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**North West Professional Standards**

**Guidance on undertaking a Optometry Record Support Audit**

**Performance Concerns**

# **Guidance on undertaking a Optometry Record Support Audit**



**Document Management**

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**Approved**

For the guidance to be approved, it **MUST** be agreed at PSOG

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| 31/07/2025 | Agreed |

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**1.0 INTRODUCTION**

1.1 An audit of an optometrist’s record keeping provides an opportunity to assess the level of record keeping against expected standards. It may be as part of a professional standards investigation or in the case of an applicant to the National Performers List (NPL) as confirmation that their record keeping is at an acceptable level to be on the NHS Optometrist Performers List.

1.2 This guide has been produced so that it can be used by Optometrist Advisors working for NHSE North West when using the refreshed Optometrist Record Review (ORR) template for all investigations requested by the Professional Standards Group (PSG) and or an Optometrist Advisor as part of an applicant to the NPL to confirm their record keeping is at an acceptable level.

1.2 Its purpose is to set out when points should be awarded so that there is more consistency between all advisors and allow more reliable and comparable scores to be achieved by the performers when the ORR is undertaken.

1.3 Each section will have advice on what is required to be seen in the clinical records for the performer to get the points that are available, and the evidence base it relates to.

**2.0 BACKGROUND**

2.1 The current tool, that has been used by NHS England North West, was developed by LOC Support Unit (LOCSU) along with relevant professional bodies to enable GOS contractors to have access to a standardised template, allowing them to check their compliance against GOS contractual requirements.

2.2 It was identified that this audit tool provides a lot of quantitative data but does not provide enough qualitative detail.

2.3 The current audit only demonstrates where a performer reaches a basic level and does not reflect the expectations of good record keeping as defined by relevant professional bodies.

2.4 The north west region has undergone a collaborative process with optometrist advisors and members of the professional standards team to review and refresh the previous optometrist audit tool.

**3.0 ASSESSMENT OUTCOME AND RATIONALE**

3.1 The acceptable outcome for this ORR has been established based on a combination of quality assurance principles, benchmarking practices, and clinical governance standards. This threshold reflects a realistic and constructive approach to auditing clinical documentation with the following primary aims:

1. **Promoting High Standards While Supporting Improvement**

Setting the acceptable assurance outcome at 80% encourages a consistently high standard of record-keeping while recognising the complexities of clinical practice. It strikes a balance between aspirational quality and the practicalities of delivering care in a dynamic optometrist practice environment. Each individual record should score more than 18 points.

1. **Benchmarking Against Common Practice**

80% threshold has been maintained against the current tool. This level is considered an acceptable minimum standard to identify strengths and areas for development without penalising providers unduly.

1. **Supporting Staff Engagement and Learning**

A more attainable target such as 80% helps foster a supportive and developmental audit culture. It encourages staff to engage with the audit process and view it as a tool for reflection and improvement, rather than as a punitive measure.

1. **Acknowledging Human and Clinical Variation**

The standard acknowledges that clinical documentation can vary based on factors such practitioner experience and operational demands and clinical presentation. Allowing for a degree of variation supports a fair and context-sensitive evaluation process.

**4.0 CORE PURPOSE OF A RECORD CARD AUDIT**

4.1 Ensure compliance with standards: To check whether clinical records meet NHS guidelines, GOC standards, professional body guidance and local commissioning requirements.

4.2 Improve patient safety and continuity of care: High-quality records ensure that care is safe, appropriate and consistent, even when more than one clinician is involved.

4.3 Identify training and development needs: Highlight gaps in knowledge or performance from an individual practitioner’s perspective as well as across the optometry team, which can guide CPD and process improvements.

4.4 Reduce legal and regulatory risk: Poor or incomplete records are a major risk factor in legal claims and GDC fitness to practise cases. Auditing helps mitigate these risks.

4.5 Support clinical governance: Optometry record audits are a fundamental part of clinical governance and demonstrate accountability, reflective practice and continuous improvement.

