THE SASKATCHEWAN ASSOCIATION OF OPTOMETRISTS
STANDARDS OF PRACTICE

PREAMBLE

The Professional Bylaws of *The Optometry Act, 1985* provide for Standards of Practice:

"(6.1) In the practice of optometry a member shall follow the generally accepted standards of practice and procedures in the determination of the state of the eye and its adnexa and in the assessment and care of the patient.

(6.2) Guidelines defining procedures considered necessary for the compliance with the standards required in Section (6.1) shall be compiled from time to time at the direction of council, and copies of such guidelines shall be made available to each member."

Standards of Practice: Approved by the Council of the Saskatchewan Association of Optometrists – September 30, 2016

PART 1 INTRODUCTION:

STANDARDS OF PRACTICE, POLICIES AND GUIDELINES

The Saskatchewan Association of Optometrists provides Standards of Care, Policies and Guidelines under the authority of the Professional Bylaws of the Optometry Act, 1985.

They are considered the minimum standard of professional behavior and ethical conduct which ensures safe, competent, and ethical professional care to all patients.

Standards of Practice, Policies and Guidelines are in constant evolution to reflect advances in optometric and medical science, new competencies, development of innovative technology, and updates to scope of practice. Copies of Standards of Practice, Policies and Guidelines shall be made available to all members.

SCOPE OF PRACTICE

The practice of optometry is the assessment of the eye and the human vision system and the diagnosis, treatment, management and prevention of:

1. Disorders of refraction
2. Sensory and oculomotor disorders and dysfunction of the eye and the vision system
3. The diagnosis, treatment and management of eye disease as outlined in the bylaws and the Standards of Care

GENERAL PRICIPLES OF OPTOMETRIC PRACTICE

1. Optometrists practice based on expert and current knowledge

2. Optometrists practice ethically
3. Optometrists practice in consideration of the individual rights, interests and consent of their patients
4. Optometrists practice to achieve appropriate outcomes in the interest of individual patients
5. Optometrists maintain fiduciary relationships with their patients
6. Optometrists maintain the confidence and privacy of their patients
7. Optometrists are accountable to their patients individually
8. Optometrists are accountable to their colleagues corporately

PART 2 CLINICAL AND PRACTICE MANAGEMENT STANDARDS:

CLINICAL EQUIPMENT AND FACILITY REQUIREMENTS

CLINICAL EQUIPMENT

Optometrists must have access to, and ensure proficient use of equipment, instrumentation, drugs and supplies for the following:

- Measurement of visual acuity for distance and near
- Evaluation of visual fields and colour vision
- Determination of refractive status of the eyes, both objectively and subjectively
- Measurement of corneal thickness and curvature
- Assessment of ocular motility and binocular function
- Examination of the eye and ocular adnexa including
  - A biomicroscope
  - Ophthalmoscope both direct and indirect and accessory lenses
- Measurement of intraocular pressure
- Pupillary dilation, cycloplegia, topical ocular anesthesia and ophthalmic disclosing agents (i.e. NaFI)
- Measurement of the parameters of spectacles
- In office treatment of common primary ocular emergencies
- Disinfection of instruments
- Diagnostic contact lenses
- Infection control and cleanliness

When optometrists do not have a specific instrument, they must have arrangements in place whereby the tests may be performed elsewhere, by requisition or referral, and the results obtained for analysis and retention in the clinical record.

FACILITY REQUIREMENTS

- The optometric entity address
- An individual telephone service
- Secure storage for timely and accurate retrieval of health information about patients
- Office facilities that are orderly, clean and comfortable
- Separate examination areas so that the privacy of the patient and the patient's confidence in the optometrist are protected

- In office sinks and /or antisepsis stations and disposal facilities sufficient to maintain infection control standards

INFECTION CONTROL IN THE OPTOMETRIC OFFICE

Optometrists and staff shall practice effective hand washing before and after any physical contact with a patient. Hands should be washed with soap and water and thoroughly dried with a disposable paper towel. Hand sanitizers may be used in-between soap and water washing; however, hand sanitizers are not considered adequate to replace washing with soap and water.

