CPO COMPETENCIES

Competencies are topics (skills and concepts) that a paraoptometric should know and understand to work in an optometric eyecare setting. This list represents a foundation of knowledge needed to be successful when taking a paraoptometric examination.

AMERICAN OPTOMETRIC ASSOCIATION

C01: Ophthalmic Optics

Myopia (Nearsighted)

- Minus Lens – Thicker on edges than in center

Hyperopia (Farsighted)

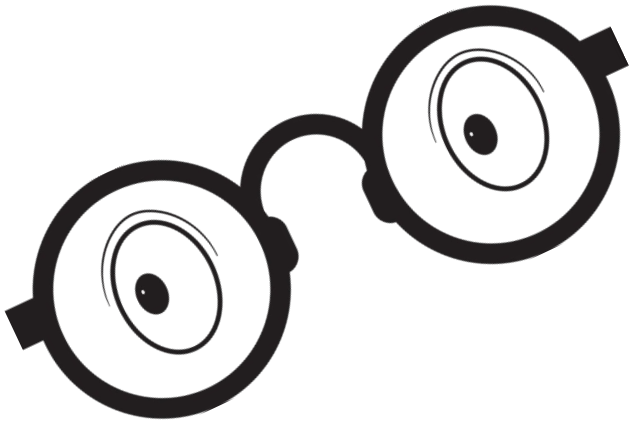
- Plus Lens – Thicker in center than on edges

Astigmatism (Toric)

- Cylindrical lens- greater refractive power in one direction than the other.

Presbyopia - Need for help up close corrected with the following types of lenses:

- Progressive Lens – no line bifocal. Corrects distance, intermediate, and near.
- Lined Bifocal- distance and near.
- Lined Trifocal- distance, intermediate(small), near
- DVO- distance vision only
- NVO- near vision only
- Computer – for a specific distance at intermediate
- Seg Heights need to be measured for all Presbyopia lenses.
- Pupillary Distance between the eyes needed for all lenses/glasses.



C02: Basic Math & Algebra

- Plus lens distance is added to the plus lens in add for the full near Rx
  {Plus +plus = more plus}

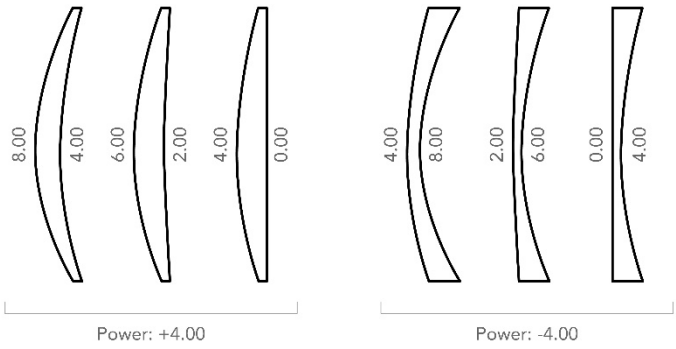
i.e. + 1.25 distance + +2.00 add = +3.25 near lens

- Minus lens with an add depends on amount of minus.

i.e. -5.00 + +2.00 add = -3.00 near lens
-1.00 + +2.00 add = +1.00 near lens

- Transposing from +cylinder to minus cylinder
  1. Take the cylinder and add it to the sphere for the new sphere.
  2. Make the cylinder minus
  3. Change the axis to 90 degrees away from the original.

i.e. -1.00 + 2.00 x 90 – transposed = +1.00 – 2.00 x 180



C03: Basic Medical Terminology and Abbreviations

Abbreviations

IOP	intraocular pressure
AMD	age related macular degeneration
PD	pupillary distance
SEG	segment height
OCT	optical coherence tomography
NCT	non-contact tonometry
OD	right eye
OS	left eye
OU	both eyes
HIPAA	health information portability and accountability act
EHR	electronic health record
EMR	electronic medical record
CL	contact lens
RGP	rigid gas permeable (CL)
VT	vision therapy
SVT	sports vision training
PT	patient
DFE	dilation
IPL	intense pulsed light therapy
GLS	glasses
VF	visual field
CAT	cataracts
YAG	procedure to clean out a lens after CAT surgery
ABN	advanced beneficiary notice