4.6 Driving continuous quality improvement and standards of professional practise: By turning routine documentation into a source of learning, accountability and clinical excellence through highlighting gaps and inconsistencies, promoting reflective practice, standardising clinical documentation, identifying training needs and improving patient safety.

4.7 A optometry record card audit is only one component of a professional standards investigation and should not be relied upon solely to make regulatory decisions. Those involved including optometry advisors and PSG members should be aware of the advantages and the disadvantages of this approach.

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| **✓ Advantage** | **Explanation** |  | **🗙 Disadvantage** | **Explanation** |
| **Objective Evidence** | Provides documented, tangible evidence of clinical activity and decision-making. | Focuses on Records, Not Skill | Assesses record-keeping, not actual clinical competence, communication skills, or patient outcomes. |
| **Standards-Based Assessment** | Allows comparison of records against NHS standards (e.g., GOC standards) and College of Optometirst guidance. | Potential for Documentation Bias | A practitioner might maintain excellent records but still provide substandard care — or vice versa. |
| **Identifies Gaps or Risks** | Can highlight deficiencies in record-keeping, consent documentation, recommendations etc. | Snapshot, Not Holistic | Only reflects the selected records, not necessarily the full scope of practice or performance. |
| **Encourages Reflective Practice** | Promotes self-awareness and improvement through reflection on clinical documentation | Time-Consuming | Preparing and reviewing records for audit requires administrative time and effort. |
| **Supports Patient Safety** | Good records contribute to continuity of care and medico-legal protection. | Subject to Interpretation | Audit results may vary depending on the auditor’s experience or strictness of criteria. |
| **Quantifiable and Repeatable** | Results can be measured, benchmarked, and re-audited to track improvement over time. | Retrospective, Not Real-Time | Only provides historical information — may not reflect current or evolving practices. |
| **Non-Invasive Assessment** | Does not directly interrupt clinical practice or patient care. | May Create Anxiety | Can cause stress for practitioners, especially if poorly explained or perceived as punitive. |

**5.0 AUDIT CRITERIA**

5.1 When clinical records are reviewed as part of an audit, there is an inference that the quality and completeness of the record is comparable to the quality of the care provided. However, there is little research in this area given the legal and ethical complexities involved in undertaking it. The connection between quality of care provided and completeness of records is *inference* rather than *correlation*.

5.2 The audit tool does allow the Optometry Advisor to review the performer’s “modus operandi” and reasoning. Whilst the audit itself is a Quantitative Analysis, it opens the window to a Qualitative review. The Optometry Advisor can then see if the performer’s is providing care within the latest guidelines and has kept up to date.

5.3 The assumption can then be made that a Optometrist who has kept up to date and has good records is more likely to provide a good quality of care that is safe and appropriate for the patient.

5.4 The routine audit should look at several different patient types that a optometrist undertakes on a day-to-day basis; to get a good overview of the standard of care they are providing to their patients.

**6.0 OPTOMETRY RECORD REVIEW AUDIT**

6.1 This ORR template will be used as the baseline standard for **ALL** audits carried out in the Northwest. It will look at **10** randomly selected cases as a minimum.

6.2 The audit can be carried out face to face as part of a practice visit or remotely.

**7.0 PROFESSIONAL STANDARDS GROUP (PSG) REQUESTED AUDIT**

7.1 The audits requested from the PSG vary depending upon what the issues were in the individual case. The group can specify in the Terms of Reference for the investigation if they require a STANDARD (as above) ten record card audit which in most cases will provide the information required.

7.2 Alternatively, PSG can request specific items be looked at in detail and suggest a specific number of cases for the clinical type they want to look at in detail eg patient presenting at risk of developing glaucoma.

**8.0 COMPLETION OF AUDIT TEMPLATE**

8.1 The audit template is set up so that there is a maximum score of 46 per individual record and there are 23 metrics evaluated.

8.2 For each patient that is reviewed the following need to be recorded, so that if requested later the patient reviewed can be identified.

1. Initials - enter the initials of patient in template.
2. Any patient identifier number that is used within the practice.

