b%20all%20wales%20raising%20concerns%20\(whistleblowing\)%20policy%2021-08-2013.pdf](http://www2.nphs.wales.nhs.uk:8080/phwpapersdocs.nsf/($all)/765d60ff0c871fe280257be1005828f4/$file/27%2011b%20all%20wales%20raising%20concerns%20(whistleblowing)%20policy%2021-08-2013.pdf) [Accessed 12 Dec 2019]

Speakup Helpline 08000 724 725 speakup.direct [Accessed 12 Dec 2017]

Whistleblowing for employees Available from: gov.uk/whistleblowing [Accessed 12 Dec 2019]

³⁹ General Optical Council (2016) Standards of practice for optometrists and dispensing opticians para 11.3 Available from: standards.optical.org/ [Accessed 12 Dec 2019]

⁴⁰ The Public Interest Disclosure Act 1998. Available from: legislation.gov.uk/ukpga/1998/23/contents

⁴¹ The Public Interest Disclosure (Northern Ireland) Order 1998. Available from: legislation.gov.uk/nisi/1998/1763/contents

⁴² Public Concern at Work www.pcaw.org.uk [Accessed 12 Dec 2019]

Guidance for professional practice

⁴³ Learning from patient safety incidents. Available from: improvement.nhs.uk/resources/learning-from-patient-safety-incident/ [Accessed 12 Dec 2019]

⁴⁴ Northern Ireland Adverse Incident Centre (NIAIC). Reporting an adverse incident. Available from: health-ni.gov.uk/articles/reporting-adverse-incident [Accessed 12 Dec 2019]

⁴⁵ MHRA Yellow Card Scheme. Available from: yellowcard.mhra.gov.uk/ [Accessed 12 Dec 2019]

⁴⁶ MHRA. Report a problem with a medicine or medical device. Available from: gov.uk/report-problem-medicine-medical-device [Accessed 12 Dec 2019]

Safeguarding children and ~~vulnerable~~ adults at risk

[This Guidance does not change what you must do under the law.](#)

[B.110.](#) You should follow the guidance issued by the Optical Confederation.⁴⁷

[B.111.](#) You should be familiar with local procedures for reporting concerns relating to safeguarding.¹

Useful information and links

[HM Government \(2015\) What to do if you're worried a child is being abused: Advice for practitioners. Available from assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/419604/What_to_do_if_you_re_worried_a_child_is_being_abused.pdf \[Accessed 13 Dec 2019\].](#)

[How to report someone as unfit to work with children or vulnerable adults. www.gov.uk/report-unfit-work-children-vulnerable-adults \[Accessed 13 Dec 2019\]](#)

[National Institute of Health and Care Excellence \(2017\): Child abuse and neglect \(NG76\). Available from: nice.org.uk/Guidance/ng76 \[Accessed 12 Dec 2019\]](#)

[NHS safeguarding app. available from myguideapps.com/projects/safeguarding/default/ \[Accessed 13 Dec 2019\]](#)

[NHS Wales \(2014\) Primary Care Guidance: Children and young people who are not brought to healthcare appointments Available from: wales.nhs.uk/sitesplus/documents/888/primary%20care%20guidance%20children%20and%20young%20people%20who%20are%20not%20brought%20to%20healthcare%20appointments.pdf \[Accessed 12 Dec 2019\]](#)

[NSCC: Safeguarding children and child protection. Available from learning.nspcc.org.uk/safeguarding-child-protection/ \[Accessed 13 Dec 2019\]](#)

[Office of the Public Guardian \(2015\): Safeguarding policy. This gives definitions of safeguarding. Available from: assets.publishing.service.gov.uk/government/uploads/system/uploads/attach](#)

¹ For example, the NHS safeguarding app. available from [myguideapps.com/projects/safeguarding/default/ \[Accessed 13 Dec 2019\]](#)

Guidance for professional practice

[ment_data/file/595194/SD8-Office_of-the-Public-Guardian-safeguarding-policy.pdf](#) [Accessed 13 Dec 2019]

[Royal College of Nursing \(2019\). Safeguarding children and young people: Roles and competencies for healthcare staff intercollegiate document. Available from: rcn.org.uk/professional-development/publications/pub-007366](#) [Accessed 12 Dec 2019]

[Social Care Institute for Excellence: Safeguarding people with dementia. Available from: scie.org.uk/dementia/after-diagnosis/support/safeguarding.asp](#) [Accessed 12 Dec 2019]

⁴⁷ Optical Confederation (2019) Guidance on safeguarding, mental capacity, deprivation of liberties and the Prevent Strategy. Protecting children and vulnerable adults. Available from: [www.fodo.com/guidance/safeguarding/](#) [Accessed 6 Feb 2020]

Communication, partnership and teamwork

Partnership with patients

Key points

To maintain a good relationship with your patients you must:

- make the care of the patient your first and overriding concern.
- give patients information in a way they can understand and make them aware of what to expect.
- respect patients' dignity and privacy.
- listen to patients and take account of their views.
- assist patients in exercising their rights and making informed decisions about their care.
- respect the choices they make.

[This Guidance does not change what you must do under the law.](#)

Communicating effectively with patients

- C.1. You must make the care of the patient your first and overriding concern.⁴⁸
- C.2. You must give your patients information in a way they can understand and make them aware of what to expect. They should have the opportunity to ask questions or change their mind.⁴⁹
- C.3. You must be alert to unspoken signals which could indicate a patient's lack of understanding, discomfort, or lack of consent.⁵⁰
- C.4. You should identify yourself clearly to your patients, including your name, as it is shown on the GOC register.
- C.5. You should not make false or misleading statements, for example when describing your knowledge, experience or specialty.
- C.6. Only if you are currently a College member can you use the affix MCOptom or FCOptom. You should not use this in conjunction with the affixes D.Optom, FBOA, FSMC or FSAO.
- C.7. You should give patients the following, as appropriate:
 - a. full and accurate information about the optometric services you offer

College of Optometrists

- b. an explanation of technical expressions
 - c. information about their condition
 - d. a clear description of what can and cannot be achieved with a prescribed appliance
 - e. written information, for example appointment letters, in:
 - accessible formats, and
 - large print for visually impaired people,⁵¹ and
 - f. clear information about any referrals. See section on Working with colleagues.
- C.8. You must respect patients' dignity and privacy. This includes a patient's right to confidentiality.
- C.9. You must listen to patients and take account of their views, including their preferences and concerns, responding honestly and appropriately to their questions.
- C.10. You should not convey disapproval of patients' preferences, life choices or beliefs.
- C.11. You should encourage patients to comment on the services you provide.
- C.12. You should make arrangements, where it is practical, to meet patients' communication and language needs.
- C.13. If you are responsible for practice staff you should ensure they have relevant training in communication skills and the awareness of visual impairment.
- C.14. You should allow patients to be accompanied by someone in the consulting room.
- C.15. You must assist patients fully in exercising their rights and making informed decisions about their care. You must respect the choices they make.
- C.16. If you are examining children, or adults with learning disabilities or acquired cognitive impairment, you should involve parents or carers in making decisions as appropriate and where it is in the patient's best interests. See section on Consent.

College of Optometrists

C.17. You should offer patients appropriate written information about local or national services which can help them, for example how those diagnosed with sight-threatening conditions can get help. Leaflets on some eye conditions are available from the College.

C.18. You do not have to tolerate abusive behaviour.

Methods of Communication

C.19. If you provide NHS services you must take steps to provide information to disabled patients in a format of their choice. This may, for example, include writing to them in large print, or sending them information electronically. The Optical Confederation has produced guidance on this.⁵²

C.20. You should ask for patient consent if you wish to communicate with your patients using electronic methods, such as email or text. You should act promptly if a patient asks to receive their communications in a different format. The Information Governance team of NHS England has provided guidance on using email and text messaging for communication with patients.⁵³ If you do not provide NHS services, you should take similar steps.

Communicating about the costs of your services

C.21. You must explain to patients the costs of the professional services and products you are offering before they commit to payment.^{54 55}

C.22. You should itemise the costs of:

- a. options available for lenses and frames, and
- b. any additional features, such as coatings or tints.

Further information

National Institute of Health and Care Excellence (2012): Patient experience in adult NHS services: improving the experience of care for people using adult NHS services [nice.org.uk/guidance/cg138/chapter/1-guidance](https://www.nice.org.uk/guidance/cg138/chapter/1-guidance)

⁴⁸ General Optical Council. (2016) Standards of Practice for Optometrists and Dispensing Opticians standards.optical.org [Accessed 2 Jan 2020]

⁴⁹ General Optical Council. (2016) Standards of Practice for Optometrists and Dispensing Opticians standards.optical.org [Accessed 2 Jan 2020]

⁵⁰ General Optical Council (2016) Standards of Practice for Optometrists and Dispensing Opticians, para 2.3 standards.optical.org [Accessed 2 Jan 2020]

⁵¹ In England, the Accessible Information Standard applies for NHS patients, including those using General Ophthalmic Services. See [england.nhs.uk/ourwork/accessibleinfo/](https://www.england.nhs.uk/ourwork/accessibleinfo/) [Accessed 2 Jan 2020]

⁵² Optical Confederation (2016) NHS Accessible Information Standard guidance for community optical practices [opticalconfederation.org.uk/downloads/accessibleinfoguidanceopticalconfedjuly16.pdf](https://www.opticalconfederation.org.uk/downloads/accessibleinfoguidanceopticalconfedjuly16.pdf) [Accessed 2 Jan 2020]

⁵³ [england.nhs.uk/wp-content/uploads/2016/04/Using-email-and-text-messages-for-communicating-with-patients.pdf](https://www.england.nhs.uk/wp-content/uploads/2016/04/Using-email-and-text-messages-for-communicating-with-patients.pdf) [Accessed 2 Jan 2020]

⁵⁴ Consumer Protection from Unfair Trading Regulations 2008, SI 1277. Available from: legislation.gov.uk/uksi/2008/1277/contents

⁵⁵ Price Marking Order 2004 SI102. Available from: legislation.gov.uk/uksi/2004/102/contents/made

Consent

Key points

- You must respect the rights of patients to be fully involved in decisions about their care.
- You must obtain consent from patients who have capacity before starting treatment.
- Making decisions about treatment for patients who lack capacity is governed in England and Wales by the Mental Capacity Act 2005, in Scotland by the Adults with Incapacity (Scotland) Act 2000 and in Northern Ireland by the Mental Capacity Act 2016 (not yet in force).
- Patients over the age of 16 are presumed to have capacity to consent.
- You should involve children and young people (aged 16–17) in discussions about their treatment.
- The legal framework for treating children and young people who lack the capacity to consent differs across the UK.
- You should encourage children and young people to involve their parents in decision-making.

[This Guidance does not change what you must do under the law.](#)

Gaining consent to treatment from adults

- C.23. You must respect the rights of patients to be fully involved in decisions about their care.⁵⁶
- C.24. If the patient has the capacity to consent, you must obtain their consent before a physical examination, starting treatment or helping them with their eye care, for example putting in drops or contact lenses.^{57,58,59,60,61}
- C.25. Patients can give consent orally or in writing, or may imply consent by their behaviour, such as resting their chin on the chin rest after you have explained the procedure. However, acquiescence when the patient does not know what the examination or treatment entails is not consent.
- C.26 You should use your professional judgement to decide what type of consent is required.⁶² As most of the tests that are conducted during a routine eye examination are safe and non-invasive, implied consent would normally be sufficient for these. However, for more invasive tests, such as drop instillation, contact lens fitting or applanation tonometry you should obtain explicit consent from the patient.
- C.28. You should get written consent from a patient if:

College of Optometrists

- a. the investigation or treatment is complex or involves significant risks
 - b. there may be significant consequences for the patient's employment, or social or personal life
 - c. providing clinical care is not the primary purpose of the investigation or treatment, or
 - d. the treatment is part of a research programme or is an innovative treatment designed specifically for the patient's benefit.
- C.29. You are responsible for ensuring the patient has given valid consent. You may delegate this to another person only if you are sure they:
- a. are suitably trained and qualified
 - b. have sufficient knowledge of the proposed examination or treatment
 - c. understand the risks involved, and
 - d. are able to provide clear and accurate information in response to the patient's questions.
- C.30. If you delegate the task of seeking patient consent, but carry out the subsequent examination or treatment, you must be able to determine:
- a. whether the patient had the capacity to make the decision to proceed,⁶³ and
 - b. what steps to take if the patient lacked capacity to make that decision.
- C.31. In order for the consent to be valid, the patient must:
- a. have the capacity to consent
 - b. be informed about the procedure, and
 - c. understand the nature and purpose of the procedure.
- C.32. If you misrepresent the elements in paras [C.31.b](#)~~C.31.b~~[C.30.b](#) or [C.31.c](#)~~C.31.c~~[C.30.e](#) the patient's consent will be invalid.
- C.33. You should provide information to the patient in a balanced way and explain your reasons for any particular course of action that you recommend.
- [C.34. You must 'take reasonable care' to make sure that the patient is aware of any material risks involved in any treatment or procedure, and of any reasonable alternatives. What constitutes a material risk will depend both](#)

College of Optometrists

on what a reasonable person would consider to be significant, as well as what is significant to your particular patient.^{64,65} Failure to do this may mean you have breached your duty of care and make you liable in negligence if the patient suffers harm as a result of the treatment. You should not withhold any information necessary for the patient to make a decision, unless the patient specifically asks not to have the information. You should keep a record of any discussions.