1. Single use latex or vinyl gloves must be available in every office and are to be worn for procedures involving contact with blood or body fluids. Tears are not implicated unless contaminated with visible blood.
2. Masks and protective eyewear must be available in every office and are to be used for procedures involving the possibility of splashes of blood or other potentially infectious bodily fluids, tissues, or airborne particles.
3. All contact lens, pharmaceutical and other solutions shall be stored according to manufacturer specifications and checked for expiration dates on a regular basis. If the solution or pharmaceutical product has expired or contaminated in any way, it must be discarded in an appropriate manner.
4. Contact lens storage cases may not be reused for different patients unless disinfected following infection control guidelines.
5. Disposable Soft Trial contact lenses are to be used only once and then discarded in an appropriate manner.
6. Reusable gas permeable, specialty soft and hybrid diagnostic contact lenses may be reused following proper cleaning and disinfection.
7. Optometrists are responsible for monitoring and discarding expired or potentially contaminated trial contact lenses and solutions.
8. Contact lens training areas should be cleaned and disinfected in-between use by different patients.
9. Optometrists should dispose of sharps appropriately - do not recap or reuse used needles.
10. Sharps disposal containers must:
    a. Be spill-proof, puncture-resistant, properly labelled and able to be incinerated
    b. Have clearly defined fill line
    c. Be placed as close as possible to where sharps are used to ensure all optometrists and staff use the sharps container provided
    d. Local regulations should be consulted for instructions regarding the proper disposal of sharps in the jurisdiction
11. Any optometrist or staff member who believes they may have contracted a blood-borne infection, including but not limited to Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV) or Hepatitis C Virus (HCV) must seek the advice of a physician.
12. An optometrist must not deny optometric care to a patient positive for a blood-borne infection (e.g. HIV/HBV/HCV) or other conditions low-risk for person to person transmission when using appropriate personal protective measures (e.g. MRSA, VRE, etc.).

Disinfection and Sterilization:

1. Disinfection of NON-Critical Surfaces: non-critical surfaces are considered surfaces that may come into contact with patient's clothing and/or intact skin.
    a. General use non-critical surfaces such as examination chairs, pens, countertops, waiting room chairs, telephones etc. are to be cleaned and disinfected with a commercially available disinfectant cloth and/or solution as required.
    b. Non-critical surfaces that contact a patient's clothing and/or intact skin during patient examination procedures such as chin rests, forehead rests, occluders etc. should be cleaned and disinfected with a commercially available disinfectant cloth and/or solution between every patient.
    c. Any non-critical surface that contacts a patient's broken skin or becomes potentially contaminated in any way should be cleaned and disinfected immediately.

2. Disinfection of Semi-Critical Surfaces: Semi-Critical surfaces are surfaces that come into contact with mucous membranes (i.e.: conjunctiva, cornea, lids, tears) such as tonometer tips, pachymeter probes, gonioscopy, fundus contact lens, reusable contact lens trials, and foreign body removal instruments, etc. Semi-critical surfaces may be cleaned and disinfected by immediate cleaning of any gross tissue, soil or fluid (if present) and the following:
    a. Immersing for 10 minutes in one of the following sterilants followed by a rinse with sterile saline and air dried before reuse.
        i. 3% hydrogen peroxide
        ii. 0.5% sodium hypoclorite solution (1:10 dilution of household bleach)
        iii. Any other industry approved commercial grade germicidal sterilant solution

3. Biomedical Waste Management: Each practice should have policies and procedures for proper storage, handling and disposal of biomedical waste for post-exposure management, including keeping biomedical waste in a secure area and allowing access only to authorized personnel while waiting for transport to a disposal site. Optometrists and staff need to be aware of local waste bylaws and levels of operation of local landfills and incineration facilities in your municipality. Optometrists are to contact Saskatchewan Health if there are questions or concerns about disposing waste.