**If at any point during the audit you believe that there is a serious risk to patients, then you must inform the professional standards team of this risk as soon as possible.**

**9.0 CLINICAL PROCEDURES**

9.1 All items in this section should be assessed for **ALL** records

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|  **Item** | **Is performer identifiable from record?** |
| Standard | GOC Standards[GOC Standards - Patient records](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/8-maintain-adequate-patient-records.html)**8. Maintain adequate patient records*** **8.2.7** Details of all those involved in the optical consultation, including name and signature, or other identification of the author.
 |
| Criteria  | Performer should be clearly identifiable along with any other staff members involved in the consultation as part of any delegated clinical activity. |
| Points  | 2 | Performer name, GOC number and signature clearly recorded. Names of any staff members who have completed delegated activity  |
|  | 1 | Partial information recorded |
|  | 0 | Not recorded |

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| **Item** | **Is record legible?** |
| Standard | GOC Standards [GOC Standards - Patient records](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/8-maintain-adequate-patient-records.html)**8. Maintain adequate patient records****8.1** Maintain clear, legible and contemporaneous patient records which are accessible for all those involved in the patient’s care. |
| Criteria  | Legible if in handwritten form.  |
| Points  | 2 | Clear, easy to follow |
|  | 1 | Very difficult to decipher |
|  | 0 | Illegible  |

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| **Item** | **Reason for visit** |
| Standard | The reason for attendance is one of the listed items that should be in the record card.[GOC Standard - Standard 7](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/7-conduct-appropriate-assessments-examinations-tre.html)**7.1** Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs, cultural factors and vulnerabilities.GOC Standards[GOC Standards - Patient records](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/8-maintain-adequate-patient-records.html)* **8.2.3** The reason for the consultation and any presenting condition.

[College of Optometrist - Patient Records](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/patient-records#Whattorecord)1. the reason for the visit and any presenting condition. This should normally include the patient’s:
	* symptoms, description and duration
	* if relevant, history of ocular and general health
	* current general health
	* medication
	* family history of ocular and general health
	* visual needs in terms of occupation, recreation or general activities
	* whether the patient drives, with or without prescription
	* previous optical prescription and date of last eye examination or sight test. This can be approximate, if the exact date is not known
 |
| Criteria  | The recording of the reason for attendance is essential in setting the context of what happens next at the visit so it should be recorded in record card. |
| Points  | 2 | Reason for attendance recorded clearly in notes with detailed history associated with it. |
|  | 1 | Reason for attendance recorded but minimal detail. |
|  | 0 | No evidence of reason for attendance recorded |

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| **Item** | **Ocular History** |
| Standard | GOC Standards[GOC Standard - Standard 7](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/7-conduct-appropriate-assessments-examinations-tre.html)**7.1** Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs, cultural factors and vulnerabilities.[GOC Standards - Patient records](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/8-maintain-adequate-patient-records.html)* **8.2.3** The reason for the consultation and any presenting condition.

[College of Optometrist - Patient Records](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/patient-records#Whattorecord)**A22 (C)** * + if relevant, history of ocular and general health

[*College of Optometrists - Routine Examination*](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/the-routine-eye-examination#Conductingtheroutineeyeexamination) |
| Criteria  | There should be some record of patient’s previous ocular health and vision corrections |
| Points  | 2 | Clearly recorded  |
|  | 1 | tick/cross no explanation. Partial information |
|  | 0 | Not recorded in record card  |

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| **Item** | **Family Ocular History** |
| Standard | [GOC Standard - Standard 7](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/7-conduct-appropriate-assessments-examinations-tre.html)**7.1** Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs, cultural factors and vulnerabilities.[College of Optometrist - Patient Records](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/patient-records#Whattorecord)**A22**[*College of Optometrists - Routine Examination*](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/the-routine-eye-examination#Conductingtheroutineeyeexamination) |
| Criteria  | There should be some record of patient’s family history to evaluate any familial or genetic risks |
| Points  | 2 | Clearly recorded  |
|  | 1 | tick/cross no explanation. Partial information |
|  | 0 | Not recorded in record card  |

