Comments from Guidance KSP domain consultation October 2019

No	Respondent	Paragraph (revised paragraph in brackets)	Comment	Suggested response
1	Member	General	Members might appreciate an explanation of the difference between 'good' and 'best' practice	Thank you for your comment. We will describe more what we mean.
2	Member	Imaging chapter	Suggested inserting that prof judgement should be used to decide how many of the previous images should be looked at and how far back in time you should go?	Thank you for your suggestion. This is self-evident and as such we will keep the original wording.
3	Member	Imaging section A28-A31	Should this read 'image or scan'?	Thank you, we will amend this for clarity.
4	Member	A28-A31	A28 appears to remove the option to recommend routine clinical imaging. I believe that this sends the wrong message and fails to appreciate the value of imaging in symptom-free patients. E.g. it might seem obvious to OCT scan a 55 year old patient with strong FHG, but a 75 year old has a 4x higher risk of developing POAG than the 55 year old and OCT is important to evaluate discs and RNFL health and quantitatively monitor it. I find this recommendation obtuse and of dubious intention.	Thank you for your suggestion. The paragraph says you can use your professional judgement, so no changes needed.
5	DO	A32	You state that patient records belong to the practice where they were made. I do not necessarily believe this is correct as patient records funded by GOS may remain the property of NHS England.	This is not correct: although they make take care of them if a practice closes down and cannot find another practice to take them, NHS England is not the data controller for primary care medical records held by an optometry practice. No changes needed.

6	DO	A34	It would be useful to have mention that there is a contractual duty to advise NHS England when a practice is about to close.	This is a useful suggestion, thank you, and it also applies in the other nations. We will amend A34c to include this.
7	Member	A47	'You must not charge for any procedure you undertake as part of a GOS sight test in England, Northern Ireland, Scotland and Wales' is ambiguous. A chargeable service may be delivered at the same time as a GOS Sight Test	This is a contractual requirement for the provision of GOS. You must not charge for any part of the GOS. This does not prohibit you from performing additional examinations outside the GOS, but if the patient refuses to pay for these you must not charge them for their GOS. No changes needed.
8	Member	A48b	Why drop unaided Vision in favour of habitual? Why not advise best practice is both? Unaided is vital in cases where there is equivocation on the part of the patient to wear Rx driving or not. Unaided tells you what the vision is if they do NOT have back up specs if they are a CL wearer. Sometimes showing and demonstrating and recording unaided is the only way to convince the patient. Conflicts with A20d	Thank you for pointing out that this conflicts with A20d. The reason for this change is to make it clear that there is no point in measuring unaided vision in patients with high prescriptions who habitually wear their correction. This does not, however, prohibit you from measuring both if you feel it is clinically appropriate, as in the situations you describe. We will leave as now, but amend A20d to refer to A48b, thank you.
9	Member	A52 and A282	Good point to write on the patient's prescription if they are registered as SI or SSI. We will adopt this.	Thank you for your comments.
10	DO	A59	The table says that the recommended minimum re-examination for people with diabetes who are part of the DR monitoring scheme is 2 years. You should add clarification around the recall that the patient is having for DRS = if it is 2 years then is a 2 year eye exam also acceptable.	The DRS will be monitoring the patient's risk for developing sight-threatening diabetic retinopathy. As such they will determine the most appropriate recall for the patient for this. This would not affect the patient's need for GOS. No changes needed.
11	Member	A59	Outside the GOS this is as much a matter of patient choice.	A 59 says that '… you should not recall patients more frequently than…'. It is therefore fine if the patient presents and wishes to have a