- ~~C.34. You must provide all relevant information to the patient; failure to do this may mean you have breached your duty of care and make you liable in negligence if the patient suffers harm as a result of the treatment. You should not withhold any information necessary for the patient to make a decision, unless the patient specifically asks not to have the information. You should then record this in the patient notes.~~
- C.35. You should find out what information the patient wants as well as telling them what you think they need to know. What patients might want to know includes:
- a. the options available: risks and benefits
 - b. which option you feel is the most appropriate for them and why, and
 - c. the cost of various options
- C.36. If a carer or relative asks you to withhold information from the patient, you should not do so, unless you feel that giving the patient the information would cause serious harm. 'Serious harm' means more than the patient becoming upset or refusing treatment. If you withhold information from the patient you must record the reason in the patient notes.
- C.37. You should not put pressure on the patient to accept your recommendation.
- C.38. You should give patients with additional needs the time and support to make a decision.
- C.39. The patient may withhold their consent for any part of the consultation.
- C.40. It may constitute battery if you touch a patient without their consent.
- C.41. You should always seek legal advice if you have any doubt about the legal validity of the examination or treatment.
- C.42. Gaining consent from a patient is not a one-off event and is part of the ongoing liaison between you and the patient. You should be alert to unspoken signals which could indicate a patient's lack of understanding, discomfort, or lack of consent.⁶⁶ A patient who is capable of giving consent may withdraw it at any time, including during a procedure. If your patient does object during a procedure you should:

College of Optometrists

- a. stop the procedure, if possible
- b. find out the patient's concerns
- c. establish if it is an expression of anxiety rather than withdrawal of consent
- d. give reassurance, and
- e. explain the consequences of not completing the procedure.

C.43. An adult patient with the capacity to consent has the right to refuse any treatment, even if you feel that their decision is unwise or it would lead to them (but no one else) suffering serious harm. If you believe that there is a risk of serious harm to the patient or others due to their decision to refuse a treatment or service, such as referral, you must raise this issue with appropriate healthcare colleagues or people involved in the patient's care.⁶⁷ However, you must respect the patient's confidence when you do this.⁶⁸ This can be done by discussing the case in general without revealing details which may identify the patient. See section on Confidentiality.

Capacity to consent – adults

C.44. To make a decision about care the patient should be able to:

- a. understand and remember the information provided
- b. weigh up the information provided, and
- c. tell you their decision.

C.45. A patient's capacity may vary from one day to the next or depend on the decision they are being asked to make. You should not assume that just because the patient does not have capacity on one occasion, they lack the capacity to make all decisions.

C.46. Making decisions about treatment and care for patients who lack capacity is governed in:

- a. England and Wales by the Mental Capacity Act 2005.⁶³⁶³²⁰⁴ The Act is supported by a Code of Practice for healthcare workers which you should refer to.⁶⁹ A person lacks capacity if, at the time the decision needs to be made, they are unable to make or communicate the decision because of an 'impairment or disturbance' that affects the way their mind or brain works. Further information for those practising in England is available from the Department of Health.⁷⁰

- b. Scotland by the Adults with Incapacity (Scotland) Act 2000.⁷¹ The Act is supported by Codes of Practice for healthcare professionals which you should refer to.⁷² A person lacks capacity if they cannot make decisions or communicate them, or understand or remember their decision, because of a mental disorder or a physical inability to communicate in any form.
 - c. Northern Ireland by the Mental Capacity Act (Northern Ireland) 2016, [which partially commenced in late 2019 \(phase one – for deprivation of liberty, offences, research and money and valuables\) \(not yet in force\)](#).⁷³ The Act ~~is will be~~ supported by ~~a~~ Codes of Practice ~~for healthcare workers for phase one of the implementation~~ [which you should refer to](#). A person lacks capacity if, at the time the decision needs to be made, they are unable to understand information, retain information, appreciate the relevance of the information or communicate their decision because of an impairment of, or a disturbance in, the function of the mind or brain. The timescales for implementing [the remainder/certain parts](#) of the Act are as yet unclear, so you should seek legal advice if you have concerns about a person's capacity to make decisions.
- C.47. No one can make a decision on behalf of an adult who has capacity. If a patient asks you, or a relative or carer, to make decisions for them you should explain:
- a. that it is still important that they understand the options, and
 - b. what the treatment or investigation will involve.
- C.48. You must work on the presumption that every adult patient (over the age of 18) has the capacity to make decisions about their care, and to decide whether to agree to, or refuse, an examination, investigation or treatment.
- C.49. You must regard a patient as lacking capacity only once it is clear that, having been given all appropriate help and support, they cannot understand, retain, use or weigh up the information needed to make that decision, or communicate their wishes.
- C.50. You must not assume that a patient lacks capacity to make a decision solely because of their age, disability, appearance, behaviour, medical condition (including mental illness), beliefs, apparent inability to communicate, or the fact that they make a decision with which you disagree.
- C.51. A patient's ability to make decisions may depend on the nature and severity of their condition, or the difficulty or complexity of the decision.

- C.52. You must assess the patient's capacity to make an informed decision about the treatment and then assess if they are able to decide whether to have the treatment.
- C.53. If the patient does not have capacity, the Mental Capacity Act 2005 in England and Wales, and the Mental Capacity Act (Northern Ireland) 2016, enables the patient to authorise someone who is over 18 years of age to make decisions for them under a Lasting Power of Attorney (LPA). Alternatively, someone who has authority to make treatment decisions for that person, as a court appointed deputy, can give consent.^{74, 75} In Scotland the Adults with Incapacity (Scotland) Act 2000 enables someone to hold Power of Attorney (PoA). The phrase 'next of kin' has no legal definition or status, and such a person cannot give or withhold consent on behalf of the patient.
- C.54. There are two types of LPA. One that enables the attorney to make decisions regarding the patient's property and one that enables the attorney to make decisions regarding the patient's care or welfare. The care and welfare attorneys are called personal welfare LPAs in England and Wales, welfare PoAs in Scotland, and care, treatment and personal welfare LPAs in Northern Ireland. The attorney powers relating to the patient's property are valid if the patient has capacity. However, the attorney powers relating to care or welfare only come into play if the patient lacks capacity, or the attorney reasonably believes the patient lacks capacity. If you are relying on someone who has an LPA or a PoA to give consent on behalf of your patient you should keep a copy of the LPA or PoA document.
- C.55. You must take account of the advice on assessing capacity in the Codes of Practice that accompany the Mental Capacity Act 2005, the Adults with Incapacity (Scotland) Act 2000, the Mental Capacity Act (Northern Ireland) 2016, and other relevant guidance. If your assessment is that the patient's capacity is borderline, you must be able to show that it is more likely than not that they lack capacity.
- C.56. The decision or action taken on behalf of the patient who lacks capacity must be in their best interests.
- C.57. You should record in the patient notes your reasons for deciding that:
- a. the treatment is in the patient's best interests, and
 - b. the patient lacks capacity.
- C.58. You should offer patients who are likely to have difficulty retaining information a written record of your discussions and the decisions that were made.

Children and young people

General points on consent – children and young people

~~C.59.~~ The legal position concerning consent and refusal of treatment by those under the age of 18 is different from the position for adults. For the purposes of this guidance 'child' refers to someone aged below 16 and 'young person' refers to someone aged 16–17. ~~At 16 a young person is presumed to have capacity.~~ Children and young people cannot make a Lasting Power of Attorney.

~~C.59.~~

~~C.60.~~ You should involve children and young people as much as possible in discussions about their treatment, even if they are not able to make decisions on their own.⁷⁶

C.60. You may provide emergency treatment to a child or young person, or refer them without their consent, to save their life, or prevent serious deterioration in their health or vision.

Capacity to consent – children and young people

C.61. At 16 a young person is presumed to have capacity to make most decisions about their treatment.

C.62. Children under 16 have capacity to make decisions about their treatment if they are able to understand the nature, purpose and possible consequences of the proposed examination and treatment, as well as the consequences of non-treatment.^{77,78}

~~C.61.~~

Children and young people who lack the capacity to consent

C.63. You should involve children and young people as much as possible in discussions about their treatment, even if they are not able to make decisions on their own.⁷⁹

~~C.62.~~C.64. Where a child does not have the capacity to consent, you must get consent from someone with parental responsibility. Consent from one parent, providing that parent has the capacity to consent, is usually sufficient, but if parents cannot agree and disputes cannot be resolved informally you should seek legal advice about whether to apply to the court.

~~C.63.~~C.65. Not all parents have parental responsibility. If the parents were married at or after the child's conception, both will have parental responsibility, even if they have later divorced. For unmarried parents, both will have parental responsibility if they are named on the child's birth certificate and the child was born on or after:

College of Optometrists

- a. 1 December 2003 in England and Wales
- b. 15 April 2002 in Northern Ireland, and
- c. 4 May 2006 in Scotland

~~C.64~~C.66. The legal framework for the treatment of young people who lack the capacity to consent differs across the UK. In:

- a. England, Wales and Northern Ireland, parents can consent to investigations and treatment that are in the young person's interests
- b. England and Wales, treatment can also be provided in the young person's best interests without parental consent, although the views of parents may be important in assessing the young person's best interests
- c. Northern Ireland, treatment can be provided in the young person's best interests if a parent cannot be contacted, although practitioners should seek legal advice about applying for court approval for significant (other than emergency) interventions
- d. Scotland, young people who do not have the capacity to consent are treated as adults who lack capacity, and treatment may be given to safeguard or promote their health.

Children and young people with the capacity to consent

~~C.65. A child or young person's ability to make decisions depends more on their ability to understand and weigh up options, than on their age. When assessing a young person's capacity to make decisions, you should bear in mind that:~~

- ~~a. a child may have capacity to make decisions if you consider them to be capable of understanding the nature, purpose and possible consequences of the proposed examination and treatment, as well as the consequences of non treatment,^{80,81} and~~
- ~~b. at 16 a young person is presumed to have capacity to make most decisions about their treatment.~~

~~C.66~~C.67. You should encourage the child or young person to involve their parents in making decisions, unless the child or young person wishes to exclude them.

~~C.67~~C.68. You must get the child or young person's consent to sharing their information if you involve the family.

College of Optometrists

~~C.68~~-C.69. If a child with the capacity to consent has consented to treatment that you consider is in the child's best interests, parents cannot override this.

~~C.69~~-C.70. If a child with the capacity to consent refuses treatment, the parents, or a court, can override this decision. In Scotland, those with parental responsibility cannot authorise procedures that a child with capacity to consent has refused.

~~C.70~~-C.71. If a young person with the capacity to consent refuses treatment, the law in England, Wales and Northern Ireland is complex on whether parents can override this refusal.

~~C.71~~-C.72. Although unlikely to occur in optometric practice, if a competent child or young person refuses treatment, which you feel is in their best interests, you should contact your professional or representative body for advice.

See section on Safeguarding children and vulnerable adults.

Useful information and links

British Medical Association (2019) Parental responsibility. Available from: [bma.org.uk/advice/employment/ethics/children-and-young-people/parental-responsibility](https://www.bma.org.uk/advice/employment/ethics/children-and-young-people/parental-responsibility) [Accessed 7 Jan 2020]

British Medical Association (2019) Children and young people ethics toolkit. Available from: [bma.org.uk/advice/employment/ethics/children-and-young-people/children-and-young-peoples-ethics-tool-kit](https://www.bma.org.uk/advice/employment/ethics/children-and-young-people/children-and-young-peoples-ethics-tool-kit) [Accessed 7 Jan 2020]

Department of Health (Northern Ireland): Consent for examination, treatment or care. Available from [health-ni.gov.uk/articles/consent-examination-treatment-or-care](https://www.health-ni.gov.uk/articles/consent-examination-treatment-or-care) [Accessed 7 Jan 2020]

Social Care Institute for Excellence Dementia and decision-making. Available from: [scie.org.uk/dementia/supporting-people-with-dementia/decisions/](https://www.scie.org.uk/dementia/supporting-people-with-dementia/decisions/) [Accessed 7 Jan 2020]

Welsh Government (2017): Patient consent [wales.nhs.uk/governance-emanual/patient-consent/](https://www.wales.nhs.uk/governance-emanual/patient-consent/) [Accessed 7 Jan 2020]

⁵⁶ General Optical Council (2016) Standards of practice for optometrists and Dispensing opticians. Available from: standards.optical.org [Accessed 2 Jan 2020]

⁵⁷ Department of Health in England (2009) Reference guide to consent for examination or treatment. 2nd ed. Available from: [gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition](https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition) [Accessed 2 Jan 2020]