Terminology

Accommodation	The ability of the eye to focus from distance to near.
Ametropia	Refractive condition in which images fail to focus on the retina.
Amblyopia	Condition usually in one eye, rarely both, with reduced visual acuity. It develops when there is a breakdown in how the brain and the eye work together.
Anterior Chamber	The area inside the eye, behind the cornea, and in front of the iris.
Aphakia	Absence of crystalline lens.
Astigmatism	A refractive condition in which light rays entering the eye fail to meet in one focal point, instead there are two blurred planes of light.
Bifocal	A lens that provides both distance and near correction.
Binocular	Vision using two eyes with overlapping fields of view.
Biomicroscope (Slit Lamp)	Instrument that allows good depth perception for observing a fit for contact lenses and looking at all parts of the front and back of the eye.
Blepharitis	Common chronic inflammation and flaking of the lid margin. Patients may experience redness to the eyelid, and sandy or itchy feeling in their eyes.
Cataract	An opacity/clouding of the crystalline lens capsule
Chalazion	A small, usually painless lump on the edge of the eyelid caused by blockage of the gland at the base of an eyelash.
Chief Complaint	Patient's reason for office visit.
Confrontation Fields	A technique used to test each quadrant of patient's visual field using the fingers of the examiner while looking at their nose.
Conjunctivitis	Inflammation of the conjunctiva. "Red eye" can be caused by many things, such as infection, allergy, bacteria, virus or fungus.
Cornea	The clear avascular, transparent tissue that is located on the very front portion of the eye.
Diabetic Retinopathy	A condition that can cause vision loss and blindness in people who have diabetes.
Diopter	Unit of measurement of the lens, abbreviated as "D".
Edema	Swelling of tissues due to excess fluid accumulation.
Emmetropia	Parallel light rays are appropriately refracted to focus on the retina. "Normal" refractive condition (No Rx).
Esotropia	A form of strabismus n which one or both eyes turn inward.
Exotropia	A form of strabismus in which one or both eyes turn outward.
Flashes	Caused by mechanical stimulation of the nerves in

	the retina. Patients may observe some of these when they rub their eyes with moderate pressure. Flashes without stimulus may indicate a retinal tear or detachment.
Floaters	Caused by age-related changes that occur as the vitreous inside your eyes becomes more liquid. A change in the appearance or many new floaters may indicate inflammation or retinal detachment.
Fluorescein	A dye used topically to evaluate corneal integrity.
Fundus	Inside back surface of the eye
Glaucoma	Disease that damages your optic nerve, leading to vision loss and blindness. Usually caused by increased eye pressure. Different types exist: open angle glaucoma/low tension/neovascular/angle closure/pediatric.
Hyperopia	A refractive condition in which, when accommodation is relaxed, parallel light rays enter the eye focus behind the retina; also knows as farsightedness (+) lens.
Hordeolum	"Stye", occurs when gland or hair follicle in the eyelid becomes blocked and inflamed.
Indirect Ophthalmoscope	An instrument used to examine the inside of the fundus using a beam of light with stereoscopic views.
Intraocular Pressure (IOP)	Fluid pressure of the eye.
Iris	Colored muscular portion of the eye that surrounds the pupil and regulates its size.
Keratoconus	The corneal disease where the cornea things and bulges forward.
Keratometer	Instrument used to measure corneal curvature.
Lensometer	Instrument used for determining the power of eyeglasses or contact lens.
Macula	Central portion of the retina surrounding the fovea; responsible for acute central vision.
Macular Degeneration	A degenerative disease of the central part of the retina resulting in distortion or loss of vision.
Monocular	Use of one eye.
Myopia	A refractive condition in which, when accommodation is relaxed, parallel light rays entering the eye focus in front of the retina, knows as nearsightedness (minus lens).
Nystagmus	A vision condition where rapid, uncontrollable eye movements occur. They can occur from side to side, up and down or in a circular pattern. As a result, both eyes are unable to hold steady on objects.
Optic Nerve	The nerve that carries impulses from the retina to the brain.
Ophthalmoscope	A handheld instrument used in viewing the interior of the eye, especially the retina.
Orbit	The bony socket that contains the eye.
Peripheral Vision	What you can see to each side or up and while fixating straight ahead.