REQUIRED CLINICAL INFORMATION

Required clinical information to be obtained from patients at their first presentation for a comprehensive routine oculo-visual assessment includes:

- The identity of the patient
- The dates of entry to the record
- The identity of the person making the entry
- The chief concern or request
- A comprehensive case history, including ocular or visual symptoms or experiences, health history including medications and family history
- Occupational and avocational visual environment and demands as well as the measurement and description of the patient's ophthalmic appliances, including purpose and effectiveness
- The results of the observation, examination and measurement of:
    a. Relevant physical, emotional and mental status if deemed necessary
    b. The external eye and adnexa
    c. Pupillary function
    d. The anterior segment and corneal thickness, when indicated
    e. Ocular media
    f. The posterior segment
    g. The intraocular pressure in adults and when indicated, in children
    h. Presenting monocular visual acuities at a distance and/or near
    i. Refractive status and best corrected monocular acuity
    j. Oculomotor status and when indicated fusional reserves
    k. Other sensory functions, when indicated, such as visual fields, colour vision, stereoacuity, sensory fusion and contrast sensitivity

All required clinical information must be clearly documented in the patient's health record. In situations where it is not possible to obtain specific required information, justification must be documented.

Patient information must be kept current by recommending re-evaluation at subsequent examinations. Patient's signs, symptoms and risk factors influence decisions optometrists make about recommended frequency of re-evaluation.

In emergency or urgent situations, it may be impractical to obtain all information at the first visit. In such cases, a specific assessment is acceptable. Completion of a comprehensive oculo-visual assessment should be arranged as appropriate.

Optometrists may choose to employ ancillary procedures in addition to those mentioned above in order to enhance or refine a clinical diagnosis or management plan. This is particularly true when the rapid pace of scientific and technological advancements in instrumentation and equipment is considered. Examples of such procedures include, but are not limited to:

- Fundus photography, OCT, scanning laser ophthalmoscopy and similar high technology imaging or mapping systems
- Corneal topography
- Ophthalmic ultrasonography (A or B scan), ultrasound biomicroscopy
- Available refractive technologies (e.g. wavefront analysis)
- Visual electrophysiology (i.e. ERG's, VEP's, etc.)

DELEGATION AND ASSIGNMENT

An optometrist may delegate duties and tasks to support personnel where appropriate. Any act that is delegated by an optometrist must be ordered by the optometrist and the optometrist assumes full responsibility for such delegated acts. Acts that include direct supervision or indirect supervision may be delegated where appropriate. Patient care must not be compromised in any decision to delegate. The delegation of any act shall not negate the optometrist's responsibility to follow general accepted standards of practice.

No person other than a licensed optometrist may engage in the practice of optometry as defined in the Optometry Act, 1985. Under no circumstances shall support personnel be delegated tasks involving evaluation (or interpretation) of data, determination of diagnosis or prognosis. No support personnel shall measure subjective refractive error or determine refractive correction.

THE USE AND PRESCRIBING OF DRUGS IN OPTOMETRIC PRACTICE

Optometrists use diagnostic and therapeutic drugs in the course of providing patient care. Optometrists in Saskatchewan have the authority to prescribe drugs to manage patients with diseases and disorders of the vision system. Saskatchewan optometrists can prescribe Schedule I (as designated by the Saskatchewan College of Pharmacy) drugs for the treatment of eye disease.

A member may not prescribe any drug unless they have successfully completed the relevant certification approved by Council.

Every time a member prescribes a drug, the member shall record the following in the patient's health record:

- The date of the prescription
- Details of the prescription, including the drug prescribed, dosage and route of administration
- The number or repeats authorized if any
- Details of the counseling provided by the member
- A detailed treatment and management plan along with appropriate follow up care

Twenty four hour per day access to appropriate care must be provided while the patient is being treated with prescription drugs for acute and urgent vision conditions. This may include:

- Providing patients with home or cell number, or
- Arrangement for care through available colleagues, or
- The patient having reasonable access to a hospital or alternate medical facility emergency services

REFERRALS

A referral is a request for consultation/ and or the provision of treatment made to another regulated health care professional when a patient requires care that exceeds the optometrist's scope of practice or ability.