				consultation more often than these frequencies (providing GOC Standard 7.6 is complied with), as A59 only applies to recalls. No changes needed.
12	Member	A59	Table seems contradictory – on the one hand saying that in the absence of clinical signs you should not recall px more frequently than the stated numbers – implying that it is OK to just go for those as 'standard', but on the other hand stating that intervals shouldn't automatically be assumed to apply to each category.	We understand that this can be confusing, but the wording says that you should not automatically recall patients at these frequencies. Therefore you should use your clinical judgement as to whether it is appropriate for each individual patient. No changes needed.
13	Member	A59-A60	How are these re-examination intervals determined? It would be valuable to ensure they were evidence-based, where possible. In the Member Briefing on the NICER study outputs, updated in 2017 (see attached), the College summarise the impact these research findings have on clinical practice and states "To ensure refractive error is optimally corrected, it may be appropriate to examine children who are myopic, or at risk for myopia, annually until the age of 12-13 years, and every two years thereafter." For a consistent, evidence-based approach the Guidance as shown above should now be updated to reflect this advice. The reference used in the Member Briefing for the advice is McCullough SJ et al 2016[1].	Thank you for your suggestion. We will add an additional paragraph after A59 to say 'To ensure refractive error is optimally corrected, it may be appropriate to examine children who are myopic, or at risk for myopia, annually until the age of 12-13 years, and every two years thereafter'
14	Member	A67-71 (A68-72)	I am struggling with much of this. How on earth does a patient know what has caused a drop in vision. Literally anyone eligible can attend for a statutory contracted Sight Test (save obvious non visual ones like a sub conjunctival haemorrhage).	This section is designed for examinations of patients who present with symptoms such as flashes and floaters, red eyes etc, as well as follow-up appointments, as described in A67. It

			To retrospectively place an assumptions that a Sight Test has to be looking for a refractive problem is disingenuous and a modern NHS contractual interpretation without legal basis (despite what Guidance says). Legal restriction on needs led examination? Sure anyone can give an opinion and a nurse or clinical assistant can lead triage but you appear to be encouraging non optometrists to examine eyes. I find this perplexing. It may be legal but why do you appear to endorse it.	does not change the statutory definition of the sight test. Currently, we know that other healthcare professionals are conducting some of these examinations. We explain that there is no legal restriction only as a statement of fact, not an endorsement. No changes needed.
15	Member	A74 (A75)	A “full eye examination” whatever that is, is not a “GOS Sight Test” nor is it synonymous with that term. The new guidance is behind the curve on current practice.	Thank you for your comments. We will consult more widely on whether to replace the phrase ‘full eye examination’ with ‘sight test’.
16	Member	A87d (A88d)	Section A.87 “d. adjust the prescription that you find, to take into account the reduced distance of the patient from the test chart. This may be done by adding -0.25DS to the end result.” – surely the amount of adjustment depends on how much you’ve reduced the distance? This seems a very unscientific approach!	Thank you for your suggestion. We will remove ‘this may be done by adding -0.25D to the end result’ from this paragraph.
17	Member	A91i (A92i)	Why does the written advice to people with hearing difficulties need to be ‘simple’?	This was included because BSL users do not have English as their first language. We will amend to say ‘clear and accessible’ and refer to paragraph A96.
18	Member	A106 (A107)	MP3 is an old-fashioned term and would be better as ‘audio file’. ‘braille’ should be ‘Braille’ as it is the surname of the person who invented it. Why is the low vision section in the middle of the BV section?	Will amend MP3 and Braille, thank you. The low vision section is not in the middle of the BV section, so this must have been a formatting error, we will review and amend.

19	Member	A129 (A130)	Another area I would like the committee to consider updating or amending is in relation to A129, where "high refractive error – especially myopia and astigmatism" are listed amongst the common visual problems encountered in patients with learning disability. The idea of singling out myopia and astigmatism does not chime with the contemporary evidence, certainly for children and young people with learning disability and autism, and may be a result of older studies failing to reveal hyperopic errors, because cycloplegic refractions weren't employed. The evidence tells us that significant refractive errors of all types (hyperopic, myopic, astigmatic, anisometropic) are all more common in this population. I can provide references from our work and that of others to support this – for quick reference, they are listed in one of our recent publications[3] if you want a list, or let me know and I'll provide a list for you!	Thank you for your suggestion. We will remove 'especially myopia and astigmatism' from A129h.
20	Member	After A138	In the section on **"Useful information and links"** we wondered if you would include a link to the Ulster Vision Resources, an evidence-based resource for professionals and parents to help them in providing eyecare and/or support for those with learning disability and autism? The resources are used widely by practitioners and parents across the globe and can be found at www.ulster.ac.uk/ulstervisionresources	Thank you for your suggestion. We will include these resources.
21	Member	A139 (A140)	Suggest changing 'autism is a lifelong developmental disability' to 'lifelong developmental disorder', as otherwise people may lead to the assumption that autism is a LD.	Thank you for your suggestion. We will amend as you suggest.

