

SESLHD PROCEDURE COVER SHEET



Health
South Eastern Sydney
Local Health District

NAME OF DOCUMENT	Statewide Eyesight Preschool Screening Program (StEPS) for visual acuity using the HOTV logMAR or Sheridan Gardiner Linear Chart (SGLC)
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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Helen Gunn Manager Women and Children's Clinical Stream
AUTHOR	StEPS Area Coordinator Nadya.Shulgin@health.nsw.gov.au
POSITION RESPONSIBLE FOR THE DOCUMENT	StEPS Area Coordinator Nadya.Shulgin@health.nsw.gov.au
KEY TERMS	Vision Surveillance and screening. HOTV; SGLC; StEPS
SUMMARY	To provide staff with the knowledge and skills to engage parents and pre-school children in vision surveillance and screening.

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

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Statewide Eyesight Preschool Screening Program (StEPS) for visual acuity using the HOTV logMAR or Sheridan Gardiner Linear Chart (SGLC)

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1. POLICY STATEMENT

This policy is to communicate to Child and Family nursing staff a safe and appropriate approach to carry out the Vision screening for the StEPS program

This work practice involves:

- Child and Family Health Nurses (CFHN)
- Child and Family Clinical Nurse Specialist (CFCNS)
- Child and Family Clinical Nurse Consultants (CFCNC)
- Child and Family Nurse Unit Managers (CFNUM)

2. BACKGROUND

The Statewide Eyesight Preschooler Screening (StEPS) program is an initiative of the NSW Ministry of Health and offers all four year old children a free vision screening assessment (NSW Health PD2018_015 Statewide Eyesight Preschooler Screening (StEPS) Program). It is highly recommended all four year old children participate in the vision screening program as many vision problems remain undetected unless a child's vision is screened by a trained vision screener.

All parents/carers of children who have their vision screened through the StEPS program will be informed of the results of their child's vision screening assessment.

Should a vision problem be detected parents/carers will receive a referral letter asking them to have their child's vision fully tested by an eye health professional.

3. RESPONSIBILITIES

Child and Family Nurses:

- are responsible for carrying out the procedure correctly as part of the four year PHR check, regardless if the child attends preschool.
- StEPS training manual and modules in HETI to be adhered to and completed. Reference material to be used as needed.
- Complete four hours training with StEPS Coordinator or Orthoptist.
- Undergo three month competency check and yearly competency check thereafter.

Line Managers:

- are responsible for supporting staff in the implementation of Vision surveillance and screening by ensuring equipment is available to carry out the procedure.

4. PROCEDURE

- Obtain parent consent and record accordingly in mandatory fields in 'StEPS Ax' form.
- Wash your hands.
- Set up chart at a comfortable height for the examiner.
- Keep the chart covered prior to testing so that child cannot memorise letters.
- Measure accurate test distance from chart to child's eyes (back of chair).

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- Measure a 6m or 3m distance using your length of string provided/tape measure.
- Ensure the correct chart is used based on the testing distance selected.
- Have the child seated as it maintains an accurate distance and limits movement.
- Practice letter matching with child to make sure they understand the test.
- Test one eye at a time beginning with the RIGHT eye and cover the LEFT eye.
- Cover chart between testing the first and second eye so that child cannot memorise letters.
- Place a tissue under the eye patch to eliminate 'peeking' and for hygiene.
- Watch for 'peeking', moving the chair forward or looking side-ways.
- Start at the top of the HOTV or SGL Chart pointing to the letter from below (from underneath).
- Select one letter from each line until you reach the 6/9 line.
- Avoid letters on the end of the line or isolating letters as they are easier to see.
- Point to every letter on the 6/9 line in random order. This is the line required for a four year old child
- Record vision immediately to avoid confusing results between both eyes. Results are to be recorded in the child's blue book as well as on the 'StEPS Ax' form in the child's online medical record file.
- Vision is recorded as a ratio – Test distance / Letter size
- Once right eye result is recorded, change the patch to cover the right eye and then test the left eye.
- After completing the test, discard the tissue under the patch.
- Wipe down equipment and occlusion glasses for infection control.
- Wash hands again for infection control.
- Complete record documenting the result of screen in medical records and triaging referrals.