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| **Item** | **General Health** |
| Standard | [GOC Standard - Standard 7](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/7-conduct-appropriate-assessments-examinations-tre.html)**7.1** Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs, cultural factors and vulnerabilities.[College of Optometrist - Patient Records](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/patient-records#Whattorecord)**A22**[*College of Optometrists - Routine Examination*](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/the-routine-eye-examination#Conductingtheroutineeyeexamination) |
| Criteria  | There should be evidence in clinical record general health has been recorded to evaluate any associated eye conditions/risks |
| Points  | 2 | Clearly recorded  |
|  | 1 | tick/cross no explanation. Partial information |
|  | 0 | Not recorded in record card  |

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| **Item** | **Medications** |
| Standard | [GOC Standard - Standard 7](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/7-conduct-appropriate-assessments-examinations-tre.html)**7.1** Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs, cultural factors and vulnerabilities.[College of Optometrist - Patient Records](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/patient-records#Whattorecord)[*College of Optometrists - Routine Examination*](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/the-routine-eye-examination#Conductingtheroutineeyeexamination) |
| Criteria  | There is evidence that patient has been asked about any medications taken.  |
| Points  | 2 | Medications named or noted that the patient cannot recall the names and has not provided details of medications prescribed |
|  | 1 | Meds taken but no details on the names |
|  | 0 | Not recorded |

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| **Item** | **Presenting Unaided vision or vision with current glasses** |
| Standard | [GOC Standards - Patient records](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/8-maintain-adequate-patient-records.html)* **8.2.4** The details and findings of any assessment or examination conducted.

[College of Optometrist - Patient Records](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/patient-records#Whattorecord)**A22** For a routine eye examination this should normally include the patient’s:* unaided vision and/or vision with habitual prescription R and L, as relevant

[*College of Optometrists - Routine Examination*](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/the-routine-eye-examination#Conductingtheroutineeyeexamination) |
| Criteria  | Allows auditor to assess if appropriate advice and care was given.  |
| Points  | 2 | Appropriate monocular VAs or reason why not taken |
|  | 1 | only binocular VA or only one of DV or NV noted or not appropriate e.g. measured without glasses when wears Rx full time |
|  | 0 | Not recorded |

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| **Item** | **Refraction** |
| Standard | [GOC Standard - Standard 7](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/7-conduct-appropriate-assessments-examinations-tre.html)**7.1** Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs, cultural factors and vulnerabilities.* refraction, if conducted:
	+ subjective refraction, if cycloplegic used, what drug and concentration, batch number and expiry date
	+ distance VAs R and L
	+ reading addition with reading VA binocularly or individually if appropriate
	+ ocular muscle balance and method, at least cover test, for distance and near with new prescription if appropriate, for example significant change
	+ fixation disparity if appropriate, for example, if the patient has symptoms or shows a deviation on cover test
	+ prescription given for each task, for example, driving, visual display unit (VDU) and any associated reasons, for example, to reduce headaches, to try and improve ocular muscle balance
	+ accommodation, if appropriate

[College of Optometrists - Routine Examination](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/the-routine-eye-examination#Conductingtheroutineeyeexamination) |
| Criteria  | There is evidence that a refraction has taken place. This forms the legal basis that a sight test has taken place. It may not be undertaken in cases where patient has presented in an emergency or may not be possible in certain situations [Clinically Challenging patients guidance 2019](https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2019/03/190225-clinically-challenging-patients.pdf) |
| Points  | 2 | Full details recorded or reasons why not possible recorded |
|  | 1 | Some elements of refraction missing e.g missing add |
|  | 0 | Not entered  |

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| **Item** | **Visual acuity** |
| Standard | [GOC Standard - Standard 7](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/7-conduct-appropriate-assessments-examinations-tre.html)**7.1** Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs, cultural factors and vulnerabilities.[College of Optometrists - Routine Examination](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/the-routine-eye-examination#Conductingtheroutineeyeexamination)1. determining and recording the aided vision of each eye with the patient’s existing correction, together with the specific prescription used. If this is not possible, or inappropriate, you should determine and record the patient’s unaided vision of each eye
 |
| Criteria  | Provides an indication of appropriate recommendations  |
| Points  | 2 | Appropriate monocular VAs or reason why not taken |
|  | 1 | only binocular VA or only one of DV or NV noted or not appropriate e.g. measured without glasses when wears Rx full time |
|  | 0 | Not recorded |