REGULATORY REFERENCE

It is considered an act of professional misconduct:

- To exceed the scope of practice of the profession
- To treat or attempting to treat an eye or vision system condition which the member recognizes or should recognize as being beyond their experience or competence
- To fail to refer a patient when a member recognizes or should recognize a condition of the eye or vision system that appears to require such referral

CLINICAL STANDARD OF REFERRAL

Optometrists must be proficient in determining the necessity of appropriate referral for care. Decisions should be made about the urgency and choice of consultant based on ocular or systemic conditions and the risk factors for their patients.

Once the decision to refer has been made the member is required to:

- Have appropriate documentation of when the referral was requested
- Document the name of the consultant and the reason for referral
- Ensure the consultant has been provided with the appropriate clinical information
- Ensure when the referral letter has been written, that a copy be sent to the patient's primary health care provider when relevant
- Promptly refer acute conditions that pose an immediate threat to the health or vision of a patient

OCULAR URGENCIES AND EMERGENCIES

Urgencies and emergencies represent potential threats to the ocular or systemic health of the patient if not dealt with promptly and appropriately.

Optometrists are expected to:

- Establish appropriate protocols and ensure that staff members are trained to recognize and respond to urgent and emergency situations
- Conduct a specific examination to evaluate the immediate problem
- Counsel at risk patients about signs and symptoms that may require further care (e.g. retinal detachment signs and symptoms following posterior vitreous detachment)
- Counsel patients to whom drugs have been prescribed about potential adverse reactions and when the need for emergency services may be required
- Make themselves available or arrange for 24 hour care for patients to whom they have initiated treatment of an urgent condition

THE PATIENT RECORD AND PRESCRIPTION

Optometrists must maintain the information contained within a patient's health record in trust and in compliance with Saskatchewan's Health Information Privacy Act.

The patient's health record shall be legible and complete and include the following information:

- The identity of the patient
- The dates of entries to the record
- The identity of the person making the entry
- The patient's history
- The assessment procedures used and the results obtained
- Observations and impressions
- Diagnoses made
- Counseling provided
- Prescriptions given ocular and therapeutic
- Treatments administered
- Information from other sources, including past records and consultant reports
- Financial transactions, including billing and receipts to third parties

The right of the patient to access the information in their record or direct the information in their record to another health care provider must not be limited in any manner.

In situations where members relocate their practice or entrust the custody of records to another optometrist in another location, optometrists entrusted with the maintenance of the records must make a reasonable attempt to inform patients of the location of the records.

- Members must comply with the Health Information Protection Act and provide a copy of the patients records if requested by the patient
- Optometrists are expected to utilize reasonable and reliable backup systems
- When patient information is stored on mobile devices or offsite in an identifiable form, the information must be encrypted

CUSTODIANSHIP AND RETENTION OF THE PATIENT HEALTH RECORD

A member shall keep patient records in a systematic manner and shall retain each record for a period of at least six years after the date of the last clinical entry in a record. All records of pediatric patients shall be retained for two years past the age of majority or six years after the date they were last examined whichever may be the later date.

ELECTRONIC RECORDS

- As much as possible protect the safety of the hardware from lightning strikes, power outages , water damage and theft
- Restrict access to the records by using passwords, positioning terminals, etc. to restrict the observation of sensitive data by unauthorized people
- A reliable backup system through some form of secure data storage, which may be off site or cloud based
- Virus and spyware protection must be used
- Secure patient personal and financial information must be protected or any online transaction
- Optometrists must be diligent in maintaining current technology to protect the security of electronic patient data

PART 3 GENERAL OPTOMETRIC PROCEDURES:

ANTERIOR SEGMENT EXAMINATION

The anterior segment can be considered the front one third of the eye, encompassing the structures anterior to the vitreous humour.