22	Member	A139 (A140)	'Some people with autism also have learning disabilities'. Fombonne (2009) suggested approximately 45% of autistic individuals have a co-existing LD; I think it would be worth mentioning this here to put the statement into perspective. "some" suggests much fewer than 45%. FOMBONNE, E. (2009). Epidemiology of Pervasive Developmental Disorders. Paediatric Research, 65(6), 591-598.	Thank you for your suggestion. We will amend as you suggest, including the reference.
23	Member	A139 (A140)	It is important to highlight that autism affects each person differently, so each autistic patient will have their own different experiences and needs (the optometrist will need to adapt the following points)	Thank you for your suggestion. We will amend A139 to say: 'Autism is a lifelong developmental disorder that affects how a person communicates with and relates to other people, and how they experience the world around them.[i] It affects people in different ways *so you should adapt your routine according to the patient's needs*. *It has been suggested that 45% of* people with autism also have learning disabilities, so for these people you should refer to the chapter on Examining patients with learning disabilities'
24	Member	A140 (A142/3)	Booking an eye examination can be very stressful for autistic people, so having the facility to book online or by email is good.	Thank you for your suggestion. We have discussed this and consider that the difficulty of booking by email is that you do not have the opportunity to ask whether the patient has autism, or any other additional needs like you may do on the phone. This means that you will not know to allocate them extra time. We will include a sentence elsewhere relating to accessibility, to include having a facility for the

				patient to say whether they have special requirements.
25	Member	A140 (A142)	The layout of the practice can dictate how accessible it is for an autistic person. It would be good to mention this here, and that the checklist for autism-friendly environments by Simpson (2015) is good to verify assess your own practice. SIMPSON, S. (2015). Checklist for autism-friendly environments. [Online] Available: http://www.southwestyorkshire.nhs.uk/our-services/directory/service-adults-autism/checklist/ [accessed 02/07/2019]	Thank you for suggestion. We will include this at the end of A140 and also put it in useful information.
26	Member	A140 (A142)	As well as rooms. Also provide a list of the questions you are likely to ask (e.g. history and symptoms)	Thank you for your suggestion. We will amend paragraph A140 to read 'You should ask the patient, or their carer if appropriate, if they would like to visit the practice before their appointment, to help them become used to the surroundings and equipment. If this is not possible you could provide photographs of the rooms and the instruments that you will use, *or allow time at the beginning of the examination for the patient to familiarise themselves with the practice and the room setup. You could also provide a list of the questions you are likely to ask, such as history and symptoms*'.
27	Member	A140 (A142)	Or allow time at the beginning of the examination for the patient to familiarise themselves with the testing room setup.	
28	Member	A142 (A144)	It takes time for an autistic individual to get used to and comfortable with a new person. It should be recommended that to reduce stress and anxiety, the number of staff involved in an autistic patient's journey should be minimal.	Thank you for your suggestion. We will include an additional paragraph to read 'Reduce the number of staff involved in the patient's journey. This is because it takes time for a person with autism to become comfortable with a new person'.