Phoropter	An instrument used for determining the refractive error of the eyes.
Photophobia	Abnormal sensitivity to light.
Pinguecula	A yellow thickening of the connective tissue at the 3 and 9 o'clock positions on the bulbar conjunctiva.
Presbyopia	The condition in which lost elasticity of the lens leads to the inability to accommodate.
Progressive lens	Corrective lens which corrects distance, intermediate, and near (no line bifocal).
Pseudophakia	Term used for having an artificial lens implanted after natural lens removed.
Pterygium	A non-cancerous type of abnormal growth of pink, fleshy tissues on the conjunctiva that encroaches on the cornea.
Pupil	The round hole in the center of the iris through which light passes.
Pupillary Distance (PD)	The distance between the center of the pupil of each eye.
Retina	The innermost layer of the eye that contains rods and cones; the part of the eye where vision takes place.
Refraction	Measurement of focusing characteristics of an eye/eyes (determines prescription).
Retinoscope	A handheld instrument used to measure patients' refractive error/prescription.
Retinal Detachment	An emergency situation! The retina pulls away from its normal position, separating the retinal cells from the layer of blood vessels that provides oxygen/nourishment to the eye.
Slit-lamp Examination	Examination that looks at anterior structure at the front of the eye (magnifying microscope).
Sclera	The white portion of the eye made up of a tough, fibrous tissues that gives shape and structure to the eyeball.
Subconjunctival Hemorrhage	Very tiny blood vessels between the sclera and conjunctiva occasionally rupture. May occur spontaneously or be brought on with coughing, vomiting or sneezing. Another concern is if blood pressure is running high.
Triage	Preliminary assessment of patients to determine the urgency of treatment.
Trifocal	A lined lens that provides correction for distance, intermediate, and near.
Visual Acuity	Measure of the ability of the eye to distinguish shapes and the details of objects at a given distance.
Vitreous Humor	A thick, clear gel-like substance that fills the eye between the lens and the retina. It serves to support the retina and helps keep the eye round.
Optometrist	Doctor of optometry (O.D.) is the primary ocular health care physician. Optometrists examine, diagnose, treat, and manage diseases, injuries and disorders of the eye and visual system.

Ophthalmologist	A medical physician who specializes in the medical and surgical care of the eye, visual system, and in the treatment of eye disease and injury.
Optician	An optician interprets, duplicates, manufactures, and dispenses eyewear of the prescribed prescription. They prepare and dispense eyeglasses, lenses or related optical devices upon prescription from a licensed optometrist or ophthalmologist.
Optometric Staff/Paraoptometric	A paraoptometric is a person who works under the direct supervision of a licensed doctor of optometry, collects patient data, administers routine and technical test of the patient's visual capabilities, and assists in office management. They may also assist the optometrist in providing primary patient care examination and treatment services, including, but not limited to, contact lenses, low vision, vision therapy, ophthalmic dispensing, and office management. State laws may limit, restrict, or otherwise affect the duties that may be performed by the paraoptometric.

C04: Troubleshooting to Improve Results

Imaging, Testing and Procedures

Results from this portion of the eye exam provide important information for the doctor and become part of the patient's permanent medical record. Accurate results provide the basis for effective care.

Fundus Photography

Be familiar with fundus photography equipment. To ensure good image quality:

- Seat patient comfortably at the instrument and properly aligned, it should be at a comfortable height for the patient and the paraoptometric.
- The patient should be positioned correctly: chin in the cup, forehead against the top rest. The patient's eyes should line up with the markings on the side of the patient stabilization frame.
- Coach the patient to focus on the target, to open their eyes wide and not blink. Eye-steering can also be used to direct the patient.
  - If you need to steady the patient or help them to align correctly, ask permission before you physically move their head to the desired area.
- Sometimes random scatter dots appear in images. This is usually from dust particles that have settled on the lens. Administer proper cleaning instructions per the manufacturer.

Procedures

Motility & Alignment - In an eye exam, testing is done to evaluate the ability of the eyes to move. This is also known as ocular motility. There will also be testing to evaluate the alignment of the eyes. Although the eyes may be able to point to a target and recognize that it is a single entity, the position of the eyes when they are at rest as well as the extent of movement is very important in determining the quality of binocularity. The patient should sit or stand facing the examiner with the head straight with or without glasses. The patient is instructed to follow the examiner's finger, pen, pen-light or other appropriate object at 16 inches in front of the patient's eyes. The examiner moves the test object at various positions of gaze including left upper lateral, superior, right upper lateral, left lower lateral, inferior and right lower lateral.

Cover-uncover Test - used to detect the presence of a tropia (strabismus). In the cover-uncover test, the patient is asked to view a single letter on the eye chart (at 20 feet distance) while the examiner covers and then uncovers one eye at a time. This test is very useful in helping to determine the eye's natural or habitual position. It is also performed at a near distance (approximately 13-14 inches) using a near accommodative target.

Stereopsis Testing - The ability of the eyes to appreciate depth by using both eyes appropriately is called stereopsis. Recorded in seconds of arc, stereopsis is the highest degree of depth perception. The lower the number, the better the stereopsis. There are several tests available to measure stereopsis, many in booklet form that contain specially designed polarized plates. Each eye sees the same image, but at slightly different positions. The patient wears cross-polarized spectacles that separate the pictures and cause the patient to see a three-dimensional image.