- ⁵⁸ NHS Wales (2013) Patient consent. . Available from: www.wales.nhs.uk/sites3/page.cfm?orgid=465&pid=11930 [Accessed 2 Jan 2020]
- ⁵⁹ Welsh Assembly Government (2017): Guide to consent for examination or treatment wales.nhs.uk/sitesplus/documents/1064/Welsh%20Government%20Guide%20to%20Consent%20for%20Examination%20or%20Treatment%20%28July%202017%29.pdf [Accessed 2 Jan 2020]
- ⁶⁰ Northern Ireland Department of Health: Consent for examination, treatment or care. Available from: health-ni.gov.uk/articles/consent-examination-treatment-or-care [Accessed 2 Jan 2020]
- ⁶¹ General Optical Council (2017) Supplementary guidance on consent Available from: standards.optical.org [Accessed 2 Jan 2020] [Accessed 4 Nov 2017]
- ⁶³ Mental Capacity Act 2005. Available from: legislation.gov.uk/ukpga/2005/9/contents
- ⁶⁴ *Montgomery v Lanarkshire Health Board* [2015] UKSC 11
- ⁶⁵ Chan SW, Tulloch E, Cooper ES et al Montgomery and informed consent: where are we now? *BMJ* 2017;357:j2224 Available at: www.bmj.com/content/357/bmj.j2224 [Accessed 2 Jan 2020]
- ⁶⁶ General Optical Council. (2016) Standards of Practice for Optometrists and Dispensing Opticians para 2.3. Available from: standards.optical.org [Accessed 2 Jan 2020]
- ⁶⁷ General Optical Council (2017) Supplementary guidance on consent para 41. Available from: standards.optical.org [Accessed 2 Jan 2020]
- ⁶⁸ General Optical Council (2016) Standards of Practice for Optometrists and Dispensing Opticians para 11.7. Available from: standards.optical.org [Accessed 2 Jan 2020]
- ⁶⁹ Department for Constitutional Affairs (2007) Mental Capacity Act 2005, Code of Practice. Available from: webarchive.nationalarchives.gov.uk/+http://www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf [Accessed 2 Jan 2020]
- ⁷⁰ Department of Health (2009) Reference guide to consent for examination or treatment. 2nd ed. Available from: gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition [Accessed 2 Jan 2020]
- ⁷¹ Adults with Incapacity (Scotland) Act 2000. Available from: legislation.gov.uk/asp/2000/4/contents
- ⁷² The Scottish Government. Adults with Incapacity: forms and guidance. Available from: gov.scot/collections/adults-with-incapacity-forms-and-guidance/awi [Accessed 2 Jan 2020]
- ⁷³ The Mental Capacity Act (Northern Ireland) 2016 health-ni.gov.uk/mca [Accessed 2 Jan 2020]
- ⁷⁴ Office of the Public Guardian Lasting power of attorney: acting as an attorney. Available from: gov.uk/lasting-power-attorney-duties [Accessed 2 Jan 2020]
- ~~-2017]~~
- ⁷⁷ *Gillick-v-West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402
- ⁷⁸ In Scotland the Age of Legal Capacity (Scotland) Act 1991, s.2(4) states that a person under the age of 16 years shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.
- ⁷⁹ General Medical Council (2018) 0-18 years: guidance for all doctors. Available from: gmc-uk.org/guidance/ethical_guidance/children_guidance_index.asp [Accessed 2 Jan 2020]
- ~~-[1985] 3 All ER 402
atment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.~~

Confidentiality

Key points

- You, and anyone you employ, must protect patient information.
- You may disclose patient information in some circumstances where it is required by law or where the patient or others might be at risk of serious harm.
- You may share some limited patient information with others who provide care to your patients.
- Disclosing any other information about a patient requires their consent.
- You should anonymise patient information, where possible, and guard against unintentional or improper disclosures.
- Disclosing information about a child requires their consent, or that of their parents, unless it is in the child's best interests or they are at risk of serious harm.
- There are limitations on disclosing information to patients' relatives or carers.
- Patient information remains confidential after their death, with exceptions, for example where it is required by a court of law.

[This Guidance does not change what you must do under the law.](#)

Principles of patient confidentiality

[C.72-C.73.](#) You must respect and protect patient information.⁸² See section on Patient records.

[C.73-C.74.](#) Patients must consent before you share any information about them. See section on Consent. When asking for consent you should tell the patient:

- a. what information you want to share
- b. who you want to share it with, and
- c. how the information will be used.^{83,84}

[C.74-C.75.](#) Anyone you employ must also protect patient information.

[C.75-C.76.](#) You must keep confidential all patient identifiable information, including information which is handwritten, digital, visual, audio or retained in your memory, and this includes:

- a. clinical information about a patient's diagnosis or treatment

College of Optometrists

- b. when the patient attended the practice, and
- c. anything else that can be used to identify patients directly or indirectly, especially if combined with the patient's name or address or full postcode or date of birth.

~~C.76-C.77.~~ If an adult patient with capacity tells you not to share information with other people, you should firstly discuss this with them, and explain why you need to share the information. If they still refuse, you should not share their information, even if failure to share would leave the patient (but no one else) at risk of serious harm or death. If you believe that the patient's decision to refuse a service puts them at risk of serious harm, you must discuss this issue with appropriate colleagues,⁸⁵ whilst respecting the patient's confidence.⁸⁶ This can be done by discussing the case in general without revealing details which may identify the patient. You can share patient identifiable information if you are required to do so by law, or disclosure is justified in the public interest.

~~C.77-C.78.~~ There are exceptions to the rule of protecting patients' confidentiality which are:

- a. you may be required to provide information by law, for example if ordered by a court, or
- b. you may need to disclose information if it is in the public interest, for example where failing to disclose information would expose other members of the public to risk of death or serious harm.^{87,88}

Commented [S1]: We will insert reference to GOC confidentiality guidance when available.

~~C.78-C.79.~~ You may disclose information without patient consent if you have reason to believe that asking for consent would put you or other people at risk of serious harm.⁸⁹

Sharing information with others providing care

~~C.79-C.80.~~ You should explain to patients that you will share information where it is in their best interests unless they object, while observing principles of confidentiality set out in this guidance. People expect professionals to share information with other members of the care team, so good sharing of information, where sharing is appropriate, is as important as maintaining confidentiality.⁹⁰

~~C.80-C.81.~~ You may rely on implied consent to share confidential information with those who are providing (or supporting the provision of) direct care to the patient if you are satisfied that all of the following apply:⁹¹

- a. the person accessing or receiving the information is providing or supporting the patient's care

College of Optometrists

- b. information is readily available to patients explaining how their information will be used (for example, in leaflets, posters, on websites or face-to-face), and they have a right to object
- c. the patient has not objected, and
- d. that anyone to whom confidential information is disclosed understands that it is given to them in confidence, which they must respect.

Disclosing patient information in other situations

[C-81-C.82.](#) If you disclose information about a patient, you must:

- a. be satisfied that the patient:
 - has been informed that their personal information might be disclosed for the sake of their own care, or for local clinical audit, and that they can object, and
 - has not objected
- b. get the patient's consent if identifiable information is to be disclosed for purposes other than their care or local clinical audit, unless the disclosure is required by law or can be justified in the public interest. The public interest is unlikely to be justified if the same purpose can be achieved with anonymised information
- c. keep disclosures to the minimum
- d. observe all relevant legal requirements, including the common law and data protection legislation⁹²
- e. be able to justify why you disclosed the information, and
- f. keep a record of when you disclose information, what you disclose, and to whom.

[C-82-C.83.](#) If you, or others, wish to use patient identifiable information for teaching or research purposes, for example patient photographs, you must apply the principles in this guidance by:

- a. gaining patient consent
- b. making sure the patient understands what they are consenting to and how the information will be used, and
- c. only using or releasing the minimum information that is necessary for the purpose.

College of Optometrists

~~C.83~~-~~C.84~~. If you are using or disclosing information which does not require patient identifiable information you should use anonymised or coded information, for example in clinical audit or for reporting quality measures.

~~C.84~~-~~C.85~~. Improper disclosures can be unintentional. You should not:

- a. share identifiable information about patients where you can be overheard, for example in the practice reception area, a public place or in an internet chat forum, or
- b. share passwords or leave patient records, either on paper or on screen, unattended or where they can be seen by other patients, unauthorised practice staff, or the public.

~~C.85~~-~~C.86~~. Employers must make sure staff are trained to avoid improper disclosures.

Disclosing information about adults without their consent

~~C.86~~-~~C.87~~. If you think the patient may be engaging in an activity where they pose a very real risk of danger to the public, such as the patient operating heavy machinery or driving when they are not fit to do so⁹³, but you are not sure whether you should act, ask yourself:

- a. what might the outcome be in the short- or longer-term if I do not raise my concern? And,
- b. how could I justify why I did not raise the concern?

~~C.87~~-~~C.88~~. If you decide to proceed, you should:

- a. first tell the patient that they are unfit to engage in the activity in question and give the reasons
- b. tell the patient to tell the relevant authority
- c. put your advice in writing to the patient, if appropriate, and
- d. keep a copy of any correspondence to the patient on the patient record.

~~C.88~~-~~C.89~~. Sometimes the actions in para ~~C.88~~-~~C.86~~ might not achieve their aim, or would take too long to do so. You have a duty of confidentiality to the patient, but this is not absolute and can be broken if it is in the public interest to do so. Guidance from the Department of Health includes the example of reporting a driver who rejects medical advice not to drive as one where the public interest can be a defence to breaching patient confidentiality.⁹⁴

College of Optometrists

~~C.89~~~~C.90~~. If you conclude that the public interest outweighs the duty of confidentiality, for example a patient who has told you that they intend to commit a crime or who continues to drive after being told not to, you should:

- a. notify the relevant authority, and, if appropriate, provide evidence of clinical findings
- b. notify the patient's GP of the action being taken, and
- c. notify the patient if appropriate.

~~C.90~~~~C.91~~. If you disclose confidential information about a patient you must be prepared to explain and justify that decision. If you are unsure if this is appropriate, seek advice.

~~C.91~~~~C.92~~. In other circumstances, you should not disclose any clinical, personal or non-clinical information about a patient to a third party, even if that person says they are family or a close friend. This is because it might harm the patient if you divulge the information, for example, if the patient is a victim of abuse. This includes the patient's:

- a. name
- b. contact details
- c. personal circumstances, and
- d. any other information that might disclose the individual's whereabouts, for example whether they have been in your practice.

Disclosing information about adults who lack capacity to consent

~~C.92~~~~C.93~~. If a patient lacks capacity, you should share relevant information in accordance with the advice in paras ~~C.80~~~~C.80~~~~C.78~~ and ~~C.81~~~~C.81~~~~C.79~~ and the section on Consent. Unless they indicate otherwise, it is reasonable to assume that patients would want those closest to them to be kept informed of their general condition and prognosis.

~~C.93~~~~C.94~~. You must share relevant information with anyone who is authorised to make healthcare decisions on behalf of an adult patient who lacks capacity. This may be someone who has a welfare lasting power of attorney or equivalent. See section on Consent.

Disclosing information about children

~~C.94-C.95.~~ You must seek the consent of a child who has the capacity to consent before you share any confidential information about them. [In Scotland, anyone aged 12 or over is legally presumed to have capacity to allow or prevent access to their health records by others, including their parents. In the rest of the UK, competence is assessed depending upon the child's level of understanding.](#)⁹⁵ See section on Consent.

~~C.95-C.96.~~ You may discuss matters regarding a child who does not have the capacity to consent with someone with parental responsibility. See section on Consent.

~~C.96-C.97.~~ A parent who does not have parental responsibility for a child does not have an automatic right of access to confidential information.

~~C.97-C.98.~~ Not all parents have parental responsibility. If the parents were married at or after the child's conception, both will have parental responsibility, even if they have later divorced. For unmarried parents, both will have parental responsibility if they are named on the child's birth certificate and the child was born on or after:

- a. 1 December 2003 in England and Wales
- b. 15 April 2002 in Northern Ireland, and
- c. 4 May 2006 in Scotland.

~~C.98-C.99.~~ You should take the following steps to clarify parental responsibility and information sharing:

- a. note in the child's record the name of the person who accompanies the child
- b. try to ascertain whether the person has parental responsibility
- c. if the person does not have parental responsibility you will need to decide whether the person can provide effective authority to proceed. If in any doubt, consult your professional or representative body.

~~C.99-C.100.~~ If anyone else asks for information about the child (this can include the other parent without parental responsibility) you should direct them to the responsible person with whom you have already shared information.

Disclosing information about children or young people without their consent

~~C.100-C.101.~~ You can share confidential information about a child or young person without their consent if you consider that the benefits to the child or

young person that will arise from sharing will outweigh the public and patient's interest in keeping the information confidential. If a child or young person refuses to consent to you sharing the information you should consider their reasons for refusing, and weigh the possible consequences of not sharing the information against the harm that sharing may cause.⁹⁶ You should disclose information about a child or young person to an appropriate body without their, or their parents', consent only if:

- a. it is in the child or young person's best interests, or
- b. failure to do so might place the child or young person at risk of serious harm or where the information would help prevent, detect or prosecute a serious crime.

~~C.101~~-~~C.102~~. You should record your reasons for doing this in the patient notes.

Disclosing information to patients' relatives or carers

~~C.102~~-~~C.103~~. You should discuss with the patient what information they want you to share, with whom, and in what circumstances. This will be important if the patient has fluctuating or diminished capacity or is likely to lose capacity, even temporarily. This can help to avoid disclosures that patients would object to. It can also help to avoid misunderstandings with relatives or carers.

~~C.103~~-~~C.104~~. If anyone close to the patient wants to discuss their concerns about the patient's eye health, you should tell them, before they begin, that you might need to tell the patient about the conversation if the information affects your care of the patient.

~~C.104~~-~~C.105~~. You should not refuse to listen to a patient's relatives or carers on the basis of confidentiality. The information they provide might be helpful in your care of the patient. You should, however, consider whether it would be a breach of your patient's trust to do this, especially if they have asked you not to listen to particular people.

~~C.105~~-~~C.106~~. The phrase 'next of kin' has no legal definition or status. You should not share information with a person who the patient nominates as their next of kin unless the patient has authorised you to do this.

Disclosing information after death

~~C.106~~-~~C.107~~. You should treat patient information as confidential, even after a patient has died. Whether and what personal information you disclose after a patient's death will depend on the circumstances. If the patient had asked for information to remain confidential, you should respect their wishes. If you are unaware of the patient's wishes and are asked to disclose information you should consider:

College of Optometrists

- a. the purpose of the disclosure
- b. whether the information is likely to benefit or cause distress to the patient's family
- c. whether the information is already in the public domain
- d. whether the information can be anonymised.

C.107-C.108. Information must only be disclosed to someone who is authorised to receive it, such as the executor of the will. You should ask to see the patient's death certificate before disclosing information.