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| **Item** | **Binocular vision assessment** |
| Standard | [GOC Standard - Standard 7](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/7-conduct-appropriate-assessments-examinations-tre.html)**7.1** Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs, cultural factors and vulnerabilities.[College of Optometrists - Routine Examination](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/the-routine-eye-examination#Conductingtheroutineeyeexamination)1. assessing and recording habitual ocular muscle balance and the method used, at least cover test, for distance and near. This should be done with the habitual prescription and/or without the prescription, if appropriate
 |
| Criteria  | Appropriate tests/equipment should be used.  |
| Points  | 2 | Appropriate cover test including estimate of magnitude if deviation found for distance and near. And appropriate to correction. Might also have FD result |
|  | 1 | Cover test but only distance or near not both, or in patient with only 1 eye or no estimate of magnitude or recovery |
|  | 0 | Not recorded |

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| **Item** | **External Examination** |
| Standard | [GOC Standard - Standard 7](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/7-conduct-appropriate-assessments-examinations-tre.html)**7.1** Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs, cultural factors and vulnerabilities.[College of Optometrists - Routine Examination](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/the-routine-eye-examination#Conductingtheroutineeyeexamination)1. examining the eye internally and externally. As a minimum for internal examination, you should use direct ophthalmoscopy on the undilated eye, although alternative methods may be used. If you cannot obtain an adequate view of the fundus, you should dilate the patient’s pupils and/or use indirect methods of fundal examination. You should use slit-lamp biomicroscopy, particularly where a detailed view of the anterior eye and adnexa is required. You should record the method of assessment used
 |
| Criteria  | A slit lamp would be used as best practice. Reasons why this was not achievable and/or any alternative method used.  |
| Points  | 2 | Comment on all structures. Use of grading scales. Anterior chamber assessed via Van Herrick estimate where appropriate.  |
|  | 1 | Ticks or crosses next to each structure or Clear & healthy but with no detail of what specific structures this pertains to. |
|  | 0 | Not recorded |

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| **Item** | **Internal Examination** |
| Standard | [GOC Standard - Standard 7](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/7-conduct-appropriate-assessments-examinations-tre.html)**7.1** Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs, cultural factors and vulnerabilities.[College of Optometrists - Routine Examination](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/the-routine-eye-examination#Conductingtheroutineeyeexamination)1. examining the eye internally and externally. As a minimum for internal examination, you should use direct ophthalmoscopy on the undilated eye, although alternative methods may be used. If you cannot obtain an adequate view of the fundus, you should dilate the patient’s pupils and/or use indirect methods of fundal examination. You should use slit-lamp biomicroscopy, particularly where a detailed view of the anterior eye and adnexa is required. You should record the method of assessment used
 |
| Criteria  | Use of indirect lenses, direct ophthalmoscopy. Any ocular images reviewed. |
| Points  | 2 | Appropriate comment on all structures. Use of grading scales where indicated Anterior chamber assessed via Van Herrick estimate where appropriate.  |
|  | 1 | Ticks or crosses next to each structure or Clear & healthy but with no detail of what specific structures this pertains to. |
|  | 0 | Not recorded |

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| **Item** | **C:D ratio** |
| Standard | [GOC Standard - Standard 7](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/7-conduct-appropriate-assessments-examinations-tre.html)**7.1** Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs, cultural factors and vulnerabilities.[College of Optometrist - Patient Records](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/patient-records#Whattorecord) |
| Criteria  | A full description allows for continuity of case |
| Points  | 2 | Full disc description for each eye separately  |
|  | 1 | Recorded but information about each eye not recorded separately |
|  | 0 | Not recorded |