Worth Four-Dot Testing - Each eye provides a unique image to the brain, creating a three-dimensional image. But, unless these images fuse together, two images would be seen instead of one or one image may be suppressed. The Worth Four-Dot is a test that evaluates the ability of the patient's two eyes to fuse the two images received by the brain into one. If the eyes are misaligned, the patient will either see a double image or one of the images will be suppressed. The patient wears red/green glasses, with red placed over the right eye and green over the left eye. The room lights are dimmed to help the patient see the dots from the flashlight. The test at near is performed at approximately 33 cm. The patient is asked to respond with the number of dots of lights they see and their color. If the patient reports seeing two dots, it indicates suppression of the left eye. Seeing three dots, indicates suppression in the right eye. Seeing four dots indicates some degree of sensory fusion. Seeing five dots indicates diplopia (double vision).

Extraocular Muscle Testing - The extraocular muscles that align the eyes play an important role in vision. If the muscles don't allow the eyes to move together or move fully in all directions, binocular vision will be compromised. There are two main areas in testing the extraocular muscles. They are pursuits and saccades (pronounced saw cods).

Color Vision Assessment - Color vision is most often evaluated with the use of pseudoisochromatic plates. These plates have numbers, symbols or designs hidden within a series of colored dots. The colors of the background and foreground vary in hue and brightness. Patients with normal color vision will have little to no difficulty picking out the individual images. But, for a patient with a color vision defect, the figure won't be distinguishable from the background or will only be partially visible.

Pupil Evaluation *Perform Before Dilation Drops*

There are a number of ocular conditions and neurological disorders that can be detected through an evaluation of the pupils. This is an important part of the external evaluation. Since the size of the normal pupil needs to be assessed in various settings, it is important to perform these evaluations prior to the application of dilation drops that will unnaturally affect the size and reaction of the pupil. The first step in evaluating the pupil is to measure its size. But, as we all know, the size of the pupil will change based on the amount of lighting available, the age of a patient, the color of the iris and even systemic conditions. It is not the actual size that is the most important finding, but the change in size between illuminations and the comparison between the two eyes.

The test is performed by the patient looking at a distant target in the eye chart. The examiner shines a light from each side with a penlight or transilluminator.

Size - Measure the size of the pupils in dim light. The size can be measured by holding a millimeter rule close to the eye or by matching the size with pupil sizes printed on a near vision card or another visual aid designed for this task. Each pupil should be measured separately, and its size recorded in millimeters.

Shape - Describe and note pupil shape.

Reaction - How quickly the pupil reacts to light can vary according to the patient's age, iris color and systemic conditions and this needs to be monitored also. A penlight should be shone into each pupil separately and the speed of reaction recorded.

Tonometry

Tonometry is the measurement of intraocular pressure or IOP and is done with an instrument called a tonometer. There are several common types of tonometers that include ones that come in contact with the cornea and those that don't. As with any instrument used in an optometric practice, there are nuances to each make and model, so it is important to familiarize yourself with the specifics of the instrument used in your particular office. It's important when testing to have the patient properly aligned and to look straight ahead and not blink.

Topography

The topographer works by reflecting concentric rings off of the surface of the cornea. The topographer analyzes these rings, and a topographical map is generated showing areas with steeper curves and flatter curves.

Pachymetry

Another method of evaluating the cornea is with the pachymeter. The pachymeter measures the thickness of the cornea in any given location. If an ultrasonic probe is used to capture the information, a drop of anesthetic will need to be used prior to the test. Optical pachymetry methods do not touch the eye, so no anesthetic drops are needed for this type of pachymetry. Even though several readings are obtained, the test is simple to perform and takes less than 30 seconds per eye.

Ocular Coherence Topography (OCT)

When administering the OCT:

- Patient should be comfortably seated in front of the instrument, head in the headrest.
- Chin resting in the chin rest.
- The patient's eyes should line up with the markings on the side of the patient stabilization frame.
- The forehead should completely touch the headrest.
- Coach patient to look at a target light and let them know the equipment will move close to their face.
- Keep eyes still, do not blink and, follow the instructions given by the operator.
- Images are taken of each eye.

Note: The patient will be asked to keep their eyes open for 5 seconds for each image. The paraoptometric can use optimize and auto-focus to get the clearest image.