29	Member	A143 (A145)	It would be worth mentioning here that you need to be realistic about how late you are running. If you tell an autistic individual that you are running 10 minutes late, they WILL be expecting to be seen 10 minutes late.	Thank you for your suggestion. We will amend A143 to read 'Tell the patient if you are running late, *and be realistic about when they are likely to be seen,* so that they can wait outside or come back later'.
30	Member	A143 (A146)	Suggest changing 'during' to 'before' and explaining why each test is being conducted is useful too.	Thank you for your suggest. We will rephrase A143 to say: 'Explain why each test is being conducted, and what is going to happen before each test, using clear language. Give direct instructions, such as 'please put your chin on the chin rest' rather than asking 'can you put your chin on the chin rest''
31	Member	A144 (A147)	And allow the pace of the examination to be partly dictated by the patient to ensure it is a comfortable experience.	Thank you for your suggestion. We will amend A144 to read 'Allow extra time and *allow the pace of the exam to be partially dictated by the patient*...'.
32	Member	A144 (A147)	Provide a verbal and written summary of the outcomes so the patient can digest them when at home (they may not take it in when in the practice)	Thank you for your suggestion. We already say that the optom should tell the patient what they have found and what they should recommend (A46), and the law requires them to give them a prescription, so we feel no changes are necessary. Leave as now.
33	Member	Examining patients with autism chapter A139-A149	In the section on **"Examining patients with autism"** we would like you to consider changing the wording from 'autistic people' to "person with autism" in line with more modern terminology	Thank you for your suggestion. We will change this as suggested.
34	Member	Examining patients with autism chapter A139-A149	Please use the first person language 'autistic people'. It has been shown that autistic people prefer this https://www.autism.org.uk/about/what-is/describing.aspx	Thank you for your suggestion. We have discussed this and note that there is no universally used phrase for this. We feel that – in keeping with the other chapters – it is more

				appropriate to use the phrase 'people with autism'.
35	Member	Examining patients with autism chapter (A141)	The guidance in this section does not provide a section on ocular and health conditions which practitioners should expect to see in people with autism, as section A.129 does for patients with learning disabilities. I think this would be a more helpful and consistent approach to provide some pointers about what clinicians should expect. We have researched vision and visual function in autism spectrum disorder (ASD) and have produced peer-reviewed evidence to support practitioners providing eye care for these patients. Of particular relevance to the College guidance are findings which show that, in contrast to many other developmental conditions, practitioners should expect good (best corrected) vision in patients with ASD and where reduced acuity is identified these should not be attributed to the ASD, but investigated further.[4] Furthermore, children and young people with autism are more likely to have refractive errors with an astigmatic component,[5] strabismus and poor accommodative function.[6] These findings indicate that practitioners should ensure accommodative function is explored when providing eyecare. For an overarching review paper, current knowledge of visual function in ASD is brought together in a recent publication: Little, J. (2018), Vision in children with autism spectrum disorder: a critical review. Clin Exp Optom, 101: 504-513. doi:10.1111/cxo.12651. Dr Little has also put	Thank you for your suggestion. We have put this in an additional point after A140.

			together guidance for the eyecare professional for the National Autism Society which may be useful to signpost practitioners to: https://www.autism.org.uk/professionals/health-workers/eyecare.aspx	
36	Member	A145 (A148)	Suggest amending to say 'Some autistic people may not like you invading their personal space; *for tests that require being close to the patient, explain this beforehand so that they are prepared, but* be prepared to adapt your routine accordingly.'	Thank you for your suggestion. We feel the suggested amendment is self evident from the rest of the paragraph. No changes needed.
37	Member	A146 (A149)	The majority of autistic individuals experience altered sensory reactivity; they will be either hyper or hypo sensitive. It would be worth mentioning that here as autistic patients are likely to be more/less sensitive to lighting, light levels, colour of light, patterns, visual clutter etc. autistic individuals. GREEN, D., CHANDLER, S., CHARMAN, T., SIMONOFF, E. & BAIRD, G. (2016). Brief Report: DSM-5 Sensory Behaviours in Children with and Without an Autism Spectrum Disorder. Journal of Autism and Developmental Disorders, 46(11), 3597–3606. KIENTZ, M. & DUNN, W. (1997). A Comparison of The Performance of Children with and without Autism on the Sensory Profile. The American Journal of Occupational Therapy, 51(7), 530-537. Autistic individuals also process stimuli differently, which may impact the eye examination. They	Thank you for your suggestion. We already mention about hypersensitivity so no changes needed.