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| **Item** | **Any other comments from ophthalmoscopy** |
| Standard | [GOC Standard - Standard 7](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/7-conduct-appropriate-assessments-examinations-tre.html)**7.1** Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs, cultural factors and vulnerabilities.[College of Optometrist - Patient Records](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/patient-records#Whattorecord)internal examination, with or without dilation. If dilation is used, record which drug and concentration, batch number and expiry date:* media status + diagram of opacities if appropriate
* Optic disc assessment R and L including C/D ratio, NRR assessment and any unusual features
* A/V ratio R and L and any unusual vessel features, for example nipping, irregular calibre
* macular status R and L
* diagram of any fundal lesions
* results of peripheral retina examination
 |
| Criteria  | Good practice followed in a description of ocular structures  |
| Points  | 2 | additional detail present/ or additional detail not needed |
|  | 1 | Partial information |
|  | 0 | No reasoning recorded – failure to follow guidance  |

**10.0 OCCASIONAL PROCEDURES**

10.1 All items in this section should be assessed where indicated

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| **Item** | **Visual Fields** |
| Standard | [GOC Standard - Standard 7](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/7-conduct-appropriate-assessments-examinations-tre.html)**7.1** Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs, cultural factors and vulnerabilities.[College of Optometrist - Examination of patient at risk of Glaucoma](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/examining-patients-at-risk-from-glaucoma#Procedurestoincludeinanexaminationinroutine)**A265**The examination may also include an assessment of the central visual field using perimetry with threshold control. Where necessary, you should repeat visual field assessment to obtain a meaningful result.[College of Optometrists - Routine Examination](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/the-routine-eye-examination#Conductingtheroutineeyeexamination)**A55**If you feel it is clinically appropriate or your contract requires it, you may:g. assess visual fields, especially for those patients who are at risk of glaucoma |
| Criteria  | When examining a patient who is in an at-risk group for glaucoma, you must carry out relevant tests. Guidance varies across the UK.You should be familiar with the relevant guidance and the thresholds at which further tests should be undertaken. If local protocols apply you should comply with these.Visual fields can also assist in the assessment of the patient for other vascular and neurological conditions and completion of visual fields is not only limited to examination of patients at rick of glaucoma  |
| Points  | 2 | Visual fields plot available or normal fields noted and method of measurement and threshold etc |
|  | 1 | Partial information recorded  |
|  | 0 | Fields not completed when indicated |
|  | N/A | Visual field assessment not indicated  |

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| **Item** | **Tonometry** |
| Standard | [GOC Standard - Standard 7](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/7-conduct-appropriate-assessments-examinations-tre.html)**7.1** Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs, cultural factors and vulnerabilities.[College of Optometrist - Examination of patient at risk of Glaucoma](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/examining-patients-at-risk-from-glaucoma#Procedurestoincludeinanexaminationinroutine)**A263**You should select additional procedures to those in the routine eye examination, according to the patient’s clinical need. You should normally: 1. assess the optic nerve head. This would include assessing the size of the disc
2. measure the IOP. See section on [the use of non-contact tonometry](https://www.college-optometrists.org/Clinical-guidance/Guidance/Knowledge%2C-skills-and-performance/Examining-patients-at-risk-from-glaucoma/Use-of-non-contact-tonometry-%28NCT%29).

[College of Optometrists - Routine Examination](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/the-routine-eye-examination#Conductingtheroutineeyeexamination)**A55**If you feel it is clinically appropriate or your contract requires it, you may:f. measure intraocular pressure for patients at risk of glaucoma |
| Criteria  | You will identify the majority of patients who are at risk from chronic open angle glaucoma during a routine eye examination. They are principally patients with one or more of the following: 1. optic disc features suggestive of glaucoma
2. loss of peripheral vision
3. high IOP.
 |
| Points  | 2 | IOP includes appropriate number of readings, type of tonometer and time |
|  | 1 | Partial information recorded eg average reading only for NCT with time of measurement not recorded |
|  | 0 | Tonometry not completed when indicated |
|  | N/A | Tonometry not indicated  |

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| **Item** | **Referral Copies present** |
| Standard | [GOC Standard - Recognise, and work within, your limits of competence](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/6-recognise-and-work-within-your-limits-of-compete.html)**6.2** Be able to identify when you need to refer a patient in the interests of the patient’s health and safety and make appropriate referrals.**8.2.5** Details of any treatment, referral or advice you provided, including any drugs or appliance prescribed or a copy of a referral letter.[College of Optometrists - Referrals](https://www.college-optometrists.org/clinical-guidance/guidance/communication%2C-partnership-and-teamwork/working-with-colleagues#Referrals)**C193**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 the patient to an appropriate practitioner who is registered with a statutory regulator.**C197**If you decide not to refer the patient you must record:1. a sufficient description of the condition
2. the reason for deciding not to refer on this occasion
3. details of advice or treatment given to the patient.