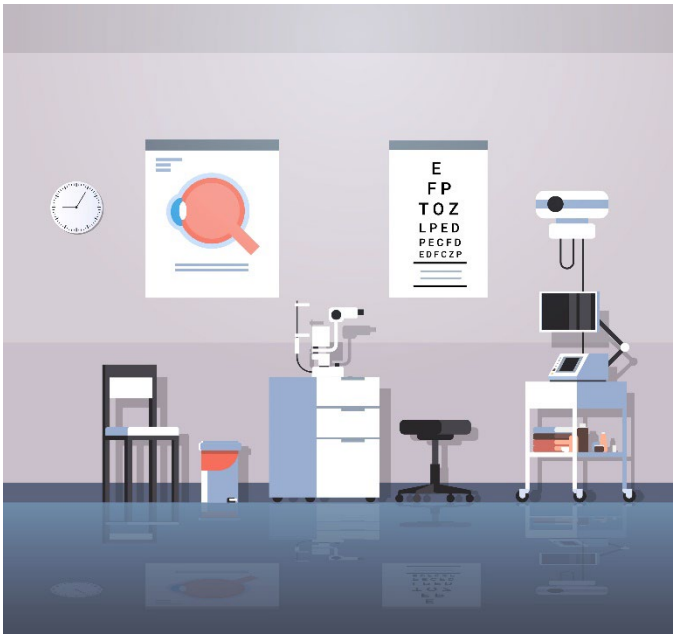
- If a patient struggles to keep their eyes still and open for 5 seconds, instill lubricating eye drops.
- If the patient has small pupils, it may be necessary to dilate the patient's pupil.

Visual Field (VF)

The patient should be comfortably seated in front of the visual field instrument, the chin resting in the chin rest, the forehead pressing in the headrest. The patient's eyes should line up with the markings on the side of the patient stabilization frame. Using the patient most recent refractive correction with the appropriate near addition placed in the trial lens frame.

Instruct patient to look at the central dot. This is the target he/she is to continue to stare at for the entire test. Instruct the patient that he/she will see flashes of light. Some will be very easy to see or bold; some will be difficult and faint. There will also be hesitations in the testing to be sure the patient isn't just clicking the button every few seconds. Let the patient know the test will be take approximately 5-7 minutes per eye. Encourage them to blink as needed during the test.

- Fixation Errors: the patient is looking off the central target
- False Negatives: the patient saw a more difficult stimulus; however, when an easier stimulus was presented in the same location, the patient did not correctly click the button. (Not clicking when he/she should be.)
- False Positives: the patient clicks the button when no stimulus was presented. (Clicking when he/she shouldn't be.)



C05: Required Documentation for Proper Recordkeeping

You must keep full and accurate records.

The patient record should uniquely identify the individual with correctly entered name, biological information, and the name of the person providing care and the date of service.

You may use abbreviations that are commonly used. *(Refer to C03)*

The record should also contain appropriate medical history including medications, conditions presently treated and the social determinants of health, which may impact the care of the patient. Allergies both medication and environmental need to be recorded.

The chief complaint and reason for visit should be clearly stated and expanded as needed.

The following tests and results must be recorded accurately in the patient's chart:

- visual acuity
- stereoacuity
- color vision assessment
- ocular motility
- pupillary
- tonometry
- confrontation visual field screening
- autorefraction and/or autokeratometry
- diagnostic and therapeutic eye drops administered
- When a patient has declined a test, you should record the reason the patient has given and the advice you have given.

You must maintain confidentiality in the collection, storage, use and disposal of records. In using electronic records, there should be an IT plan for good security, regular backups, adequate training and satisfactory disposal of old systems or equipment.

C06: Basic Eyecare Instrumentation

Auto-refractor:

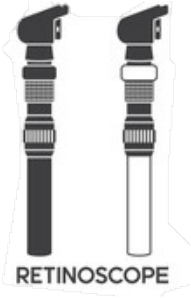
A computerized instrument used to measure a patient's refractive error. This is achieved by measuring how light is changed as it enters a person's eye. The automated refraction technique is quick, simple and painless. The patient takes a seat and places their chin on the chin rest, the forehead against the head rest. The patient's eyes should line up with the markings on the side of the patient stabilization frame. One eye at a time, the patient will look in the instrument at a picture inside. The picture will move in and out of focus as the instrument takes the readings to determine when the image is on the retina. Several readings are taken which the instrument averages and determines a base line prescription.

Phoropter:

The Phoropter is another type of refractor that is used to measure the refraction of a patient. The Phoropter has lenses mounted on a circular wheel. Typically, the patient sits behind the phoropter and looks through it at an eye chart. The doctor will then change the lenses and other settings while asking the patient for feedback on which of the settings give clearest vision. It measures the amount of myopia, hyperopia, astigmatism and presbyopia. This will allow the doctor to determine the patient's prescription for glasses or contacts.

Retinoscope:

A handheld device utilized to determine the refractive power of the eye by observing the lights and shadows on the pupil when a mirror illumines the retina. The doctor moves the light back and forth across the pupil. It is especially useful in prescribing corrective lenses for patients who are unable to give oral feedback such as a 6-month-old baby for example.