			process local information very well, such as fine details, but struggle processing complex, global and multisensory information. another important point to add here to put the impacts of autism into context for optometrists so they can think about how their eye examination routine should be altered. SIMMONS, D., ROBERTSON, A., MCKAY, L., TOAL, E., MCALEER, P. & POLLICK, F. (2009). Vision in Autism Spectrum Disorders. Vision Research, 49(22), 2705-2739.	
38	Member	A148 (A151)	I suggest removing the quote. This is because autistic individuals require a clear and precise questioning technique for subjective tests. Simply asking which is better doesn't equip them with the criteria that they should follow for their judgement. Instead, they should be clearly instructed on what they should look for. "is the circle sharper and clearer with the second or first?" I would also add that autistic patients may require all dual option tests to be repeated a few times and have longer to judge the visual image with each option.	Thank you for your suggestion. We will remove the cross cylinder example and replace 'better' with 'clearer' and also add that you may have to ask more than once.
39	Member	A149 (A152)	Autistic patients need to be regularly reassured during the examination as it can be a very stressful and anxiety provoking experience.	Thank you for your suggestion. We will add 'Regularly reassure the patient' to the end of A149.
40	Member	After A149 (A152)	It is key to ensure that all of the patient's presenting queries are answered clearly so that they can go away stress free. Although the	Thank you for your suggestion. We feel this applies to all patients and is self evident. No changes needed.

			practitioner may feel they have done this, they need to make sure of this with the patient	
41	Member	After A149 (A152)	Please add to the useful information: Gowen, E, Porter, C, Baimbridge, P, Hanratty, K, Pelham, J & Dickinson, C 2017, 'Optometric and orthoptic findings in autism: A review and guidelines for working effectively with autistic adult patients during an optometric examination', Optometry in Practice, vol. 18, no. 3.	Thank you for your suggestion. We will add this to the useful information section.
42	Member	After A149 (A152)	Please add the example of a social story in the Ulster Vision Resources which eyecare professionals can use/adapt: https://www.ulster.ac.uk/research/topic/biomedical-sciences/research/optometry-and-vision-science-research-group/vision-resources/resources-for-professionals/social-story-for-an-eye-test	Thank you for your suggestion. We will add this to the useful information section.
43	DO	A177 (A180)	'Unable to attend a practice unaccompanied due to physical or mental disability' implies that if a carer was available then a domiciliary eye examination would not be applicable.	Thank you for your suggestion. This is the wording used by the Optical Confederation and NHS England. No changes needed.
44	DO	A178 (A181)	'You must provide the service only at the request of the patient, a relative or primary carer'. Would it not be useful to include GP in this list, as they frequently request domi visits?	Thank you for your suggestion. The patient, or someone caring from them must request the sight test. This may be initiated by the GP, but the patient themselves (or their carer etc) must request it. No changes needed.
45	Member	A186 – A187 (A189-A190)	Cycloplegic refraction is recommended on page 66 under A186 – A187 'Examining Younger Children' (see screenshot below). A186f says to use cycloplegic refraction 'where necessary' but what is meant by 'where necessary'? In A187 the guidance implies that using a cycloplegic refraction is needed to get an 'accurate	Thank you for your suggestion. We agree that cycloplegic refraction is important when examining young children. When to use it would be up to the professional judgement of the optometrist, depending upon all the various clinical circumstances. We feel that detailed information on this is more a matter for CPD

			assessment of the refractive error'. The recent publication from Doherty et al (2019)[2] in OPO supports this implication and demonstrates that non-cycloplegic refraction (in children aged 6-13 years of age) cannot be expected to reveal the full magnitude of hyperopia. The younger the child, the less reliably the non-cycloplegic retinoscopy result reveals the full plus. These data support the need for cycloplegia when evaluating strabismus (as noted in A187), but moreover, practitioners should be aware that they will need to apply cycloplegia if they want to know the full picture in relation to hyperopia. In cases where a cycloplegic is contraindicated or not available, Doherty's work demonstrates that 'a non-cycloplegic retinoscopy result of ≥+1.50DS may be used by practitioners wishing to identify children aged 6-13 years at risk of clinically significant hyperopia ≥+2.50DS'.	than professional guidance, so no changes needed, but we will include reference to Doherty et al's paper in the useful information section, thank you.
46	DO	A196 (A199)	Suggest adding: You should also ascertain the frequency of their screening appointments.	Thank you for your suggestion. The Guidance as written says that the optometrist should ascertain when the patient last had screening. If this is more than a year ago it would be anticipated that the optometrist would advise the patient to check when they are next due to make sure they have not been 'forgotten about'. It is impractical for the optometrist to ascertain the frequency of the patient's screening appointments, as they would not be privy to this information, but if they advise the patient to check with the DRS service if they have not