The anterior segment examination consists of a thorough assessment of these structures to facilitate the diagnosis of disease and disorders of the eye and the vision system. Information gathered from an anterior segment examination is part of the required clinical data for a comprehensive eye examination.

Optometrists must be proficient in and equipped for examining the anterior segment. All patients should receive an anterior segment examination as part of initial and ongoing optometric care. Emphasis should be given to the evaluation of the anterior chamber angle prior to pupillary dilation and in particular with patients with diagnosed or suspected glaucoma.

An anterior segment examination is an essential component of all contact lens assessments.

Gonioscopy or use of a reliable imaging technique may be employed when a detailed assessment of the anterior chamber angle is required. Other assessment tools that can be employed, but not limited to, include OCT, wave front analysis and corneal topography. Ophthalmic dyes and optical filters are helpful in diagnosing diseases and disorders of the ocular surface.

POSTERIOR SEGMENT EXAMINATION

The posterior segment is considered as the back two thirds of the eye, encompassing the structures behind the crystalline lens.

The posterior segment examination consists of a thorough assessment of these structures to facilitate the diagnosis of disease, dysfunctions and disorders of the eye and the vision system.

Instruments and techniques to be considered in the posterior segment examination include but are not limited to:

- Direct ophthalmoscopy
- Binocular indirect ophthalmoscopy
- Monocular Indirect ophthalmoscopy
- Slit lamp biomicroscopy and slit lamp photography
- Fundus photography
- Imaging technologies

Pharmacologic dilation of the pupil is generally required for a thorough evaluation of the ocular media and the posterior segment.
Patient symptoms that require dilation include, but are not limited to the following:

- Flashes and floaters
- Unexplained vision changes

- The use of medication that may affect ocular tissues (i.e. hydroxychloroquine, phenothiazine, long term steroids)
- The presence of systemic disease that may affect ocular tissues (including but not limited to diabetes, hypertension)
- A recent history of significant ocular trauma or ocular surgery that increase risk to abnormalities of the posterior segment
- A history of moderate to high axial myopia or spherical equivalent
- When a better appreciation of the fundus is required (including but not limited to choroidal nevus, optic nerve anomalies)
- When the ocular fundus is not clearly visible through an undilated pupil (including but not limited to cataract)
- When there is a known or suspected disease of the ciliary body, vitreous, the optic nerve, the macula, peripheral retina

Dilating agents should be chosen after considering the extent of pupillary dilation required, the patient's health history and clinical ocular characteristics.

In general, an adult patient should undergo a dilated fundus examination (DFE) upon their initial presentation to an optometrist. Dilation should be performed periodically using the practitioner's best clinical judgement.

The name of the dilating agent used and the time of instillation should be recorded in the patient's record.

Fundus photography and other imaging techniques are becoming more common in optometric practice, but are meant to complement, not replace pupillary dilation.

REFRACTIVE ASSESSMENT AND PRESCRIBING

Assessing the patient's refractive error and where required prescribing an optical correction is an integral part of optometric care. Assessment methods include both objective and subjective techniques.

Objective techniques generally do not require input from the patient and include:
- Retinoscopy
- Auto-refraction
- Wave-front assessment

Subjective techniques depend on patient responses and may include the following:
- Trial frame methods
- Phoropter methods
- Auto-refractors with subjective capability

New and advanced techniques of refractive assessment continue to be developed. It is recommended that optometrists maintain current knowledge of new technologies.

SPECTACLE THERAPY

The optometrist is to offer the patient a written, signed and dated optical prescription in a timely manner. Withholding or unnecessarily delaying the release of an optical prescription, upon the request of the patient is considered professional misconduct. An expiry date based on the optometrist's clinical judgment should be included in the written prescription.