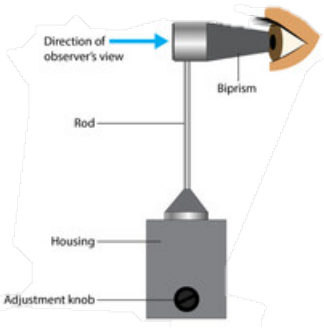


Retinal Camera:

Also called a fundus camera, this technology is used to produce high-quality images of the interior of the eye such as the macula, the retina and optic nerve. The camera produces a bright flash when the picture is taken. This camera can help the doctor in assessment of retinal diseases, documentation which can be kept for future exams to compare if there are any changes.

Slit Lamp:

A microscope with a light attached that allows your doctor to closely examine the eye. This instrument is used to examine structures of the eye such as the eyelids, eyelashes, conjunctiva, sclera, cornea, iris and lens. With special lenses, it is possible to examine the back of the eye.



Direct Ophthalmoscope:

A handhelded instrument used for examining the interior structures of the eye, such as the macula retina and optic nerve. This instrument consists of a mirror that reflects light into the eye and central hole through which the eye is examined and lenses to focus the image.

Indirect Ophthalmoscope:

An instrument with a light source and binocular magnifying viewing lenses. A handheld condensing lens is held above the eye to display a three-dimensional, inverted image of the fundus, including vitreous, macula, optic nerve and retina, including the periphery of the retina.

Tonometry Instruments:

Goldman Tonometer - a standard tonometer for accuracy. This tonometer has a small plastic probe and is mounted on a slit lamp biomicroscope. The patient will require fluorescein and an anesthetic drop because the probe needs to touch the cornea to measure the intra-ocular pressure.

Non-Contact Tonometer (NCT) - a very common device. The NCT sends a puff of air against the eye to measure the pressure within. It does not require numbing drops.

Tono-Pen - is a handheld device that requires an anesthetic drop as it must touch the cornea to get a measurement.

Rebound Tonometer (I-Care) - is a handheld device that uses a small probe to measure intra-ocular pressure. The device doesn't require drops to perform. The small probe touched the cornea so fast that that most time it can obtain a measurement within matters of seconds. This instrument can also be performed on oneself.

OPTICAL COHERENCE TOMOGRAPHY (OCT):

A non-invasive diagnostic technique that renders a cross-sectional view of the retina and the macula. An OCT displays the layers of the macula and the retina. The scans examine the optic nerve, macula as well as other parts of the retina. Some are labeled as "Nerve Scan", "Macula Scan" and "wellness".

Ultra-widefield Fundus Images (UWF)

An UWF retinal exam captures a 200-degree digital fundus image which helps the doctor in diagnosis and documentation of retinal pathology including those in the retinal periphery allowing the doctor to capture a panoramic image of more than 80% of the retina. It helps detect underlying eye diseases and monitor treatment of existing ocular diseases.

C07: Infection Control

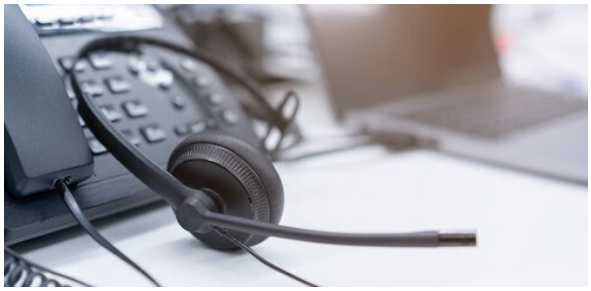
How do you control infection in an office?

- Infection control procedures:
  - Regularly washing the floors, bathrooms and surfaced with hot water and detergent.
  - Periodically wash the walls and ceilings.
  - Personal hygiene practices including:
    - Hand washing – the spread of many pathogens can be prevented with regular hand washing. Thoroughly wash your hands with water and soap for at least 15 seconds after visiting the toilet, before preparing food, and after touching clients or equipment. Dry your hands with disposable paper towels.
    - Unbroken skin – intact and healthy skin is a major barrier to pathogens. Cover any cuts or abrasions with a waterproof dressing.
    - Gloves – wear gloves if you are handling body fluids or equipment containing body fluids. If you are touching someone else's broken skin or mucus membrane or performing any other invasive procedure wear gloves. Wash your hands between each client. Use fresh gloves for each client where necessary.
    - Personal items – don't share towels, clothing, razors, toothbrushes, shavers or other personal items.
    - Clean and sterilize instruments correctly. Recommended distilled water for cleaning (regular water can leave mineral deposits)
    - Use warm soapy water with a toothbrush and distilled water to clean within 20 minutes of use.
    - If cannot clean within that time, place them in a pH neutral enzymatic solution or at the very least cover them with a moistened towel to prevent blood, tissue, and saline from drying and caking on the instruments.

- Infection control procedures when handling needles and other sharp contaminated objects include:
  - Never attempt to re-cap or bend used needles.
  - Handle by the barrel.
  - Place in an appropriate puncture-proof container (that meets the Australian and New Zealand Standards AS 4031:1992 and AS/NZS 4261:1994) – this will be orange or yellow, labelled 'Danger contaminated sharps' and marked with a black biohazard symbol.