				been seen for more than 12 months, this will have a similar effect. No changes needed.
47	Member	Glaucoma section A206 (A209) et seq	I feel there is a need to expand on CAG and measuring of angles (e.g. referring to SIGN guidance and when to refer).	Thank you for your comments. The Guidance is not supposed to be a comprehensive clinical textbook, and already signposts to local national guidance, such as SIGN and NICE. No changes needed.
48	College	A209e (A212e)	Suggesting changing one of the risk factors for glaucoma from 'Myopia >6D' to 'Myopia (myopia >6D is associated with an increased risk)', as all myopia is an important risk factor for glaucoma (taken from SIGN).	Thank you for your suggestion. We will change as suggested.
49	Member	A239 (A242)	With flashes and floaters drops that should be used as a minimum is tropicamide 1% irrespective of eye colour.	Thank you for your suggestion. The method of dilation is a matter for professional judgement, so no changes needed.
50	Member	A245 (A248)	How about some guidance on dealing with a px who is 6/12- and the fact that Snellen does not necessarily predict numberplate?	Thank you for your comment. The legal standard for driving is that the driver can see *both* the numberplate and Snellen 6/12. A patient who is 6/12- does therefore not meet the standard, even if they can read the numberplate. No changes needed.
51	Member	A251 (A254)	I like the recommendation to advise the px to have a second opinion.	Thank you. We will include this.
52	Member	A253 (A256)	The patient's reasons can't outweigh the danger to the public, other passengers and the public.	Thank you for your comments. We have discussed this and will redraft to say that you should tell the patient you intend to notify the DVLA or DVA. If the patient objects to your decision to notify the DVLA or DVA you should listen to, and record their reasons for this.
53	Member	A253 (A256)	By considering the patient's reasons for objecting to this it creates confusion to the situation and this should be made clearer. What are the valid reasons to consider if a patient intends to drive when not meeting the eyesight standards and not	

			inform the DVLA/DVA on this when advised by their optom.	
54	DO	A253 (A256)	Whilst I would agree that it would be 'best practice' for the optom to inform the patient they intend to tell the DVLA I do not feel this should be 'should' tell the patient. Perhaps 'would be advised' to tell the patient. Also, I am concerned by the phrase 'should consider the patient's reasons for objecting'. This would put the practitioner in an even worse position if they are left with the responsibility to 'consider' objections. I would not include this part of the advice.	
55	Members	A254 (A257)	Various views on whether to remove the suggestion to notify the patient's GP if the optometrist notifies the DVLA/DVA that the patient does not meet the vision standards for driving.	After discussion we will change this to: 'Consider whether to notify other healthcare professionals, such as the patient's GP'. Use GOC wording (out in Jan 2020)'.
56	DO	A267 (A270)	'You should bear in mind, however, that the restricted field of view in a bifocal or varifocal lens may lead to postural problems'. This advice around varifocal lenses is very outdated.	Thank you for your suggestion. We will remove these two sentences from that paragraph.
57	Member	A269 (A272)	Scientific evidence is either evidence for or evidence against, the term 'best' is unnecessary and judgemental. It is certainly unscientific.	'The best scientific evidence currently available does not support the use of blue-blocking spectacle lenses in the general population to improve sleep quality or conserve macular health.' This is taken from our Using Evidence in Practice on blue blocking lenses, and indicates that there is a hierarchy of scientific evidence (see GRADE, with the highest being RCTs). No changes needed.
58	Member	A319 (A322)	By this removal you endorse 'dabbling' in CL practice at all levels. CLs are the biggest single risk factor in avoidable microbial keratitis.	Thank you for your comment. This should be read with the overarching statement that you must recognise and work within the limits of