C.109. There are exceptions to maintaining patient confidentiality after death, for example if you are required to provide information by a court of law.

⁸² Department of Health (2013) Information, to share or not to share. The information governance review, (Chairman: Dame Fiona Caldicott). Available from: gov.uk/government/publications/the-information-governance-review [Accessed 2 Jan 2020]

⁸³ General Medical Council (2018) Confidentiality: good practice in handling patient information, paras 9 and 10. Available from: gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors#confidentiality [Accessed 2 Jan 2020]

⁸⁴ General Medical Council (2018) Protecting children and young people: the responsibilities of all doctors, paragraph 35 Available from: gmc-uk.org/guidance/ethical_guidance/13257.asp [Accessed 2 Jan 2020]

⁸⁵ General Optical Council (2017) Supplementary guidance on consent, para 41 Available from: standards.optical.org/supporting-guidance/ [Accessed 2 Jan 2020]

⁸⁶ General Optical Council (2016) Standards of Practice for Optometrists and Dispensing Opticians para 11.7 Available from: standards.optical.org [Accessed 2 Jan 2020]

⁸⁷ Department of Health (2010) Confidentiality: NHS code of practice. Supplementary guidance: public interest disclosures Available from: gov.uk/government/uploads/system/uploads/attachment_data/file/216476/dh_122031.pdf [Accessed 2 Jan 2020]

⁸⁸ It is the view of the British Medical Association that the Counter-Terrorism and Security Act 2015, which places a duty on some organisations – including health bodies in England, Scotland and Wales – to have 'due regard to the need to prevent people from being drawn into terrorism', creates 'no new obligations or immunities with regards to the sharing of confidential information'. 'In almost all circumstances, therefore, doctors should seek consent for the sharing of this information'. See www.bma.org.uk/news/2016/june/anti-radicalisation-strategy-confidentiality-demands-unchanged [Accessed 2 Jan 2020].

⁸⁹ General Medical Council (2018) Confidentiality: good practice in handling patient information. Available from: gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors#confidentiality [Accessed 2 Jan 2020]

⁹⁰ Department of Health (2013) Information, to share or not to share. The information governance review (Chairman: Dame Fiona Caldicott). Available from: gov.uk/government/publications/the-information-governance-review [Accessed 2 Jan 2020]

⁹¹ General Optical Council (2017) Supplementary guidance on consent para 47 Available from: standards.optical.org/supporting-guidance/ [Accessed 2 Jan 2020]

⁹³

Driver & Vehicle Licensing Agency (DVLA) (2019) Assessing fitness to drive: a guide for medical professionals Chapter 6 Visual disorders. Available from: gov.uk/government/publications/assessing-fitness-to-drive-a-guide-for-medical-professionals [Accessed 2 Jan 2020]

⁹⁴ Department of Health (2010) Confidentiality: NHS code of practice. Supplementary guidance: public interest disclosures Available from: gov.uk/government/uploads/system/uploads/attachment_data/file/216476/dh_122031.pdf [Accessed 2 Jan 2020]

⁹⁵ Information Commissioner's Office: What rights do children have? ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/children-and-the-gdpr/what-rights-do-children-have/ [Accessed 2 Jan 2020]

⁹⁶ General Medical Council (2018) Protecting children and young people: the responsibilities of all doctors, paragraphs 36 and 37 Available from: gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors [Accessed 2 Jan 2020]

Dealing with complaints

Key points

- You should deal with complaints in a sensitive and timely manner.
- You must be candid when things go wrong.
- You should not discriminate against a patient who has complained.
- If you are an NHS contractor, you must have a complaints procedure that you make available to patients. You should extend this to private patients.
- You should try to resolve complaints in practice.
- You can use the services of the Optical Consumer Complaints Service (OCCS) to help resolve complaints.
- You have responsibilities to provide information about complaints to outside agencies if requested.

[This Guidance does not change what you must do under the law.](#)

Definition

~~C.108-C.110.~~ A complaint is 'An expression of dissatisfaction, either written or spoken, and whether justified or not, which requires a response'. There is no difference between a 'formal' or an 'informal' complaint. Both are expressions of dissatisfaction'.⁹⁷

Complaints procedure

~~C.111.~~ [Good complaint handling gives you the best opportunity to de-escalate the issue. If you run a GOC registered business you must have a clear complaints protocol, and make patients aware of their channels of complaint.](#)⁹⁸

~~C.109-C.112.~~ You should encourage patients to comment on the services they have received.

~~C.110-C.113.~~ Feedback and complaints can be an opportunity to improve your service. You should use them to see how you can improve the services that you offer, and share lessons learnt from them.

~~C.111-C.114.~~ You should investigate feedback which gives rise to cause for concern as if it were a complaint.

~~C.112-C.115.~~ You should acknowledge a formal complaint within three working days [in England, Scotland and Northern Ireland, and within two working days in Wales.](#)^{99 100.101.102.103.104.105.106}

~~C.113-C.116.~~ If you provide NHS services, you must have a **written** complaints procedure that you make available to patients.^{100,101,102,103,104,105,106} A complaint that is made orally and is dealt with to the complainant's satisfaction by the end of the next working day is not considered a complaint for this purpose. You should extend this procedure to private patients.

~~C.114-C.117.~~ You should make sure your complaints procedure:

- a. is clearly displayed to patients
- b. is easy for patients to use and available in a format that they can understand
- c. enables you to deal with complaints quickly and sensitively
- d. allows you to investigate complaints in a full and fair way
- e. maintains patient confidentiality
- f. gives clear outcomes for the patient, and
- g. contributes information to practice management and improvements.

~~C.115-C.118.~~ If a patient makes a complaint, you are likely to need to access their record and use identifiable information. You should make patients aware of who will see information about them and your safeguards for minimising risks to confidentiality.

~~C.116-C.119.~~ You should keep a written log of complaints to monitor your performance in handling complaints and to identify possible areas for improvement.

~~C.117-C.120.~~ If the complaint relates to clinical care, you should keep a record of the patient complaint in the patient record.

~~C.118-C.121.~~ You should ensure that other members of the team for whom you are responsible:

- a. are familiar with the complaints procedure
- b. know how to deal with patients' concerns and complaints, and
- c. know how to apologise and offer practical solutions.

Resolving complaints

College of Optometrists

~~C.119-C.122.~~ You must give a helpful and honest response to anyone who complains about the services you have provided.¹⁰⁷

~~C.120-C.123.~~ If a patient complains about the treatment they have received they have a right for their complaint to be heard and dealt with in a sensitive and timely manner. Doing so can help avoid the complaint escalating unnecessarily.

~~C.124-C.124.~~ You should always take the complaints of children and young people seriously. You should help them in their complaint if their rights or interests have been denied or abused, if they are unhappy with the care they have received or because they have been denied care.

~~C.122-C.125.~~ You should not discriminate against a patient who has complained. You should continue to treat them with respect and courtesy.

~~C.123-C.126.~~ You should aim to resolve informal complaints at the time they are made, within the practice. If the complaint is formal you should:

- a. send the patient a written acknowledgement within three working days (two working days in Wales) of receiving their complaint and explain how the complaint will be handled, with timeframes¹⁰⁸
- b. tell the patient if you cannot keep to the timeframe and why¹⁰⁸¹⁰⁸²
- c. give the patient a named individual with whom they can liaise¹⁰⁸¹⁰⁸¹¹²
- d. try to contact the patient verbally to discuss their concerns¹⁰⁸¹⁰⁸¹¹²
- e. ask the patient what they want as an outcome¹⁰⁸¹⁰⁸¹¹²
- f. offer the patient a face-to-face meeting to discuss their concerns. You should agree to a request by the patient to have someone with them at the meeting¹⁰⁸¹⁰⁸¹¹²
- g. avoid being defensive when dealing with complaints
- h. keep the patient informed about the progress in dealing with their complaint
- i. deal with all the points raised in a complaint
- j. offer an apology, where appropriate. Giving an apology does not mean you are admitting responsibility, it is a way of showing concern and understanding
- k. if the patient's complaint is justified, offer a fair solution, which may include offering to put things right at your own expense if you have

College of Optometrists

made a mistake. At the end of your investigation, write to the patient explaining:

- what you have decided
 - any practical solutions you can offer
 - whether you are going to make any changes to your practice as a result
- I. if the patient wishes to take the complaint further, tell the patient that they can complain to the General Optical Council (GOC) or the Optical Consumer Complaints Service (OCCS).

~~C.124-C.127.~~ You must keep records of the complaint, and relevant documents. This would include details of oral and written communication between you and the patient and a chronology of the investigation process. Any internal documents should be objective and non-judgemental. [108108142](#)

Providing information about complaints

~~C.125-C.128.~~ If other bodies, such as the OCCS, the GOC or local health organisations, are involved in the complaint, you should provide helpful and honest information in response to a request as promptly as possible. Through your complaints procedure you should make the patient aware of who will see the information about them and the safeguards that are in place to minimise any risks to confidentiality.

~~C.126-C.129.~~ If the GOC asks for information from you regarding a complaint, you must, subject to any statutory restrictions, give the GOC the information promptly. If you do not provide the information within 14 days, the GOC may seek a court order requiring the information to be produced, unless this is prohibited by ~~law~~~~any other enactment~~, for example the Data Protection Act [20181998](#).

~~C.127-C.130.~~ If a court asks for information from you regarding a complaint you must, subject to any statutory restrictions, give the information promptly.

Useful information and links

General Optical Council (2017) Supplementary guidance on the professional duty of candour. Available from: standards.optical.org/supporting-guidance/ [Accessed 2 Jan 2020]

Local Government Ombudsman, Healthwatch and the Parliamentary and Health Service Ombudsman (2014) *My expectations for raising concerns and complaints*. Available from:

College of Optometrists

healthwatch.co.uk/sites/healthwatch.co.uk/files/vision_report_0.pdf [Accessed 2 Jan 2020]

NHS Scotland (2017) Complaints handling procedure. Available from: valuingcomplaints.org.uk/handling-complaints/complaints-procedures/nhs [Accessed 2 Jan 2020]

NHS Wales: Putting Things Right: Guidance on dealing with concerns about the NHS from 1 April 2011
wales.nhs.uk/sitesplus/documents/861/Healthcare%20Quality%20-%20Guidance%20-%20Dealing%20with%20concerns%20about%20the%20NHS%20-%20Version%203%20-%20CLEAN%20VERSION%20-%2020140122.pdf
[Accessed 2 Jan 2020]

Optical Consumer Complaints Service opticalcomplaints.co.uk

The Patients Association (2013) Good practice standards for NHS complaints handling. Available from: noeccn.org.uk/resources/Documents/Education%20Group/Resources/Good-Practice-standards-for-NHS-Complaints-HandlingSept-2013.pdf [Accessed 2 Jan 2020]

Royal College of Nursing (2014) Good practice for handling feedback. Available from: org.uk/professional-development/publications/pub-004725 [Accessed 2 Jan 2020]

⁹⁷ The Patients Association (2013) Good practice standards for NHS complaints handling. Available from: noeccn.org.uk/resources/Documents/Education%20Group/Resources/Good-Practice-standards-for-NHS-Complaints-HandlingSept-2013.pdf [Accessed 2 Jan 2020]

⁹⁸ General Optical Council (2019) Standards for Optical Businesses, para 2.1.4 Available from: standards.optical.org/ [Accessed 2 Jan 2020]

¹⁰⁰ LOCSU. Quality in Optometry (England). Available from: qualityinoptometry.co.uk [Accessed 2 Jan 2020]

¹⁰¹ The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 SI 309

¹⁰² HSC Business Services Organisation: complaints information. Available from hscbusiness.hscni.net/services/2607.htm [Accessed 7 Jan 2020]

NHS Scotland (2017) Complaints handling procedure. Available from: valuingcomplaints.org.uk/handling-complaints/complaints-procedures/nhs [Accessed 2 Jan 2020]

¹⁰³ The Patient Rights (Complaints Procedure and Consequential Provisions)(Scotland) Amendment Regulations 2016 SSI 401. Available from: legislation.gov.uk/ssi/2016/401/contents/made

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¹⁰⁵ Wales: Putting Things Right: Guidance on dealing with concerns about the NHS from 1 April 2011 wales.nhs.uk/sitesplus/documents/861/Healthcare%20Quality%20-%20Guidance%20-%20Dealing%20with%20concerns%20about%20the%20NHS%20-%20Version%203%20-%20CLEAN%20VERSION%20%20-%2020140122.pdf [Accessed 2 Jan 2020]

¹⁰⁶ National Health Service (Concerns, Complaints and Redress Arrangements)(Wales) Regulations 2011, SI704(W.108). Available from: legislation.gov.uk/wsi/2011/1706/contents/made

¹⁰⁷ General Optical Council. (2016) Standards of Practice for Optometrists and Dispensing Opticians. Available from: standards.optical.org [Accessed 2 Jan 2020]

¹⁰⁸ The Patients Association (2013) Good practice standards for NHS complaints handling. Available from: noeccn.org.uk/resources/Documents/Education%20Group/Resources/Good-Practice-standards-for-NHS-Complaints-HandlingSept-2013.pdf [Accessed 2 Jan 2020]

Social media and online behaviour

Key points

- Social media is about communicating using internet-based applications such as forums, blogs and social networking sites.
- You should maintain standards of professional communication even when using social media.
- Social media can support your work by sharing information in professional networks.
- There are risks to using informal means of communication and any online postings you make are subject to the laws of copyright and defamation.
- You should maintain your own, and patient, privacy to protect personal information.
- You should be aware that anonymity is difficult to maintain when using social media.
- You should declare any conflicts of interest when posting material online.
- You should refer to sections on Confidentiality, Partnership with patients, Maintaining boundaries and Working with colleagues.