**C198**If you decide not to refer the patient you should inform the patient’s GP of any relevant findings, if the patient consents. |
| Criteria  | * 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.
 |
| Points  | 2 | Referral copy attached with relevant details and an indication of urgency. Copy of referral offered to patient  |
|  | 1 | Referral made but lacking in detail eg urgency, appropriate clinic selected  |
|  | 0 | Referral not made where indicated  |
|  | N/A | Referral not indicated  |

**11.0 QUALITY INDICATORS**

11.1 All items in this section should be assessed in all records

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| **Item** | **Has an appropriate recall interval been set** |
| Standard | [**DOH MOU 2002**](https://www.fodo.com/downloads/managed/Guidance/Sight%20test%20intervals/1_Frequency%20of%20Sight%20Tests%20-%20Department%20of%20Health%20letter.pdf)[**College of Optometrists Guidance**](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/the-routine-eye-examination/frequency-of-eye-examinations) |
| Criteria  | Using the risk assessments carried out on patient has an appropriate recall interval been noted in the record card that relates to the information reviewed. |
| Points  | 2 | Recall set and well documented and justified |
|  | 1 | Recall set but not justified. |
|  | 0 | No recall interval set  |

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| **Item** | **Advice Given** |
| Standard | [GOC Standards - Patient records](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/8-maintain-adequate-patient-records.html)**8.2.5** Details of any treatment, referral or advice you provided, including any drugs or appliance prescribed or a copy of a referral letter.[GOC Standard - Standard 7](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/7-conduct-appropriate-assessments-examinations-tre.html)**7.2** Provide or arrange any further examinations, advice, investigations or treatment if required for your patient. This should be done in a timescale that does not compromise patient safety and care.[College of Optometrists - Routine Examination](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/the-routine-eye-examination#Conductingtheroutineeyeexamination)A22 (f) Conclusions |
| Criteria  | Should include* details of discussions with the patient, including options and oral and written advice given, for example, to drive with spectacles
* any change in patient management
* details of any written information given to the patient, such as patient information leaflets, and
 |
| Points  | 2 | Specific and tailored to patient |
|  | 1 | Generic -cut and pasted into record - not patient specific |
|  | 0 | Not documented |

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| **Item** | **Any images/OCT present are consistent with recorded findings** |
| Standard | [GOC Standards - Patient records](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/8-maintain-adequate-patient-records.html)* **8.2.4** The details and findings of any assessment or examination conducted.

[College of Optometrists - Routine Examination](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/the-routine-eye-examination#Conductingtheroutineeyeexamination) |
| Criteria  | Review of any associated images e.g. Fundus pictures, OCT, UltraWide Field ImagesEnsure that images are consistent with descriptions in the clinical record card |
| Points  | 2 | Consistent  |
|  | 0 | Not consistent e.g disc descriptions not appropriate, missed clinical features  |
|  | N/A | Images not available for this patient  |