				your professional competence (A7). No changes needed.
59	DO	A326 (A329)	'You should determine and advise on the length of the fitting period. This will be when you decide that the patient does not need any contact lens check-ups other than those scheduled routinely'. Would this be clearer if this was changed to 'This will be when you decide that the fitting is complete and the patient can now attend just for routine aftercare appointments'.	Thank you for your suggestion. We do not use the word 'aftercare' for contact lens check-ups, as 'aftercare' has a specific meaning in the Opticians Act. As it stands we feel this paragraph is clear, particularly as it is referenced in the subsequent paragraph (A327) which says 'When the fitting is complete (see para A326a) you must give the patient their contact lens specification'. No changes needed.
60	DO	A366i (A369i)	Sorry I do not understand this point.	Thank you for your comment. This relates to the fact that patients who have plano lenses do not – by law- have to be fitted with them or have a specification. We have reworded it to make this clearer.
61	Member	A385 (A388)	A lot of must do. All must should have a caveat of unless you can prove a bullet proof reason not to do it. i.e. extended wear lens for 4 weeks post cataract op in elderly patient with arthritis might not be able to remove, BUT will fall with plano and -6 in specs and without Rx.	The use of the word 'must' indicates a legal or regulatory obligation. We use 'should' where there is the option not to do something. The example you give would be covered by the rest of the paragraph which says 'If the px has EW CLs and, because of their disability is unable to handle them, you must teach their carer how to remove their lenses'. No changes needed.
62	Member	A389 (A392)	Removal of the mention of the increased risk in children wearing orthoK lenses is good, but there is no mention of myopia control, once again behind the curve.	We agree that myopia management is an important and evolving topic. We have separate guidance on this, which we keep under review regularly. No changes needed.
63	DO	CL sections	Remove reference to 'contact lens check-up' and replace with 'contact lens aftercare'. This is used	Thank you for your comment. Since the changes to the Opticians Act in 2005, 'Aftercare'

			in other places within the document and is the preferred standard wording from the BCLA, ABDO and other professional organisations.	has a legal meaning, so we changed this to 'contact lens check-ups', keeping 'aftercare' to refer to the duties that are legally required from suppliers. No changes needed.
64	DO	CL sections	You reference 'overnight wear'. Either 'continuous' or 'extended wear' are more accurate terms with reference to this type of contact lens modality.	Thank you for your comment. We use both 'overnight wear', to include orthokeratology lenses, and 'extended wear' to mean extended wear lenses. No changes needed.
65	Member	Contact lens section	Is there now an argument to include a short section on myopia control lenses and advice to practitioners (alongside orthoK, EW) to acknowledge this development in the profession.	Thank you for your comment. We agree that myopia management is an important and evolving topic. We have separate guidance on this, which we keep under review regularly.
66	Member	Drugs	Do you need to add a specific comment about pregnancy and the use of fluorescein given the guidance that has been issued recently?	Thank you for your comment. This is in the Optometrists Formulary. No changes needed.
67	Member	General	Progressive myopia in children and methods to manage this.	Thank you for your comment. We agree that myopia management is an important and evolving topic. We have separate guidance on this, which we keep under review regularly.
68	Member	General	Some is repetitive. Some link errors. Will look better when edits accepted.	Thank you for your comment. Some repetition is deliberate, as people may only look at one section at a time. We will proof and check links before publication.
69	Member	About the Guidance	Please do NOT use the term eye examination (no statutory definition) synonymously with 'Sight Test' which is, and which should be capitalised.	Thank you for your comment. We use the term eye examination to explain that the routine 'sight test' is more than just the testing of a person's vision. We will be seeking wider views on whether to replace the phrase 'routine eye examination' with 'routine sight test'.
70	Member	General	'Good practice' rather than 'best' is preferred. Convention says guidance applies 80% of the time to 80% of the people.	Thank you for your comment.

[i] autism.org.uk/about/what-is.aspx