



Doing The Right Thing



Px 1 is an 11 year old boy. His parents are concerned about his vision as his Rx has increased since his last eye test.

His current refraction is: R: -1.50/-0.25x180 L: -1.25/-0.50x180

His previous refraction was a year ago and was: R: -1.00DS L: -0.75/-0.50x180

The parents are worried that his vision will end up as bad as theirs as they are also both myopic. Dad is approx -3.00 R&L whilst Mom is approx -6.50 R&L. During the test the Optom explains to the parents that it is a natural progression and that it is normal for myopia to increase in childhood, and that the eyes are perfectly healthy. This upsets Mom as she realises how difficult it is with her high level of myopia and she doesn't want her son to suffer in the same way

Discussion Points:

- How would you reassure the px's Mother?
- Was the advice of the optom correct? What other advice could be given?
- What optical solutions would you recommend for this px? Consider both spectacle and contact lens options.



Px 2 is an elderly gent. He has come in for an eye test as over the last year his vision doesn't seem as sharp as it was previously. He is 72 years old and lives alone in a small village. His family all live abroad. He has never had an eye test before as he has always felt that his vision is OK. He wears ready readers for close work but no distance spectacles.

Upon examination it is noticed that the px has the start of a cataract in his RE.

The px's unaided vision is recorded as: R: 6/18 L: 6/15

With correction this improves to: R: 6/12 L: 6/6

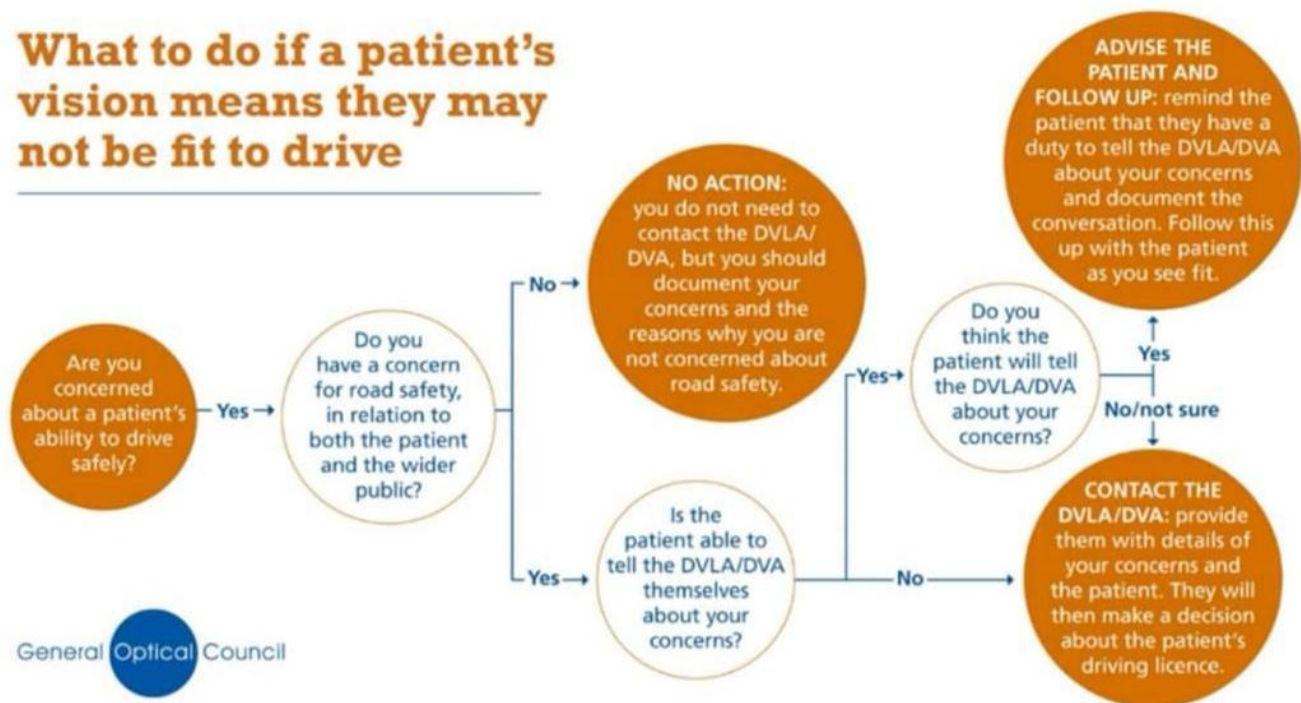
The optom advises the px that he will need to be referred for his cataract and that he will also need to purchase spectacles as he currently falls below the required driving standards in the UK. The px doesn't feel this is necessary as he can see perfectly well and in over 50 years of driving has never had a crash. He is reluctant to buy specs as he feels the cost is too high and that he is going to have to buy another pair after the cataract operation



Discussion Points:

- What action should the optom take now?
- What spectacle options would you recommend to the px?
- Is there any compromise you could make with the px to ensure a positive outcome for everyone?