When providing spectacle therapy the optometrist must:

- Review with the patient any relevant environmental, occupational, avocation, and physical factors affecting spectacle wear
- Review the details of the prescription
- Advise or delegate a trained staff member to provide information regarding appropriate ophthalmic materials
- Verify or delegate a trained staff member to verify completed spectacles to ensure they meet required tolerances
- Fit or delegate a trained staff member to fit and adjust the patient's spectacles
- Counsel or delegate counseling to a trained staff member on aspects of spectacle wear, including but not limited to: the use, expectations, limitations, customary adaptation period and maintenance requirements of the provided spectacles

Patients experiencing unexpected difficulty in adapting to a new spectacle prescription should be counseled to seek re-examination by the prescriber to assess the appropriateness of the prescription. Optometrists who dispense appliances based on a prescription from another practitioner are expected to ensure the prescription has been filled accurately, however they are not responsible for the efficacy or accuracy of that practitioner's prescription.

Optometrists must use their professional judgment when deciding to provide spectacle therapy to any patient with an expired prescription. Optometrist must advise patients of any risks and should obtain informed consent before dispensing an expired prescription.

INITIAL CONTACT LENS FITTING

Optometrists are required to obtain clinical information to determine the suitability of patients for contact lens wear when proceeding with a contact lens fitting. Analysis of the following is required:

- The health of the cornea, conjunctiva, lids, tarsal and bulbar conjunctiva and the integrity of the tear layer
- Corneal curvature
- Refractive status and visual acuity
- The effects that contact lens wear may have on the function of the accommodative, oculomotor and sensory systems
- Relevant environmental, occupational, avocational, emotional and systemic health factors affecting contact lens care

The optometrists must provide the patient with information about proceeding with treatment including advantages, risks, limitations and costs of contact lens therapy.

In fitting contact lenses the optometrist must determine by diagnostic fitting or calculation, lenses that are suitable for the patient. The initial lenses are to be evaluated on a patient's eye and modified as required.

Instructions are to be provided by the optometrist or a trained delegated staff member on the following:

- Contact lens hygiene
- Lens insertion and removal
- Use of specific contact lens care products
- Recommended wearing times and replacement schedules
- Normal and abnormal adaptive symptoms
- Contraindications to contact lens wear
- A schedule for progress evaluations
- Appropriate instructions on how and when to access emergency care

Once the optometrist has determined that the adaptation process is complete, the parameters of the contact lens is correct, and the patient's eye health is not compromised, then the contact lens specification can be finalized. Optometrists are entitled to remuneration for all professional services involved in the above determination. The patient has the option of obtaining contact lenses from their optometrist or requesting a copy of the contact lens specification in order to obtain contact lenses elsewhere.

Optometrists must recommend continuing care to established contact lens patients and must maintain records with information concerning:

- The age and wearing schedule of the patient's current contact lenses
- The current lens care regime
- Adverse reactions associated with contact lens care
- Health and medication changes

Patients should be assessed to determine if they are achieving acceptable
- Lens appearance and fit
- Wearing time
- Comfort with the lenses
- Corneal clarity and integrity
- Stable corneal curvature
- Conjunctival and lid appearance
- Tear characteristics
- Over-refraction to obtain best corrected acuity
- Compliance with recommendations on lens care, handling, replacement and wearing schedule

After assessment the optometrist should identify any problems and counsel patients as necessary.

SPECIFIC EYE DISEASES AND DISORDERS

GUIDELINES FOR GLAUCOMA ASSESSMENT, TREATMENT AND MANAGEMENT

Refer to Professional Bylaws (January 8, 2016) the current "Guidelines for Treatment and Management of Ocular Diseased with Oral Medication and Treatment and Management of Glaucoma" are considered a Standard of Care not a Guideline as recorded in the bylaw document appendix.

Part 4 SEXUAL CONDUCT

Optometrists must maintain professional boundaries with their patients and not exploit them in any way. The following issues are pertinent to situations where the patient-optometrist relationship may be compromised by sexualized behaviour.

- Trust is the basis of the patient-optometrist relationship.
- The onus is always on the optometrist to maintain professional boundaries with a patient and not to exploit the patient in any way. The nature of a fiduciary relationship makes a consensual sexual relationship between an optometrist and patient impossible.
- The patient is considered to be the vulnerable individual in the professional relationship between an optometrist and a patient.
- Power imbalance exists in the patient-optometrist relationship, and the risk for abuse may develop as a result of the power imbalance.
- Sexualized behaviour in the patient-optometrist relationship is never acceptable. A breach of sexual boundaries has potential for significant harm to the patient as the optometrist cannot provide objective care when a sexualized relationship exists.