[This Guidance does not change what you must do under the law.](#)

About social media

[C.128-C.131](#). Social media describes internet-based applications which allow individuals to create and exchange content and communicate with others. Examples of social media can include forums, blogs, microblogs (for example Twitter), wikis, podcasts, content communities (for example YouTube, [WhatsApp](#) and Flickr), and social networking sites (for example Facebook and LinkedIn).¹⁰⁹

[C.129-C.132](#). You should follow the principles and standards of good communication if you are communicating in a professional or personal capacity, irrespective of the medium. See sections on Partnership with patients and Working with colleagues.

[C.130-C.133](#). You should not share identifiable information about patients in an internet chat forum as this would be an improper disclosure. See section on Confidentiality.

[C.134-C.134](#). You must respect copyright if you link or include images or other material.

Benefits and risks of using social media

College of Optometrists

~~C.132~~-~~C.135~~. If you use social media it can support your work as an optometrist and enhance your patient care by:

- a. being involved in clinical, public health or policy forums and networks
- b. participating in professional networks to find out about good practice
- c. contributing to information about eye health and services which patients can access .

~~C.133~~-~~C.136~~. You should consider the purpose of your online profile and use appropriate security and preference settings.

~~C.134~~-~~C.137~~. Social media sites can blur the boundary between professional and personal life, and comments that you publish in a personal capacity may become accessible by a much wider audience.

~~C.135~~-~~C.138~~. If you identify yourself as working for a particular organisation, you must make it clear that any views you express are personal ones, and not necessarily those of your employer.

~~C.136~~-~~C.139~~. If patients contact you for professional purposes, using your private profile, you should indicate you are unable to respond privately and redirect them to your professional profile or contacts. See section on Maintaining boundaries.

~~C.137~~-~~C.140~~. Communications with colleagues and other professionals may be more informal and less precise than if you use other formal means of communication, and this might lead to miscommunication. You should also be aware that by making an online posting you are publishing text and this is subject to the same laws of copyright and defamation as other written or verbal communications, whether you make them in a personal or professional capacity.^{110,111} You should not make personal or derogatory comments about patients or colleagues on public internet forums. You should be aware that material that is posted online can be traced back to the original author, even if it is done anonymously.

~~C.138~~-~~C.141~~. Social media sites can often lack context and a posting can be misinterpreted.

Privacy and confidentiality

~~C.139~~-~~C.142~~. Issues of privacy and confidentiality are important if you use social media because online information can be easily accessed by others. You should be aware of the limitations of privacy online and regularly review privacy settings in your profiles. This is important because:

- a. social media sites cannot guarantee confidentiality, irrespective of your privacy settings

- b. your patients, colleagues and other professional contacts may be able to access your personal information
- c. information about your location may be embedded within photographs and other content, available for others to see
- d. if you post significant amounts of your personal information online, patients may have access to this and this may impact upon your professional relationship with them, and
- e. once information is published online it cannot be removed completely, as other users can distribute it more widely or comment on it.

C.140-C.143. You must not share patient identifiable information through social media, without the patient's explicit consent, even if it is on a site for practitioners and is not accessible to the public. When you ask for the patient's consent you must tell the patient exactly how you intend to share the information, what it will be used for, and where it will be available. You should keep a record of these discussions and ask the patient to sign, indicating their consent.

C.141-C.144. You can share anonymised patient information on sites that are for practitioners only. However, you should remember that even if you anonymise patient information, the amount of additional information that is available online may mean that patients can be identified. This is a breach of patient confidentiality.

C.142-C.145. You must not discuss individual patients or their care with anyone, including the patients themselves, on publicly accessible social media.

Friend Requests

C.143-C.146. You should think carefully about connecting with a patient on social media sites and should only do this in a professional context. If a patient sends a friend request to your personal account you should decline this.

Anonymity

C.144-C.147. If you contribute optometric advice or comments to a publicly accessible social media site and identify yourself as an optometrist you should also identify yourself by name. Any material written by an author representing themselves as an optometrist is likely to be taken on trust.

C.145-C.148. If you upload content anonymously you should be aware that it can be traced back to its point of origin.

Conflicts of interest

C.146-C.149. If you post material online you should be open about any conflict of interest and declare any financial or commercial interests in healthcare organisations, companies or any other interests that may be perceived to influence your opinion. This applies even if you post material anonymously.

Useful information and links

The British Medical Association has guidance on social media for doctors. This includes Social media, ethics and professionalism (2018), Social media – practical guidance and best practice (2018) and the Medical students’ ethics toolkit – students and social media (2015). Available from www.bma.org.uk/advice/employment/ethics/social-media-guidance-for-doctors [Accessed 6 Jan 2020]

NHS Digital Social Media Guidance². Available from digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/nhs-digital-style-guidelines/how-we-talk/social-media [Accessed 6 Jan 2020]

Nursing and Midwifery Council (2016) Guidance on using social media responsibly. Available from: nmc.org.uk/globalassets/sitedocuments/nmc-publications/social-media-guidance.pdf [Accessed 6 Jan 2020]

NHS Employers (2014) New to the NHS? Your guide to using social media in the NHS. Available from: nhsemployers.org/~media/Employers/Publications/NOVEMBER%20Your%20guide%20to%20using%20social%20media%20in%20the%20NHS.pdf [Accessed 6 Jan 2020]

¹⁰⁹ General Medical Council (2013) Good Medical Practice: doctors’ use of social media. Available from: gmc-uk.org/guidance/ethical_guidance/21186.asp [Accessed 6 Jan 2020]

¹¹⁰ Copyright, Designs and Patents Act, 1988. Available from: legislation.gov.uk/ukpga/1988/48/contents

¹¹¹ Defamation Act, 2013. Available from: legislation.gov.uk/ukpga/2013/26/contents

² Although this is written for people working for NHS Digital, it contains useful tips on how to use social media when working for an organisation.

Maintaining boundaries

Key points

- You are in a position of trust with your patients and their carers and you must not abuse that professional position.
- Sexual or inappropriate emotional relationships with current or former patients are likely to cross professional boundaries.
- You should seek advice from a colleague or professional body if you are in doubt about maintaining professional boundaries.
- You should also alert colleagues to the risks of unprofessional behaviour and report their actions if they are putting patients at risk.

[This Guidance does not change what you must do under the law.](#)

Principles of maintaining boundaries

[C.147-C.150](#). You must never abuse your professional position,¹¹² for example by pursuing a sexual or inappropriate emotional relationship with a patient or their carer. This is because it can damage public trust in the optometric profession, and the inappropriate relationship may affect decisions you can make about a patient's care.

[C.148-C.151](#). You are in a position of power and trust with your patients and you should maintain appropriate boundaries in how you communicate with your patients and their carers.

[C.149-C.152](#). You should not express personal beliefs, including political, religious and moral beliefs, to patients in ways that could exploit them if they are vulnerable or which might distress them.

[C.150-C.153](#). The definition of a carer in this section of guidance is a professional carer, family member, partner or friend who looks after the patient to the extent that they are part of their clinical experience, for example a parent who accompanies their child to hospital.

[C.151-C.154](#). If you are attracted to a patient you must not act on these feelings. If you are not sure whether this is affecting your professional judgement you should discuss this with a colleague or with your professional or representative body.

[C.152-C.155](#). You should be sensitive to cultural differences in personal boundaries.

Current patients

[C.153-C.156](#). If a patient or their carer pursues a sexual or inappropriate emotional relationship with you, you may need to seek advice from a colleague or professional or representative body to decide on the best course of action.

[C.154-C.157](#). If the situation cannot be resolved you should not continue to treat the patient.

Former patients

[C.155-C.158](#). You should think carefully before pursuing a personal relationship with a former patient or carer. However consensual a relationship appears to be, if a complaint is made the onus will always be on you to show you have acted professionally and sought appropriate advice.¹¹³

[C.156-C.159](#). A sexual or personal relationship with a former patient or their carer may be inappropriate because:

- a. your former professional relationship may still influence the relationship
- b. the patient was vulnerable when they were under your care and may still be vulnerable, or
- c. you may still be caring for other members of the patient's family.

Colleagues

[C.157-C.160](#). If you are aware that a colleague or other healthcare professional has breached personal or sexual boundaries with a patient or carer you should speak to the colleague, if possible, and alert them to the dangers of this unprofessional behaviour.

[C.158-C.161](#). If you are asked for advice by a colleague who feels attracted to a patient or carer, but has not acted inappropriately, you are not required to inform anyone. You should remind your colleague that they must not abuse their professional position.

[C.159-C.162](#). If you consider a colleague is putting patients at risk you should consult the relevant professional, representative or regulatory body. See section on Raising concerns.

Useful information and links

College of Optometrists

The British Medical Association has guidance on social media for doctors, which is also useful for maintaining boundaries. This includes Social media, ethics and professionalism (2018), Social media – practical guidance and best practice (2018) and the Medical students' ethics toolkit – students and social media (2015). Available from www.bma.org.uk/advice/employment/ethics/social-media-guidance-for-doctors [Accessed 6 Jan 2020]

General Pharmaceutical Council (2017) Guidance on maintaining clear sexual boundaries. Available from: pharmacyregulation.org/sites/default/files/in_practice-guidance_on_maintaining_clear_sexual_boundaries_may_2017.pdf [Accessed 7 Jan 2020]

¹¹² General Optical Council. (2016) Standards of Practice for Optometrists and Dispensing Opticians. Available from: standards.optical.org [Accessed 7 Jan 2020]

¹¹³ Professional Standards Authority (2008) Clear sexual boundaries between healthcare professionals and patients: responsibilities of healthcare professionals. Available from: <https://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/sexual-boundaries-responsibilities-of-healthcare-professionals-2008.pdf> [Accessed 7 Jan 2020]

Working with colleagues

Key points

- You must work with colleagues in ways that best serve patients' interests and communicate effectively with them.
- You must act quickly to protect patients from risks posed by colleagues.
- You must treat colleagues fairly.
- You should only delegate patient care to appropriately skilled and experienced practitioners.
- You should keep the patient informed if you delegate aspects of their care to a colleague.
- You should write clear referral letters that contain relevant information about the condition, reason for referral and level of urgency.
- You should give patients written information or a copy of the referral letter and tell them what to expect.
- Use your professional judgement about the urgency of a referral, taking into account College guidance or local protocols.
- If you delegate patient care, or supervise others, you are still responsible for the patient and the clinical findings.
- The protected functions of sight testing or contact lens fitting can only be undertaken by someone who is registered to perform those functions.
- For good continuity of care you must keep good records and provide necessary patient information to practitioners to whom you refer, delegate or are supervising.

[This Guidance does not change what you must do under the law.](#)

Your role

[C.160-C.163](#). You must work with colleagues in ways that best serve patients' interests and communicate effectively with them.¹¹⁴

[C.161-C.164](#). You must ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession.

[C.162-C.165](#). You must not make any patient doubt the knowledge or skills of colleagues or other health professionals by making unnecessary or unfounded comments about them, either privately or publicly, for example through social media.

[C.163-C.166](#). You must act quickly to protect patients from risks posed by colleagues or the environment in which services are provided. The safety of patients must come first. If you have serious concerns about any practitioner's

fitness to practise you should raise this with them first if you feel able to. If necessary you should escalate your concerns to an appropriate person. This could be the colleague's line manager, employer, or person in a Primary Care Organisation or hospital. If you remain concerned you should consult the relevant professional, representative or regulatory body.

[C.164-C.167](#). Raising a concern is different from making a complaint. See section on Raising concerns. If you make a complaint, you might be asked for evidence to prove your case. When you raise a concern, you should not be expected to prove the issue you are concerned about. If you are not sure whether you should act, ask yourself:

- a. what might the outcome be in the short- or longer-term if I do not raise my concern? And,
- b. how could I justify why I did not raise the concern?

[C.165-C.168](#). You must treat your colleagues fairly. You must not allow your personal views to adversely affect your relationship with them. You must not discriminate against colleagues on the grounds of:

- a. age
- b. disability
- c. gender reassignment
- d. marriage and civil partnership
- e. pregnancy and maternity
- f. race
- g. religion or belief
- h. sex, or
- i. sexual orientation.

[C.166-C.169](#). If you receive a prescription for dispensing from another practitioner and there is an anomaly or a complaint of non-tolerance after dispensing, you should, with the patient's consent, contact the prescribing practitioner. You should agree a course of action with them and the patient. The Optical Confederation has produced guidance on this.¹¹⁵

[C.167-C.170](#). You are encouraged to contribute to the professional development of your colleagues.

Working in teams

~~C.168-C.171.~~ You should communicate effectively with team members.

~~C.169-C.172.~~ Even if you have your own practice, you should consider yourself as part of the wider eye care team, for example when you refer a patient to a colleague.

~~C.170-C.173.~~ You should work constructively in teams, including multi-disciplinary teams, and respect the skills and contributions of colleagues.

~~C.171-C.174.~~ You are accountable for your own professional conduct and the care you provide while working as part of a team.

~~C.172-C.175.~~ If you are leading a team you should ensure that:

- a. each team member understands the scope of their role, including what decisions and actions have and have not been delegated to them
- b. the team provides care which is safe, effective and efficient
- c. the team understands the need to provide a patient-centred service which is polite, responsive and accessible
- d. patient information is kept confidential
- e. you encourage a culture that allows open, non-judgemental discussion of problems and mistakes which enables constructive feedback and contributes to continuous improvement
- f. team members are appropriately supported and undertake professional development that is relevant to their role and level of experience
- g. team members are not asked to undertake tasks for which they are not competent, and
- h. you have the necessary leadership skills, or work to develop the skills.