C08: Basic Telephone Etiquette

- Answering the phone is the first contact and impression of your office. The telephone is considered to be the lifeline of every business.
  - The phone should be answered by the third ring.
  - When answering the phone be sure to say thank you for calling (your office name), my name is, and how can we help you today.
  - You must speak clearly and be considerate.
  - Be sure to listen closely to the patient, so you know how to help them and take notes if necessary.
  - Use proper professional language.
  - If needing to put the patient on hold first confirm the call is not urgent and then ask to put them on hold or transfer the call.
    - Note: Always use the hold button rather than placing your hand over the mouth receiver.
  - When taking a message for the doctor or coworker be sure to get the correct name and spelling, accurate phone number, along with date and time.
    - Always repeat the information back to the caller so you verify you have the correct information.
  - Assure the patient you will give the correct person the message as soon as they are available.
  - Before ending the call ask the patient if there is anything else you can assist them with and if not, thank them before hanging up the phone.



C09: Patient Confidentiality

It is a national standard to ensure the security, privacy and protection of the patient's healthcare data. This is critical to all healthcare personnel and institutions. Any protected health information (PHI) that can identify a patient or the patient's relatives, employers, or household members, must be omitted. The federal law Health Insurance Portability and Accountability Act (HIPAA) was created to protect sensitive patient health information. The HIPAA policy applies to everyone in the medical field from the janitorial services to the volunteers.

C10: Diversity in the Workplace and Cultural Competency

Diversity, equity, inclusion and cultural competency are four closely linked values held by many organizations that are working to be supportive of different groups of individuals, including people of different races, ethnicity, religions, abilities, and sexual orientations.

These four values are often grouped together because they are interconnected, and it is only in combination that their true impact emerges. But all of these terms are also easily misunderstood. It is important to grasp the individual meanings and implications.

The following diversities are who represent in the workforce.

- Gender diversity: Is what makes up the composition of men, women, and sexual orientation in the workforce.
- Age diversity: People in a group mostly from one generation or have a mix of ages
- Ethnic diversity: People in a group share common national or cultural traditions or represent different backgrounds.
- Physical ability and Neuro diversity: The perspectives of people with disabilities, whether apparent or not.

Equity refers to fair treatment for all people, so that the norms, practices and policies in place identity is not predictive of opportunities or workplace outcomes. Equity differs from equality in a subtle but important way. While equality assumes that all people should be treated the same, equity takes into consideration a person's unique circumstances.

Inclusion refers to how the workforce experiences the workplace and the degree to which organizations embrace all employees and enable them to make meaningful contributions. Companies that are intent on recruiting a diverse workforce must also strive to develop a sufficiently inclusive culture, such that all employees feel their voices will be heard.

C11: Proper Storage of Tools & Supplies

- When storing and transporting surgical instruments a rubber or silicone protector needs to be put on the sharp surface.
- A well-ventilated room is best for storage.
- Do not pile instruments on top of each other.
- Instruments must not touch each other.
- Types of storage:
  - A metal tray should be used for storage, transportation, and some sterilization procedures.
  - A case, either metal or plastic with a protective silicone mat.
    - Cases can also be used for storage, transportation, and some sterilization processes.
  - Rolls - made of strong fabric, are inexpensive. Each pocket holds a single instrument.
    - Secure the roll with ribbon or cord, not elastic, as elastic can degrade in heat.
    - Use rolls only for storage and transportation of instruments, not for any other purpose.

C12: Contact Lens Care

To many patients, insertion and removal is the focus of contact lenses but caring for contact lenses is equally important.

Two Main Components:
- Cleaning component
- Disinfecting/storage component

Cleaning Components:
- Solution – remove oil, mucus and debris found on the surface of the lens prior to disinfection or storage.
- Rubbing of the lens – removes elements from the lens that can otherwise irritate the sensitive surfaces of the eye and underside of the eyelid.
  - Prepares the lens for disinfection so the disinfectant can work on the surface of the lens and not on the debris on the surface of the lens.