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| **Item** | **Prescribing**  |
| Standard | [GOC Standard - Standard 7](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/7-conduct-appropriate-assessments-examinations-tre.html)**7.3** Only prescribe appliances, drugs, or treatment when you have adequate knowledge of the patient’s health.**7.4** Check that the care and treatment you provide for each patient is compatible with any other treatments the patient is receiving, including (where possible) over-the-counter medications.**7.5** Provide effective patient care and treatments based on current good practice.**7.6** Only provide or recommend examinations, treatments, drugs or appliances if these are clinically justified and in the best interests of the patient. Give patients information about all the relevant options available to them, including the option of no further treatment or intervention, in a way they can understand.[College of Optometrist Guidance - After the eye test](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/the-routine-eye-examination#Aftercompletingtheroutineyeexamination)**A56**When you have completed the tests you should tell the patient what you have found and what you would recommend. You should also recommend when they should have their next eye examination.**A57**You should provide patients with leaflets about the most common eye conditions, as appropriate.24**A58**You must only issue a prescription for the correction of visual defects when it is clinically justified and in the best interests of the patient.25 In all other cases, give the patient a written statement confirming a correction is not required or that there is no change in the current prescription. You should note on the prescription whether the patient is registered as sight impaired or severely sight impaired. This is because their spectacles can only be dispensed by, or under the supervision of, a registered optometrist, dispensing optician or doctor.**A59**If you examine a patient who might have an eye condition or eye surgery that may change the prescription in the short- to medium-term, you should consider carefully whether it is in the patient’s best interests to have new spectacles. You should explain the benefits and disadvantages of prescribing spectacles that will be appropriate only for a short time. |
| Criteria | If glasses were prescribed is the reason for prescribing clear from the record. |
| Points  | 2 | Specific and tailored to patient |
|  | 1 | Generic -cut and pasted into record - not patient specific |
|  | 0 | Not documented |
|  | N/A | Not prescribed/not required  |

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| Item | Clinical decision making |
| Standard | [GOC Standard - Standard 7](https://optical.org/standards-and-guidance/standards/standards-of-practice-for-optometrists-and-dispens/7-conduct-appropriate-assessments-examinations-tre.html)**7.5** Provide effective patient care and treatments based on current good practice.[College of Optometrists - Routine Examination](https://www.college-optometrists.org/clinical-guidance/guidance/knowledge%2C-skills-and-performance/the-routine-eye-examination#Conductingtheroutineeyeexamination)**A62**You may need to justify your actions at a later date, so if you decide not to conduct tests that would normally be expected, you should record the reasons for not carrying out those tests. You should remember that when conducting a sight test, certain tests are required by law, see section on [The routine eye examination or sight test](https://www.college-optometrists.org/Clinical-guidance/Guidance/Knowledge%2C-skills-and-performance/The-routine-eye-examination). |
| Criteria | Have any of the findings indicated where appropriate tests/actions have not been undertaken.  |
| Points  | 2 | Sound clinical decision making  |
|  | 1 | Partial information recorded |
|  | 0 | Inappropriate e.g referral urgency was not within the correct timescale |

**12.0 Document review and optometry advisor calibration**

12.1 Following introduction of the new standard ORR template it would be prudent to review the functionality of the documents once in use.

12.2 Initially after 12 months then again 6/12 months later and then yearly reviews to see if it is still fit for purpose and relates to all current guidelines.

12.3 Optometry Advisor calibration can be carried out annually to review the approach and ensure all are working within acceptable parameters.

**13.0 Standards or references used in producing guidance document.**

13.1 These are the links to all guidance documents used to produce the review guide and can be included in the appendices of any reports written for PSG.

**Appendix 1: Compassion and kindness in managing professional performance cases**

When a optometry practitioner is subject to a professional standards investigation, it can be an incredibly stressful and worrying time, impacting an individual’s mental health and wellbeing. Throughout all of our professional standards processes here in the north west, we seek to adopt a compassionate and kind approach, applying the principles of the LOTUS Compassionate Leadership Framework and Toolkit which has been developed to support all those involved in managing professional standards concerns.

We all have a responsibility to practice compassion whilst providing clarity and understanding throughout the investigation process.

A compassionate approach will always take account of the following which can be applied when undertaking ORRs:

 

Consideration of contributory factors might be causing the practitioner’s difficulty with record keeping is important and whilst the factors can be diverse, they can be important in determining the most appropriate remediation and learning:-

More information on adopting a compassionate approach when managing performance concerns and investigations can be found by [clicking on this link](https://www.england.nhs.uk/north-west/nhs-north-west-professional-standards/growing-compassion-in-professional-standards/).