~~C.173-C.176.~~ If you are working in a team providing shared care to a patient and you believe a decision taken by the team would harm the patient you should tell someone who can take action. As a last resort you should take action yourself to protect the patient's safety or health.

~~C.174-C.177.~~ If you examine a patient who is under the care of the hospital eye service, you:

- a. may decide not to conduct tests that would have been done at the hospital
- b. should record your reasons in these cases

- c. should bear in mind that a patient being assessed for one condition may not have been checked for another unrelated condition, and
- d. should inform hospital eye service colleagues of your findings if you feel it would influence their management of the patient.

~~C.175-C.178.~~ If you participate in a community service or co-management scheme, you should refer patients back to their usual practitioner for their routine eye examination.

Referrals

~~C.176-C.179.~~ You may refer a patient or you may receive a referral from a colleague. If you receive a referral, you should address the reasons for referral and advise the patient to consult their regular practitioner for routine eye care.

When to refer

~~C.177-C.180.~~ If you observe a sign or symptom of injury or disease which you cannot manage within your competence or scope of practice, you should refer patients to an appropriate practitioner who is registered with a statutory regulator.

~~C.178-C.181.~~ You should consider national and local guidance on referrals.

~~C.179-C.182.~~ The National Institute for Health and Care Excellence [recommends that patients with signs of possible glaucoma or related conditions at a routine sight test have additional tests before they are referred for a diagnosis](#) ~~has published evidence on the effectiveness of a repeat readings service for patients with suspect high intraocular pressure.~~¹¹⁶ The Scottish Intercollegiate [Guidelines](#) Network has published guidance on glaucoma referral and safe discharge.¹¹⁷

~~C.180-C.183.~~ If, in your professional judgement, you do not need to refer the patient, or it is impractical to do so, you may decide to manage the condition yourself.¹¹⁸

~~C.184-C.184.~~ If you decide not to refer the patient you must record:

- a. a sufficient description of the condition
- b. the reason for deciding not to refer on this occasion, and
- c. details of advice or treatment given to the patient.

~~C.182-C.185.~~ If you decide not to refer the patient you should inform the patient's GP of any relevant findings, if the patient consents.

~~C.183-C.186.~~ The welfare of the patient must not be compromised.

~~C.184-C.187~~. You must refer patients with appropriate urgency. If there are local protocols in place for referrals, including emergency or urgent referrals, you should follow these. If in doubt, you should seek advice from the on-call ophthalmologist to determine the most appropriate pathway for the patient. Where there are no local protocols, guidance on which conditions are considered an emergency and which are considered urgent can be found in para ~~C.28.aC.28.aC-205.a~~ and ~~C.28.aC.28.aC-205.b~~.

~~C.185-C.188~~. Patients have a right to be fully involved in decisions about their care.

~~C.186-C.189~~. If the patient does not wish to be referred you should:

- a. ensure the patient understands why the referral is necessary
- b. record a full account in the patient records, and
- c. obtain the patient's signature on a declaration that they do not wish to be referred.

Whom to refer to

~~C.187-C.190~~. You must only refer patients to a practitioner with the appropriate qualifications and registration.¹¹⁹

~~C.188-C.191~~. When you refer a patient, you also transfer responsibility for the relevant part of the patient's care.

~~C.189-C.192~~. If the patient is not registered with a GP or wishes to see a doctor privately, you should give the patient the referral letter and tell them to register with a GP or to arrange a private appointment with an appropriate doctor, for example an ophthalmologist. Alternatively, you can send your advice by recorded delivery to the patient and enclose the referral letter.

Telling the practitioner

~~C.190-C.193~~. You should write a clearly worded letter of referral and include:

- a. relevant details from the eye examination
- b. the reason for referral
- c. details of discussions with the patient and any with the practitioner to whom you are referring, and
- d. the level of urgency.

~~C.191-C.194.~~ If the patient is already receiving care for the observed sign of injury or disease you should notify the practitioner who is caring for the patient if you believe your findings might provide additional, useful information.

~~C.192-C.195.~~ If you send the referral letter directly to the practitioner to whom you are referring you should ensure that the patient's GP is kept informed. This may be relevant in an emergency or where you use a referral centre.

Telling the patient

~~C.193-C.196.~~ If you are referring the patient to a doctor, the law says you must give the patient a written statement of the reasons for referral, immediately following the sight test.^{120,121} If you cannot write the referral letter immediately following the sight test, you can write the reason for referral elsewhere, for example on the patient's prescription.

~~C.194-C.197.~~ You should ensure the patient understands the urgency of the referral.

~~C.195-C.198.~~ You should tell the patient when they should expect to hear about their referral and what to do if they do not hear within that timescale.

~~C.196-C.199.~~ You should tell the patient what to do if their symptoms get worse before they are seen.

~~C.197-C.200.~~ You should give patients copies of any correspondence relating to them so that they are clear about their condition and the care they are receiving. This can also be useful in case the original correspondence goes astray when the patient sees the clinician to whom they have been referred.

~~C.198-C.201.~~ If the patient is not legally responsible for their own care, you should copy the letter to the person who is legally responsible.

~~C.199-C.202.~~ You should provide copies of correspondence in an accessible format~~large print for patients with visual impairment.~~

~~C.200-C.203.~~ You should ask young people who have the capacity to consent to treatment if they would like to receive copies of information~~letters~~ about them and how they would like to receive this~~ese~~. ~~You should also check if they prefer to collect a copy of any letter containing personal information or have it sent to their home.~~

~~C.204-C.204.~~ You should not copy a letter to a patient if:

- a. they decline a copy
- b. the letter contains information about another person who has not given their consent for you to disclose this information (other than if the patient originally provided this information or if you remove this information from the copy letter), or

- c. you feel it may cause harm to the patient, although giving bad news is an insufficient reason for withholding a copy of the letter.

Sending the referral

~~C.202-C.205.~~ If you post the copy of the referral letter to the patient:

- a. check where they would like it to be sent, and
- b. use the patient's full name in the address and check with them if they share the same name as someone else at that address, to avoid confusion with other family members.

~~C.203-C.206.~~ When you send a referral, make sure it is sent by a secure method or the patient has given consent for it to be sent by an alternative method.

Recording the referral

~~C.204-C.207.~~ You should keep copies of all referral letters and a note of the discussions held with the patient, including the advice you gave.

Urgency of referrals

~~C.205.~~ This list is intended to be guidance about which conditions require emergency or urgent referral. Familiarise yourself with and follow relevant local protocols for referral. If a patient presents with a condition requiring an emergency referral you may wish to seek advice from the on-call ophthalmologist. This list is not exhaustive. You should use your professional judgement and look at the College's clinical management guidelines for further information.

~~a. emergency referral (within 24 hours), symptoms or signs suggesting:~~

- ~~• acute glaucoma~~
- ~~• acute dacryocystitis in children, or in adults if severe~~
- ~~• cellulitis (preseptal or orbital)~~
- ~~• corneal foreign body penetrated into stroma, or with presence of a rust ring (unless optometrist is specifically trained in rust ring removal)~~
- ~~• CRAO < 12 hours old~~
- ~~• endophthalmitis~~
- ~~• facial palsy, if new or with loss of corneal sensation~~

- herpes zoster ophthalmicus with acute skin lesions (emergency referral to GP for systemic anti-viral treatment with urgent referral to ophthalmology if deeper cornea involved)
- hyphaema
- hypopyon
- IOP \geq 40mmHg (independent of cause)
- microbial keratitis
- orbital cellulitis
- papilloedema
- penetrating injuries
- pre-retinal haemorrhage, although a pre-retinal haemorrhage in a diabetic patient with known proliferative retinopathy who is already being actively treated in the HES would not need an emergency referral
- retinal detachment unless this is long-standing and asymptomatic
- scleritis
- sudden severe ocular pain
- suspected temporal arteritis
- symptomatic retinal breaks and tears
- third nerve palsy with pain
- trauma (blunt or chemical), if severe
- unexplained sudden loss of vision
- uveitis,
- vitreous detachment symptoms with pigment in the vitreous, or
- viral conjunctivitis if severe (e.g. presence of pseudomembrane)

b. urgent referral (within one week. We recognise that in some areas there may not be an appropriate pathway for patients to be seen within a week.

You should familiarise yourself with local referral pathways to ensure the patient is seen within an appropriate timescale), symptoms or signs suggesting:

- acute dacryoadenitis
- acute dacryocystitis if mild
- atopic keratoconjunctivitis with corneal epithelial macro-erosion or plaque
- unilateral blepharitis if carcinoma suspected
- chlamydial conjunctivitis (refer to GP)
- CMV and candida retinitis
- commotio retinae
- corneal hydrops if vascularisation present
- CRVO with elevated IOP (<40mmHg. If ≥ 40 mmHg refer as emergency)
- herpes zoster ophthalmicus with deeper corneal involvement—urgent referral to ophthalmology, but refer to GP as an emergency for systemic anti-viral treatment.
- IOP >35 mm Hg (and <40mmHg) with visual field loss
- keratoconjunctivitis sicca if Stevens Johnson syndrome or ocular cicatricial pemphigoid are suspected
- retinal detachment if not an emergency, see above
- retrobulbar/optic neuritis
- ocular rosacea with severe keratitis
- rubeosis
- squamous cell carcinoma
- steroid induced glaucoma
- sudden onset diplopia,
- vernal keratoconjunctivitis with active limbal or corneal involvement, or

- ~~'wet' macular degeneration/choroidal neovascular membrane, according to local fast track protocol.~~

Delegation

~~C.206-C.208.~~ Delegation is different from referral. See section on Working with colleagues. Referral is when you arrange for another practitioner to provide a service that falls outside your scope of practice, contract or professional competence, such as referring a patient to a contact lens optician for contact lens care. Delegation is when you ask a colleague to provide care or undertake a procedure on your behalf.

~~C.207-C.209.~~ When you delegate care, you are still responsible for:

- a. the overall management of the patient, and must ensure that your patient receives the same standard of care that you would provide, and
- b. the work of the person to whom you have delegated the procedure and any clinical findings.¹²²

~~C.208-C.210.~~ When you delegate, you should be satisfied that the person to whom you delegate has the skills and experience to provide the relevant care or undertake the procedure. If harm can result from the procedure, such as instilling eye drops or insertion and removal of a contact lens, you must remain on the premises so you can intervene if necessary.¹²³

~~C.209-C.211.~~ You should not ask someone who is not suitably qualified to interpret any clinical findings.

~~C.210-C.212.~~ You should explain to the patient that you are delegating a particular part of their care to your colleague and that you will discuss any clinical findings with the patient.

~~C.211-C.213.~~ You must not delegate any part of the protected functions of sight testing or contact lens fitting, including any part that would be regarded as assessing the patient or exercising professional judgement, other than to someone who is registered to perform the protected functions.

Supervision

~~C.212-C.214.~~ This section covers general principles of supervision. If you supervise pre-registration optometrists you should follow the guidance in the College's Pre-registration Scheme Supervisor Handbook.

~~C.213-C.215.~~ If you are in a practice where colleagues need supervising, you must ensure that a named practitioner is responsible for supervising them each day and that everyone is clear who the supervising practitioner is.

College of Optometrists

~~C.214~~-C.216. If you supervise colleagues, you should:

- a. ensure that you have the necessary skills to supervise them
- b. observe their work
- c. give them regular constructive feedback on their performance.

~~C.215~~-C.217. You remain responsible for the patients under the care of anyone you supervise.

~~C.216~~-C.218. You must be in a position to give advice and support or delegate supervision to someone who can do so.

~~C.217~~-C.219. You must supervise dispensing to patients under the age of 16 or to those who are registered sight impaired unless this is done by another optometrist, dispensing optician or doctor.

~~C.218~~-C.220. You must supervise a trainee optometrist, dispensing optician or medical student, or a dispensing optician training to be a contact lens optician if they are performing restricted functions, unless they are being supervised by another optometrist, dispensing optician, doctor or a contact lens optician, as appropriate. You must make a judgement about their capability and how closely they need to be supervised. At the very least you must be on the premises when the restricted function is taking place so you are in a position to intervene if necessary.

~~C.219~~-C.221. If you supervise a colleague, for example, someone who is returning to work or is undergoing additional training, you must assess their capability so that you can tailor their supervision to their level of competence.

Continuity of care

~~C.220~~-C.222. When referring, delegating or supervising, you must keep good records and ensure that your colleagues have all the information they need to care for your patient. See section on Working with colleagues for the information you should include when making a referral.

~~C.221~~-C.223. If you care for another clinician's patient you must keep good records.

¹¹⁴ General Optical Council. (2016) Standards of Practice for Optometrists and Dispensing Opticians. Available from: standards.optical.org [Accessed 8 Jan 2020]

¹¹⁵ Optical Confederation (2014) Managing non-tolerance issues. Available from: opticalconfederation.org.uk/downloads/guidance/optical-confederation-managing-non-tolerances-guidance-final-20th-dec-14.pdf [Accessed 8 Jan 2020]

¹¹⁶ National Institute for Health and Care Excellence Quality Standard 180 (Feb 2019) . Available from: nice.org.uk/guidance/qs180/chapter/Quality-statement-1-Referral-chronic-open-angle-glaucoma-and-related-conditions [Accessed 8 Jan 2020].