What to do if a patient's vision means they may not be fit to drive





ABDO: “The knowledge of a patient’s visual acuity and how this may impinge on their driving ability is a confidential matter and may not be disclosed to a third party. If a patient is suspected of being below the legal standard for driving, s/he has a legal responsibility to inform the DVLA. Any advice which you give to the patient should be noted on the record. In the first instance talk to the patient, advise them they are unfit to drive and try to persuade them to stop. Remind the patient that s/he is legally responsible for informing the DVLA or DVA if they do not meet the vision standard for driving. However, if the patient has told you that they will not stop driving, you may conclude the public interest outweighs the duty of confidentiality. You may wish to seek the advice of your professional body or the prescriber.”



College of Optometrists:

If you decide that the patient is unfit to drive, you should:

1. first tell the patient that they are unfit to drive and give the reasons. You may wish to discuss your concerns with a relative or carer, if the patient consents to this
2. tell the patient that they have a legal duty to inform the DVLA or DVA about their condition
3. put your advice in writing to the patient
4. record your advice and keep a copy of any correspondence to the patient on the patient record, and
5. notify the patient's GP, if appropriate, with the patient's consent.



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.⁷⁸

If you conclude the public interest outweighs the duty of confidentiality, you should:

- notify the appropriate authority (DVLA or DVA) in writing, and, if appropriate, provide evidence of clinical findings (see useful information below)
- notify the patient's GP of the action being taken, and
- notify the patient, if appropriate.



Px 3 is 36 year old male. He currently wears extended wear contact lenses. He wears them for 28 days at a time then removes them for one weekend per month.

The px last had an aftercare two years ago and purchases the lenses online after being given a copy of his contact lens specification at the last appointment.

The px has come in complaining that his vision seems smeary in the lenses towards the end of the day. He has noticed this over the past few weeks and is eager to get them sorted as he is going away for his summer holidays in a couple of weeks. The px is examined and advised that he should change his lens modality to a two weekly lens to resolve the problem of the lenses becoming smeary. The px was also advised to make sure to rub and rinse the lenses each night before storage.



Discussion Points:

- Was the advice correct? Was the choice of lens suitable?
- What could be the cause of the problem?
- What kind of slit lamp examination would be necessary to find the route of the problem? - What lenses would you recommend for the patient and what other advice would you give?



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Infection Control In Practice



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Working in practice means coming into close contact with the general public, which in turn means exposure to germs, bugs and potential infections. This webinar will look at how we can minimise the risk of contamination to protect ourselves and our patients.





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First of all we are going to discuss the “danger zones”, by which we mean the areas where infection can be spread.

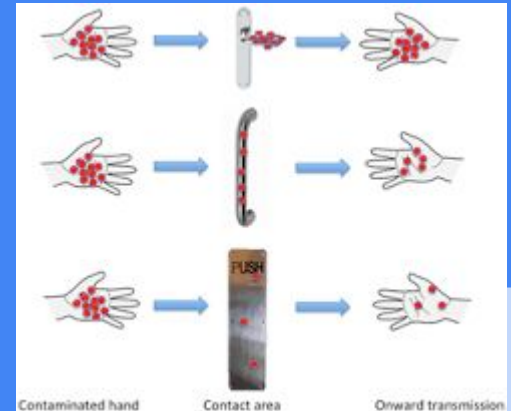


This can occur in two ways:

Person to Person



Transmission via a contaminated object





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So, what are the 4 main routes of transmission of infection from person to person?



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1. Physical touch

This can happen in many ways in practice. From meeting and greeting your patients with a handshake and adjusting spectacles to performing eye examinations.



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2. Airborne Particles

- 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



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3. 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



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4. 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.
- Very low risk in practice, however, use of communal tools such as sharp screwdrivers could result in a sharps injury and possible transmission of an infection.



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What effective measures can we take
to minimise the risk of person to
person transmission?