Furthermore, sexual relationships are not possible according to the Standards of Practice (A. General Principals of Optometric Practice). Applicable principals are listed below:

1. Optometrists practice ethically
2. Optometrists practice in consideration of the individual rights, interests and consent of their patients
3. Optometrists practice to achieve appropriate outcomes in the interest of individual patients
4. Optometrists maintain fiduciary relationships with their patients

The Optometric Professional Bylaws (5.1) (a) and (h) also restrict sexual misconduct, as optometrists vow to accept primary concern and to maintain at all times the dignity, honour and integrity of the profession.

Inappropriate Behaviour in the Patient-Optometrist Relationship

The following are examples of behaviour that are considered inappropriate:

- Altering or removing a patient's clothing
- Sexually demeaning or suggestive comments
- Requests for "dating"
- Sexualized touching, fondling, hugging, kissing, and petting
- Sexual intercourse

Behaviours that are considered inappropriate are not limited to behaviours listed above. Termination of a professional relationship in order to pursue a sexual relationship has always been considered to be unethical.

Precautions in Practice

Consideration should be given to the following:

- An optometrist should be careful to ensure that any remarks or questions that are asked cannot be construed as demeaning, seductive or sexual in nature.
- When sensitive subjects, such as sexual matters, have to be discussed, the optometrist should explain why the questions have to be asked, so that the intention cannot be misconstrued.
- Hugging and/or kissing a patient is considered high risk behaviour that can be misinterpreted. Any touching that is not part of the physical examination must be of a type that cannot be misconstrued.
- Although chaperones are not mandatory, an optometrist should consider carefully whether a chaperone would contribute to an individual patient's feeling of comfort and security. Also, a chaperone may protect the optometrist from unfounded allegations. If a patient asks to have an appropriate support person in the room, that request must be honoured.
- The scope of the examination and the reasons for examination should be explained to the patient.
- An optometrist should be mindful of the particular cultural preferences in the diverse patient population.
- Every optometrist should minimize personal vulnerability by appropriate recognition and attention to personal illness, stressors, and emotional needs.
- When any questions or concerns arise, the optometrist should feel free to contact the College for advice or direction.

Ethical Duty to Report

Optometrists have responsibilities regarding the reporting of sexual misconduct by another registrant to the College.
Subject to the patient's consent, the optometrist has an ethical responsibility to report to the College if a patient discloses information that leads the optometrist to believe that another optometrist may have acted improperly with an adult patient. To assist in such instances, the following guidelines are provided:

- The optometrist must provide the patient with information on how to file a complaint with the College.
- If the patient does not wish to file a formal complaint immediately, then the optometrist must offer to file a third party report with the patient's written consent.
- If the patient does not give permission to proceed, then the optometrist has fulfilled the ethical duty in the case of sexual misconduct involving a patient. The optometrist should document the event, indicating that the patient does not wish a complaint or third party report to be made to the College.
- Patient consent is not required in the case of suspected sexual abuse of a minor. In Saskatchewan, you have a legal obligation to report suspected abuse of a minor, even if you believe a report has already been made.

Adjudication of Sexual Misconduct Complaints

All allegations of sexual misconduct must be carefully investigated and reviewed by the College. Each situation is considered on its own merit, carefully taking into account factors such as:

- The nature of the patient-optometrist relationship
- The patient's vulnerability including:
  - the presence of a disorder likely to impair judgment or hinder independent decision-making
  - age under 19

Optometrist factors including:

- previous sexual misconduct
- degree of exploitation
- impairment
- actual or threatened bodily harm or violence

For more information on the complaint process and procedure on concerns of sensitive or intimate nature, please contact the Registrar of the Saskatchewan Association of Optometrists.