¹¹⁷ Scottish Intercollegiate Guidelines Network (2015) Glaucoma referral and safe discharge Available from: sign.ac.uk/sign-144-glaucoma-referral-and-safe-discharge.html [Accessed 8 Jan 2020]

¹¹⁸ General Optical Council (1999) Rules relating to injury or disease of the eye SI 3267. Available from: legislation.gov.uk/uksi/1999/3267/contents/made [Accessed 8 Jan 2020]

¹¹⁹ General Optical Council (2016) Standards of Practice for Optometrists and Dispensing Opticians, para 10.3 Available from: standards.optical.org [Accessed 8 Jan 2020]

¹²⁰ Opticians Act 1989, s.26(1)(b)(ii). Available from: optical.org/en/about-us/legislation/opticians_act.cfm

¹²¹ Sight Testing (Examination and Prescription)(No 2) Regulations 1989 SI 1230 s3(1)(b)(iii)

¹²² General Optical Council (2016) Standards of Practice for Optometrists and Dispensing Opticians, para 10.3 Available from: standards.optical.org [Accessed 8 Jan 2020]

¹²³ General Optical Council (2016) Standards of Practice for Optometrists and Dispensing Opticians, para 10.3 Available from: standards.optical.org [Accessed 8 Jan 2020]

Maintaining trust

Honesty and integrity

Key points

- You must be honest and trustworthy.
- You must make the care of the patient your first and continuing concern.
- You must not discriminate against patients or colleagues.
- You must act quickly to protect patients from risks posed by colleagues.
- You must inform the General Optical Council (GOC) of any matter that may impair your fitness to practise.
- You must declare to the GOC all criminal convictions, cautions and disciplinary proceedings, except minor road traffic offences.
- You must co-operate with inquiries, fitness to practise hearings and complaints procedures.
- Your financial and commercial practices must not compromise patient safety.
- You must not accept inducements or gifts that may be seen as affecting your patient care.
- You must be honest in your financial and commercial dealings with patients and all other parties.
- You must be covered by adequate and appropriate insurance to practise in the United Kingdom throughout the period of your registration.

[This Guidance does not change what you must do under the law.](#)

Principle

D.1. You must be honest and trustworthy.¹²⁴

Treating patients and colleagues fairly

Patients

D.2. You must make the care of the patient your first and continuing concern.
[124124250](#)

D.3. You must ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession. [124124250](#)

D.4. You must treat every patient politely and considerately. [124124250](#)

D.5. You must respect patients' dignity and privacy. [124124250](#)

- D.6. You must not allow your personal views to adversely affect your relationship with patients.
- D.7. You should tell patients if any investigation or treatment you recommend is not supported by evidence or by established practice.
- D.8. You are not obliged to see a patient, provided you have reasonable grounds for your decision, such as a threat to your safety or that of your colleagues or the public. You should record your reasons for refusal.
- D.9. You must not discriminate against patients on the grounds of:¹²⁵
- a. age
 - b. disability
 - c. gender reassignment
 - d. marriage and civil partnership
 - e. pregnancy and maternity
 - f. race
 - g. religion or belief
 - h. sex, or
 - i. sexual orientation.
- D.10. You must stop practising if your fitness to practise is affected by your physical or mental health and may put others at risk. [124124128](#)

Colleagues

- D.11. You must work with colleagues in ways that best serve patients' interests, and communicate effectively with them. [124124128](#)
- D.12. You must not make any patient doubt the knowledge or skills of colleagues or other health care professionals by making unnecessary or unfounded comments about them, either privately or publicly, for example through social media.
- D.13. You must act quickly to protect patients from risks posed by colleagues. The safety of patients must come first. If you have serious concerns about any practitioner's fitness to practise you should raise this with them first if you feel able to. If necessary you should escalate your concerns to an appropriate person. This could be the colleague's line manager, employer, or person in a

Primary Care Organisation or hospital. If you remain concerned you should consult the relevant professional, representative or regulatory body.

- D.14. Raising a concern is different from making a complaint. If you make a complaint, you might be asked for evidence to prove your case. When you raise a concern, you should not be expected to prove the issue you are concerned about. If you are not sure whether you should act, ask yourself:
- a. what might the outcome be in the short- or longer-term if I do not raise my concern? And
 - b. how could I justify why I did not raise the concern?
- D.15. You must treat your colleagues fairly. You must not discriminate against colleagues, see para ~~C.168C-168C.165~~.¹²⁵⁺¹²⁵⁺¹²⁹ You must not allow your personal views to adversely affect your relationship with them.
- D.16. If you receive a prescription for dispensing from another practitioner and there is an anomaly or a complaint of non-tolerance after dispensing, you should contact the prescribing practitioner. You should agree a course of action with them and the patient. The Optical Confederation has produced guidance on this.¹²⁶

See sections on Partnership with patients and Working with Colleagues.

Openness in legal or disciplinary hearings

- D.17. You must follow the law.
- D.18. You must inform the General Optical Council (GOC), all relevant authorities and your employers if there are any matters relating to your character, behaviour, judgement or health that may impair your fitness to practise.¹²⁷
- D.19. You must declare to the GOC and all relevant authorities all criminal convictions, cautions and disciplinary proceedings, including minor misdemeanours but not road traffic offences which are dealt with by a fixed penalty notice.¹²⁶⁺¹²⁶⁺¹³⁰
- D.20. You must co-operate with formal and informal investigations, fitness to practise hearings and complaints about yourself or colleagues, whilst following guidance on confidentiality.¹²⁸
- D.21. The College has produced guidance for optometrists who undertake work as expert witnesses.¹²⁹

See sections on Confidentiality, Dealing with complaints, Working with colleagues and Raising concerns.

Integrity and conflicts of interest

- D.22. You must ensure that your financial and commercial practices do not compromise patient safety.¹²⁴¹²⁴¹²⁸
- D.23. You must be honest in your financial and commercial dealings with patients, colleagues, employers, insurers and other organisations.
- D.24. You must not accept inducements or gifts that may be seen as affecting your patient care or your recommendation of a course of action, for example referring a patient to a particular clinic.¹³⁰
- D.25. You must never accept gifts, ~~or~~ hospitality or bequests that may affect, or be seen to affect, your professional judgement or the public's trust in the profession. You must also not put pressure on patients or their families to make donations to other people or organisations.
- D.26. You must be honest about and declare any conflict, or perceived conflict of interest. This applies to your practice as well as to related activities such as attending meetings and giving lectures.
- D.27. You must only refer a patient to a colleague if this is in the patient's best interests, rather than for your own, or a colleague's, financial gain or benefit.

See section on Partnership with patients.

Indemnity

- D.28. You must have an appropriate level of professional indemnity and, where appropriate, product liability insurance.¹³¹
- D.29. You must ensure that your insurance covers any changes in your scope of practice and responsibilities.
- D.30. You must ensure that your insurance cover continues if you:
- change insurers
 - take a career break, or
 - stop practising, since claims can be made many years after an event.
- D.31. You should choose your insurer after gaining a full understanding of the nature of the cover available and the difference between 'claims made' and 'claims occurring' insurance.
- D.32. In a 'claims made' insurance plan, your membership of the plan at the time the claim is made is what determines eligibility for cover. It works on the basis that all claims made while you are a member of a 'claims made' insurance plan

are covered, even if the incidents which give rise to the claim occurred when you were not a member. So the claim must be made while you are a member of the plan. All incidents in your past are covered, even if they happened before you joined that insurance plan. When you leave a 'claims made' plan you should take out run-off cover from your previous insurer, or retrospective cover from your new insurer, to ensure that your insurance for past events continues. Your insurer can arrange that cover for you.

D.33. In a 'claims occurring' insurance plan, your membership of the plan at the time of the incident which later gives rise to the claim is what determines eligibility for cover. It works on the basis that any event that occurs during the period for which you have bought cover will be insured, even if the claim arises in a period during which you are no longer a member of that plan. If, after you cease to be a member of a 'claims occurring' plan, a claim is made against you regarding an event that occurred while you were a member of the plan, then claims relating to that incident will be covered. If you move from a 'claims made' insurer to a 'claims occurring' insurer you need to make sure that you buy run-off cover from your previous insurer, or retrospective cover from your new insurer for the period you were in practice before joining the 'claims occurring' plan. Your insurer can arrange that cover for you.

D.34. If you are a locum or work in more than one business, you should be fully acquainted with the extent and nature of the insurance policy or policies which cover your work for each business. If you rely on one employer's insurance, you should be aware that one employer's cover may not extend to another employer.

Useful information and links

NHS England (2019) Tackling fraud, bribery and corruption: economic crime strategy 2018-2021. Available from: [england.nhs.uk/publication/tackling-fraud-bribery-and-corruption-economic-crime-strategy-2018-2021/](https://www.england.nhs.uk/publication/tackling-fraud-bribery-and-corruption-economic-crime-strategy-2018-2021/) [Accessed 7 Jan 2020].

Ministry of Justice. The Bribery Act 2010: Quick start guide. Available from: [justice.gov.uk/downloads/legislation/bribery-act-2010-quick-start-guide.pdf](https://www.justice.gov.uk/downloads/legislation/bribery-act-2010-quick-start-guide.pdf) [Accessed 7 Jan 2020]

Optical Confederation (2011) Bribery Act guidance. Available from: [opticalconfederation.org.uk/downloads/bribery-act---optical-confederation-guidance-for-members.pdf](https://www.opticalconfederation.org.uk/downloads/bribery-act---optical-confederation-guidance-for-members.pdf) [Accessed 7 Jan 2020]

Optical Confederation (2015) Cooling-off period guidance. Available from: [opticalconfederation.org.uk/downloads/uk-cooling-off-period-guidance---september-2015---links-updated-february-2016.pdf](https://www.opticalconfederation.org.uk/downloads/uk-cooling-off-period-guidance---september-2015---links-updated-february-2016.pdf) [Accessed 7 Jan 2020]

College of Optometrists

Royal College of Ophthalmologists Refractive surgery standards. Available from: <https://rcophth.ac.uk/standards-publications-research/refractive-surgery-standards/> [Accessed 7 Jan 2020]

¹²⁴ General Optical Council (2016) Standards of Practice for Optometrists and Dispensing Opticians. Available from: standards.optical.org [Accessed 7 Jan 2020]

¹²⁵ Equality Act 2010. Available from: legislation.gov.uk/ukpga/2010/15/contents

¹²⁶ Optical Confederation (2014) Managing non-tolerance issues. Available from: opticalconfederation.org.uk/downloads/guidance/optical-confederation-managing-non-tolerances-guidance-final-20th-dec-14.pdf [Accessed 7 Jan 2020]

¹²⁷ General Optical Council (2013) Declarations guidance for fully qualified registrants. Available from: optical.org/en/Registration/Making_declarations/index.cfm [Accessed 7 Jan 2020]

¹²⁸ General Optical Council. Investigating complaints. Available from: optical.org/en/Investigating_complaints/ [Accessed 7 Jan 2020]

¹²⁹ College of Optometrists Expert witnesses. Available from: college-optometrists.org/the-college/expert-witnesses.html [Accessed 7 Jan 2020]

¹³⁰ Bribery Act 2010. Available from: legislation.gov.uk/ukpga/2010/23/contents

¹³¹ Opticians Act 1989 s.10A. Available from: optical.org/en/about_us/legislation/opticians_act.cfm

Research and audit

Key points

- You must make the care and safety of the patient your first and continuing concern.
- You should ensure that you have gained ethical approval for any research you undertake on people or animals.
- You must work within relevant legislation.

[This Guidance does not change what you must do under the law.](#)

Definition of research

D.35. Research is a systematic activity that:

- a. attempts to answer a clearly defined question
- b. employs systematic and rigorous methods, and
- c. leads to generalisable and new knowledge.¹³²

Ethical research

D.36. You must make the care and safety of the patient your first and continuing concern.¹³³

D.37. If you undertake research on people or animals, you should seek ethical approval, where appropriate, using the relevant research ethics approval process.

D.38. In the UK, the routes to ethical approval are:

- a. university ethics committees, or
- b. The ~~National~~ Research Ethics Service, which is part of the Health Research Authority.¹³⁴

D.39. If your research involves even one NHS patient or record you should apply for ethical approval using the HRA Approval system.

D.40. University research will be subject to the ethics processes in place at the individual institution.

College of Optometrists

D.41. You must work within the relevant legislation; see Useful information and links section below.

D.42. Where you conduct research on people you must get consent from the research participants before involving them in any research project. For people who are unable to consent you will need to make an additional application.

D.43. You must maintain confidentiality.¹³⁵

[D.44.](#) You must act with honesty and integrity when designing, supervising or carrying out research.

[NHS National Data Opt-out](#)

[D.44-D.45.](#) [You must give patients a choice as to whether or not their information is used for research and planning.](#)^{136,137}

See sections on Consent and Confidentiality.

College research ~~misconduct~~principles

[D.45-D.46.](#) You should protect the evidence base for optometry and vision science as follows:

- a. you should publish data of any trial in humans within one year of completion of the trial. This applies even if the trial appears to have been unsuccessful; publishing all data helps to ensure the evidence base is robust¹³⁸
- b. you should not enter into contracts that restrict your ability to publish results or provide appropriate access to data; such agreements can prevent researchers from independently publishing unbiased reports of their research
- c. you must not deliberately [fabricate or](#) falsify data or information
- d. you must not deliberately misrepresent data. Doing so may lead to untrue or misleading findings which may skew the evidence base
- e. you must not plagiarise others' work
- f. you should declare any interest or connection relevant to the outcome of a research project in all dissemination. This will enable a fair evaluation of any potential conflicts of interest
- g. you should name all authors involved in a publication before submission of a paper, to ensure transparency, and

- h. you should avoid duplicate publication of the same material in multiple journals to ensure transparency for literature reviews and a robust evidence base.