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Hand hygiene:

You must decontaminate your hands, as appropriate:

1. before every episode of direct patient contact or care
2. after every episode of direct patient contact or care
3. after any exposure to body fluids (including tears)
4. after any other activity or contact with a patient's surroundings that could potentially result in hands becoming contaminated, and
5. after removal of gloves.





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You should also decontaminate your hands:

1. before (and after) contact lens insertion or removal
2. after going to the toilet
3. when hands are visibly dirty
4. before (and after) contact with ocular surfaces and adnexae
5. before (and after, if necessary) administering medication, for example eye drops, and
6. after any possible microbial contamination, e.g. contact with body fluids, wounds, or clinical waste.

Hand-washing technique with soap and water

- 1 Rub palms together
- 2 Get rid of dirt from between fingers
- 3 Rub what people see, like nose
- 4 Rub what people see, like nose
- 5 Get on one more side
- 6 Get on the other side
- 7 Rub what people see, like nose
- 8 Rub what people see, like nose
- 9 Rub what people see, like nose
- 10 Don't stop, don't stop
- 11 It's like I got the music in my head
- 12 Taping it's gonna be alright
- 13 Cause the album gonna
(the, the, the, the, the)

Create your own
<https://www.youtube.com/watch?v=6nXjQZjYh0c>

Shake it Off
Taylor Swift

Adapted from the original health lesson, also adapted from the World Health Organization Guidelines on Hand Hygiene in Health Care
© World Health Organization 2009. See <http://www.who.int/hand/hand/hand-hygiene-guidelines/en/> for details.

Remember, it is important to wash your hands properly as demonstrated in the guidelines:



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Antibacterial Hand Gel

- Alcohol is not a cleaning agent so you should perform a proper hand wash with soap and water at the beginning and completion of the clinic session, as well as after exposure to body fluids.
- Antibacterial hand gels 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



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- Alcohol hand rubs 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.
- Having antibacterial hand gel available throughout the practice is a great way to encourage patients to maintain good hand hygiene.
- Communal areas, such as waiting areas, dispensing desks, reception or by the frame displays are good places to position them as patients in these areas will touch items around them.



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Remember, it is important to maintain the integrity of your skin

To maintain the integrity of your skin, you should:

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

Minimise the risk of airborne infection

1. covering your nose and mouth and using a tissue whilst coughing or sneezing
2. disposing of used tissues in the nearest receptacle as soon as possible
3. performing hand hygiene after coughing or sneezing
4. not working in clinical practice if you have an acute upper respiratory tract infection, such as the common cold, and
5. avoiding touching your mouth, eyes and nose unless you have performed hand hygiene



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So, what about infection from objects in practice?

The list is endless! We use many items of equipment in the test room that come into contact with the patient, as well as dispensing equipment and diagnostic equipment used for pre-screening.

Items such as frames, keyboards, mice, tools, pay points and phones are also hot spots as they are picked up and touched throughout the day by numerous people.

The practice environment has many surfaces and fixtures (such as door handles and light switches) where airborne particles can settle and easily be passed onto hands.



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Task...

Take an imaginary walk through your practice, following the patient journey and make a note of each object, or item a patient may come into contact with.



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What effective methods of preventing infection from inert objects could be implemented in practice?



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You should use the following routine infection control precautions:

1. maintain good hand hygiene
2. decontaminate equipment after use
3. disinfect used linen, and
4. decontaminate the environment:



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Now we need to think about our patients. Identifying which patients could be more “at risk” is the first step in the event of an infectious disease being present in the community.

How can we protect our vulnerable patients?



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- Create a Vulnerable Patients database
- Manage recall - this could include limiting recall to vulnerable patients or adding information on to the contact advising the patient to call the store if they meet the vulnerable criteria
- Social distancing in practice - book patients in during a quiet time of day
- Maintain high standards of hygiene in practice
- Telephone triage - speak to patients prior to attending so they can be advised of any risk

Communication is key!



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- Covid has made us think and adapt but we must not lower standards post Covid
- Maintaining high standards of infection control show your patients that you are clinical and value their health
- Infection control measures not only protect patients, but they also protect you!
- Reduction in sickness levels will benefit the business
- Use this time to think and reflect about your working environment. How can you improve infection control? Where are the danger areas? How can you implement infection control measures?
- Think about your patients and what methods you can introduce to improve infection control
- Be safe, stay alert!