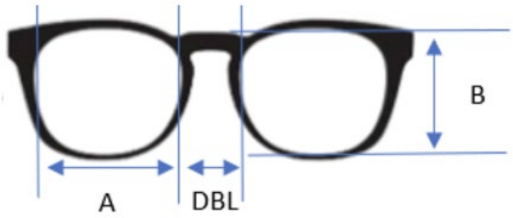
Soft Contact Disinfection:
Chemical or Multipurpose Solutions (MPS)
- Most widely used system today
- Easy to use
- With MPS, same solution is used to clean and disinfect
- Rubbing is still important

Gas Permeable (GP) Lens Storage:
- Cleaned with separate daily cleaner or all-in-one solution
- Stored in wetting and soaking or conditioning solution
- Makes lenses more wettable when they are applied

Enzyme Cleaner:
Soft & Gas Permeable Lenses
- Removes protein deposits that are bound to the lens surface.
- Use and frequency are determined by the doctor

C13: Considerations in Proper Frame Styling & Fitting

Frame Sizes:
Did you know there is a worldwide standard for frame sizing? It measures the actual size of the lens opening. This system is known as the Boxing System.
  - When drawn out, it resembles a box.



Pro Tip: In optical medicine and retail we work in millimeters, mm.

  - **A = Eye Size**
    - The horizontal width of the lens at the lens center. Make sure to include the depth of the bevel when measuring the frame.
  - **B = Eye Height**
    - The vertical height of the lens at the lens center. Make sure to include the depth of the bevel when measuring the frame.
  - **DBL =** (distance between lenses) aka bridge size
    - The smallest distance between the lenses.

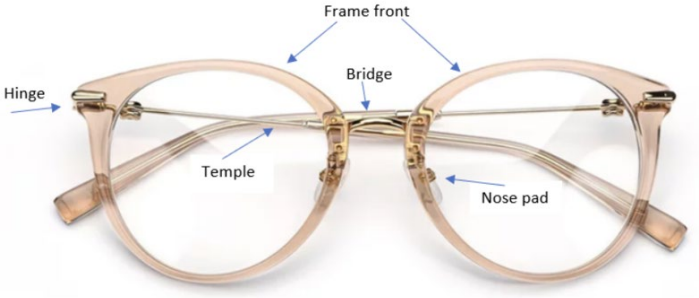
- The best indicator of a well-fitting frame is well centered eye. A well centered eye reduces the need to decenter a lens during manufacturing thus ensuring that the lens will be no thicker than absolutely necessary.

- A frame that is too big will cause the eyes to be positioned too near the bridge of the frame. This will cause minus (-) lenses to be thick on the temple side of the frame and plus (+) lenses to be thick in the nasal area of the frame.

- A frame that is too small will cause the eyes to be positioned to near the outer portion of the frame. This will cause minus (-) lenses thickness to be near the bridge, and plus (+) lenses to be thick in the temple side of the frame.

Pro Tip: Check the temple length. It should be able to follow behind the ear without sticking out past the bottom of the mastoid bone or be too short as to provide no bend.

Frame Components:



- Plastic Bridge Styles

Saddle bridge: Most common. For best fit it should be like a saddle on a horse… no gaps.

Keyhole bridge: Great for smaller noses. The smaller space between the lenses are the best point of contact.

C14: Office Emergency Protocols

All offices should have their own emergency protocol. Every employee needs to know what the protocols are for their office and where to find any necessary supplies. By being thorough in your preparation process, you can mitigate the damage done to your facility while protecting both your patients and employees. All rooms need to have a map to the closest emergency exit. Depending on the location of the practice it is important to know the different recommended standards for each natural disaster. Following the three Cs for emergency will ensure awareness, safety and protection to staff and patients. The 3 Cs:

Check

Check the environment for any signs of unsafety or danger (fire, smoke, structural damage, etc.). This helps to maintain the safety of staff and patients along with the first responders.

Call

When calling in a disaster/emergency situation, it is important to do this as quickly as possible and have all the essential information (name, address & reason for call). When calling in an emergency call 911 or the local emergency number. Remain calm, speak clearly and stay on the line with the dispatchers until they tell you it is ok to hang up.

Care

Depending on the emergency have a staff member stay with the person/emergency. Provide First Aid or CPR if needed until first responders arrive. Once the first responders have arrived, your staff should stand out of the way unless instructed differently by the first responder.

C15: Building Good Rapport with Patients & Chairside Manner

Patients make judgments on how they "feel" when visiting or communicating with the office. How do we make them feel? The emotional element is the strongest driver of patient satisfaction.

We must make an effort to go beyond just the technical skills to create good rapport. We want our patients to feel *welcomed, important and respected*.

In helping to make that emotional connection, we need to communicate empathy and respect and let them know we are partners in their care.

- Smile and be friendly
- Use their name, and introduce yourself
- Be attentive, positive and understanding
- Lend a hand
- Actively listen and speak kindly
- Control your behavior/reactions by being poised and courteous

Skills to Help You Succeed:

- Observe your patient
- Have conversation starters in mind
- Look for the good
- Learn how to cope with stress and emotions
- Be self-aware
- Learn to problem-solve
- Practice critical thinking
- Work on communication skills
- Learn how to resolve conflict

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