Definition of audit

~~D.46-D.47.~~ [Audit is a test of whether things are being done as they should. It compares current practice with predefined standards. Audit may raise questions that might be answered by further research.](#)¹³²¹³²²⁵⁸ Examples of things that may be audited in optometric practice are the completeness of clinical records and the outcome of optometric referrals, for example whether feedback is received from the clinician to whom the patient has been referred.

Audit principles

~~D.47-D.48.~~ [If you are only using your existing patient record base for the purpose of audit you do not need to get patient consent since they have already given their consent to you creating and retaining their records. You must get patient consent if you are publishing any patient identifiable data.](#)

~~D.48-D.49.~~ [Clinical audit projects must conform to appropriate ethical standards. The Health Quality Improvement Partnership has produced a guide to managing ethical issues in clinical audit.](#)¹³⁹ Normally audits can be undertaken without the requirement of ethical approval, however, there may be rare instances where the nature of the audit or the local guidelines mean it is necessary to get approval. The chart on Differentiating clinical audit, service evaluation, research and usual practice or surveillance work in public health gives some useful definitions of audit and research.¹⁴⁰

~~D.49-D.50.~~ [You should identify, and agree with other practice staff as appropriate, the audit:](#)

- a. purpose
- b. scope
- c. topic, and
- d. criteria or standards.

~~D.50-D.51.~~ [You should use an audit to measure the level of performance in your practice.](#)

~~D.51-D.52.~~ [You should use the results of your audit to inform changes and improvements in your practice.](#)

~~D.52-D.53.~~ [You should review any changes made on a regular basis.](#)

Useful information and links

College of Optometrists Clinical audit in optometric practice (2019) Available from: college-optometrists.org/guidance/supplementary-guidance/clinical-audit-in-optometric-practice.html [Accessed 7 Jan 2020]

College of Optometrists Clinical audit training. Available from: learning.college-optometrists.org/ [Accessed 7 Jan 2020]

Health Research Authority hra.nhs.uk/

Health Research Authority and Medical Research Council. Is my study research? Decision tool. Available from: hra-decisiontools.org.uk/research/ [Accessed 7 Jan 2020]

NHS Digital: National data opt-out. Available from: digital.nhs.uk/services/national-data-opt-out [Accessed 8 Jan 2020]

NHS Research and Development Forum. Available from: rdforum.nhs.uk/content/ [Accessed 7 Jan 2020]

NHS Research Scotland nhsresearchscotland.org.uk/ [Accessed 7 Jan 2020]

NICE et al (2002) Principles for best practice in clinical audit. Oxford: Radcliffe Medical. Available from: uhbristol.nhs.uk/files/nhs-uhbt/best_practice_clinical_audit.pdf [Accessed 7 Jan 2020]

UK Research Integrity Office (2009): Code of practice for research: promoting good practice and preventing misconduct. Available from: ukrio.org/wp-content/uploads/UKRIO-Code-of-Practice-for-Research.pdf [Accessed 6 Feb 2020]

Relevant legislation

Adults with Incapacity (Scotland) Act 2000 [Available from: legislation.gov.uk/asp/2000/4/contents](https://legislation.gov.uk/asp/2000/4/contents)

Animals (Scientific Procedures) Act 1986 Available from: legislation.gov.uk/ukpga/1986/14/contents

Data Protection Act 2018 Available from: legislation.gov.uk/ukpga/2018/12/contents

EU General Data Protection Regulation (GDPR) Available from: ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/ [Accessed 7 Jan 2020]

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Human Tissue (Scotland) Act 2006 Available from:

legislation.gov.uk/asp/2006/4/contents

The Human Tissue Act 2004 (Ethical Approval, Exceptions from Licensing and Supply of Information about Transplants) Regulations 2006 (SI 1260)

Available from: legislation.gov.uk/uksi/2006/1260/contents

Mental Capacity Act 2005 Available from:

legislation.gov.uk/ukpga/2005/9/contents

¹³² Health Research Authority (2020) UK policy framework for health and social care research, Available from: hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/ [Accessed 7 Jan 2020]

¹³³ General Optical Council (2016) Standards of Practice for Optometrists and Dispensing Opticians. Available from: standards.optical.org [Accessed 7 Jan 2020]

¹³⁴ hra.nhs.uk/about-us/committees-and-services/res-and-recs/ [Accessed 7 Jan 2020]

¹³⁶ nhs.uk/your-nhs-data-matters/ [Accessed 8 Jan 2020]

¹³⁷ digital.nhs.uk/services/national-data-opt-out

¹³⁸ All Trials campaign Available from: alltrials.net/find-out-more/all-trials/#_ftn9 [Accessed 6 Feb 2020]

¹³⁹ Health Quality Improvement Partnership Guide to managing ethical issues in quality improvement or clinical audit projects November 2017 Available from: hqip.org.uk/wp-content/uploads/2017/02/guide-to-managing-ethical-issues-in-quality-improvement-or-clinical-audit-projects.pdf [Accessed 8 Jan 2020]

¹⁴⁰ Health Research Authority and Medical Research Council. Is my study research? Decision tool. Available from: hra-decisiontools.org.uk/research/ [Accessed 7 Jan 2020]

Annex 1 Equipment list for the routine eye examination

The following equipment is suggested:

- accommodation rule
- Amsler charts
- applanation tonometer *
- colour vision test
- condensing lens for binocular indirect biomicroscopy with the slit-lamp
- direct ophthalmoscope
- distance and near oculomotor balance tests
- focimeter
- keratometer
- letter matching card
- near vision tests (adults and children)
- near vision unit, for example Mallett unit
- pen torch
- peripheral visual field equipment
- retinoscope
- slit-lamp biomicroscope
- suitable test chart
- test for stereopsis
- threshold controlled visual field equipment
- trial lenses, trial frame and accessories.

* Non-contact tonometers are suitable for screening but contact applanation tonometers (preferably Goldmann) are preferred when considering referral.

The following additional equipment may be appropriate:

- autorefractor
- binocular headset indirect ophthalmoscope
- children's acuity charts
- contrast sensitivity chart
- digital imaging system
- equipment for foreign body removal
- equipment for punctum plug insertion and tear duct syringing
- non-mydratic camera
- prism bars
- refractor head
- slit-lamp mounted camera
- supplementary vision charts (for example low vision charts, Sheridan Gardiner, Landolt C, etc).

Annex 2 Ophthalmic abbreviations

Eye examination terms

AC	Anterior chamber	Ext	External (eye)
AC 4/4	grade 4 Anterior chamber angle	FB	Foreign body
AC 3/4	grade 3 Anterior chamber angle	FD	Fixation disparity
AC 2/4	grade 2 Anterior chamber angle	FF	Foveal fixation
AC 1/4	grade 1 Anterior chamber angle	FOH	Family ocular history
AC 0/4	grade 0 Anterior chamber angle (closed)	F/U	Follow up appointment
AC/A	Accommodative convergence/ accommodation ratio	GH	General health
Acc	Accommodation	G(M)P	General (medical) practitioner
Ad	Advised	HA	Headaches
Add	Addition	HARC	Harmonious abnormal retinal correspondence
AIT	After-image transfer	HM	Hand motion vision – state distance
ALT	Alternating	Hx	History
ALT SOT	Alternating esotropia	IOL	Intra-ocular lens implant
ALT XOT	Alternating exotropia	IOP	Intra-ocular pressure
ARC	Anomalous retinal correspondence	ISNT	Inferior, Superior, Nasal, Temporal (rule used to assess optic disc appearance)
A/V	Arteriole/Venue ratio	K	Keratometry
BE	Both eyes	LE	Left eye
BIO	Binocular indirect ophthalmoscopy	LHyperT	Left hypertropia
BSV	Binocular single vision	LHypoT	Left hypotropia
BV	Binocular vision	LOs	Lenticular opacities
BVD	Back vertex distance	L/R FD	L/R fixation disparity
BVP	Back vertex power	L/R	L hyperphoria
CD	Centration distance	LSOT	Left esotropia
C/D	Cup/disc ratio	LVA	Low vision aid
CF	Count fingers vision – state distance	MDU	Mallett distance unit
CT	Cover test	MNU	Mallett near unit
c/u	Check-up	M.Wing	Maddox Wing
CW	Close work	MR	Maddox Rod
Δ	Prism dioptre	NCT	Non-contact tonometer
D	Dioptres	ND	Neutral density filter
DC	Dioptres cylinder	NPL	No perception of light
DNA	Did not attend	NPC	Near point of convergence or no previous correction
DOB	Date of birth	NRC	Normal retinal correspondence
DS	Dioptres sphere	NV	Near vision
DV	Distance vision	NWT	Normal wearing time
DVD	Dissociated vertical divergence	o symptoms	Zero symptoms
EF	Eccentric fixation	φ	Horizontal orthophoria
		θ	Vertical orthophoria
		⊕	Horizontal & vertical orthophoria

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OCs	Optical centres	SOP/ESOP	Esophoria
Occ	Occupation	SOT/ESOT	Esotropia
OH	Ocular history	Supp.	Suppression
OMB	Oculo motor (or muscle) balance	V	Vision (unaided)
ONH	Optic nerve head	VA	Visual acuity (corrected)
Oph	Ophthalmoscopy	VAL	Left visual acuity
PD	Pupillary distance	VAR	Right visual acuity
PERRLA	Pupils equal, round, reactive to light and accommodation	VDU	Visual display unit
PH	Pinhole	VF	Visual field
PL	Perception of light	VPS	Variable prism stereoscope
POH	Previous ocular history	WD	Working distance
PPA	Peripapillary atrophy	X/12	X months
Px	Patient	X/52	X weeks
RAPD	Relative afferent pupillary defect	X/7	X days
RE	Right eye	XOP/EXOP	Exophoria
Ret.	Retinoscopy	XOT/EXOT	Exotropia
RHyperT	Right Hypertropia		
RHypoT	Right Hypotropia		
RNFL	Retinal nerve fibre layer		
RPE	Retinal pigment epithelium		
RSOT	Right Esotropia		
Rx	Prescription		
SLE	Slit lamp examination		
SLM	Slit lamp microscope		

NB: NAD is frequently used but is not recommended

Clinical condition terms

AMD/ARMD	Age related macular degeneration	DR	Diabetic retinopathy
ACG/CAG	Angle closure glaucoma	ESR	Erythrocyte sedimentation rate
BDR	Background diabetic retinopathy	GPC	Giant papillary conjunctivitis
BP	Blood pressure	IDDM	Insulin dependent diabetes mellitus
BRAO	Branch retinal artery occlusion	IRMA	Intra-retinal microvascular abnormality
BRVO	Branch retinal vein occlusion	KCS	Keratoconjunctivitis sicca
CAG	Closed angle glaucoma	KP	Keratic precipitates
Cat	Cataract	LASEK	Laser epithelial keratomileusis
CLAPC	Contact lens associated papillary conjunctivitis	LASIK	Laser in situ keratomileusis
CLARE	Contact lens associated red eye	LTG	Low tension glaucoma
CLPU	Contact lens associated peripheral ulcer	MI	Myocardial infarction
CNS	Central nervous system	MS	Multiple sclerosis
CRAO	Central retinal artery occlusion	NIDDM	Non-insulin dependent diabetes mellitus
CRVO	Central retinal vein occlusion	NRR	Neuro-retinal rim
CVA	Cerebrovascular accident	NS	Nuclear sclerosis
		NTG	Normal tension glaucoma

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PDR	Proliferative diabetic retinopathy	SPEE	Superficial punctate epithelial erosions
PDT	Photodynamic therapy	TIA	Transient ischaemic attack
PK	Penetrating keratoplasty	T1 diab	Type 1 diabetes
POAG	Primary open angle glaucoma	T2 diab	Type 2 diabetes
PPDR	Preproliferative diabetic retinopathy		
PRA	Pan retinal ablation		
PRK	Photorefractive keratectomy		
PRP	Pan retinal photocoagulation		
PSCC	Posterior sub-capsular cataract		
PVD	Posterior vitreous detachment		
RD	Retinal detachment		
RK	Radial keratotomy		
RP	Retinitis Pigmentosa		
SEAL	Superior epithelial arcuate lesion		
SLK	Superior limbic keratoconjunctivitis		
SPK	Superficial punctate keratitis		

Contact lens terms

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	Rigid gas permeable
CLAPC	Contact lens associated papillary conjunctivitis	SCL	Soft contact lens
CLARE	Contact lens associated red eye	SiH	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

Pharmacy and drug terms

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

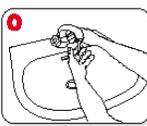
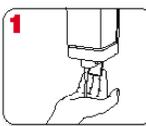
Annex 3 World Health Organization guidance on handrubbing and handwashing techniques

How to handrub? WITH ALCOHOL-BASED FORMULATION

How to handwash? WITH SOAP AND WATER

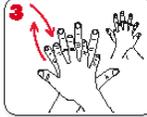
1a  **1b** 

Apply a palmful of the product in a cupped hand and cover all surfaces.

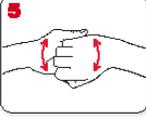
0  **1** 

Wet hands with water
apply enough soap to cover all hand surfaces.

2  Rub hands palm to palm

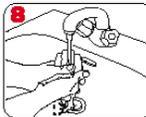
3  right palm over left dorsum with interlaced fingers and vice versa

4  palm to palm with fingers interlaced

5  backs of fingers to opposing palms with fingers interlocked

6  rotational rubbing of left thumb clasped in right palm and vice versa

7  rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa

8  rinse hands with water

9  dry thoroughly with a single use towel

10  use towel to turn off faucet

 20-30 sec

8 

...once dry, your hands are safe.

 40-60 sec

11 

...and your hands are safe.



WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.



October 2006, version 1.

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