5. DOCUMENTATION

- Vision results to be documented on the 'StEPS Ax' form in the child's Electronic Medical Records (EMR).
- Vision results are to be documented in the child's Personal Health Record Book (PHR).
- Referrals - Parents/carers are to receive an LHD StEPS referral letter if applicable and an 'order' created in EMR flagging this child to the LHD StEPS Coordinator for follow up.

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6. StEPS Department SESLHD/ISLHD contact details

StEPS Department
Sydney Children's Hospital, High St
RANDWICK, NSW 2031
FAX: 02 9382 0279
Office mobile: 0409-009-619
Clinic Bookings: 02 9382 0277
Nadya Shulgin - Mobile: **0422-009-619**
Email: Nadya.Shulgin@health.nsw.gov.au
StEPS email: SCHN-SCH-STEPS@health.nsw.gov.au

7. APPENDIX

- A. StEPS consent & result form
- B. StEPS referral letter for parent
- C. Nurse guide to completing online 'StEPS Ax' forms
- D. Nurse guide to creating an 'order' – sending a referral to the StEPS Coordinator

8. AUDIT

Annual File audit

7. REFERENCES

- Rose.K., Younan, C., Morgan, I. & Mitchell, P. (2003). Prevalence of undetected ocular conditions in a plot sample of school children. *Clinical & Experimental Ophthalmology*, 31 (3), 237-240. StEPS Vision
- [NSW Ministry of Health PD2018_015 Statewide Eyesight Preschooler Screening \(StEPS\) Program](#)
- StEPS Vision training video '*Setting up and conducting vision screening in StEPS*' & '*Using the HOTV logmar vision screening chart*'
- StEPS Program training manual

9. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
June 2009	Draft	StEPS Coordinator. CNC in Child & Family Health SHN
February 2010	0	E.Cooper CNC in Child & Family Health SHN
December 2012	1	Michael Cosstick, Orthoptist, SES LHD, Emer Cooper, CNC, ISLHD
August 2018	2	Nadya Shulgin, Orthoptist & StEPS Coordinator SESLHD/ISLHD
August 2018	2	Endorsed by Executive Sponsor

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APPENDIX A StEPS CONSENT & RESULT FORM

	OFFICE USE ONLY	
	FAMILY NAME	MRN
	GIVEN NAME	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
	D.O.B. ____ / ____ / ____	M.O.
ADDRESS		
StEPS CONSENT AND RESULT		LOCATION / WARD
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		
Parent / Guardian to Complete (please use black or blue pen)		
Parent / Guardian (relationship to child) Name: _____		
Mobile: _____		Home Phone: _____
Address: _____		
		Postcode: _____
Email: _____		
CONSENT FOR VISION SCREENING		
<p><i>I understand that the Statewide Eyesight Preschool Screening (StEPS) Program is for screening purposes only. Screening tests, checks and examinations can never be 100% accurate. Sometimes a screening may cause a false alarm or miss a problem. Occasionally a new problem may occur after your child has had a screening test. For this reason, if you have concerns about your child's eyes now or at any time in the future, please see an eye health professional.</i></p>		
<input type="checkbox"/> Yes, I consent to have my child's vision screened		Signed: _____ Date / /
<input type="checkbox"/> No, I decline to have my child's vision screened because (please tick below)		
<input type="checkbox"/> already received a screen <input type="checkbox"/> already under care <input type="checkbox"/> other		Signed: _____ Date / /
Verbal consent: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Name _____ Designation _____		Signed _____ Date / /
Reason for verbal consent _____		
Child's Details (please use black or blue pen)		
Child's Name: _____		Gender: M <input type="checkbox"/> F <input type="checkbox"/>
Date of Birth: _____	Medicare Number: [] [] [] [] [] [] [] [] [] [] / []	
Name of Preschool / Child Care Centre: _____		
Days child attends centre (please tick all that apply): Mo <input type="checkbox"/> Tu <input type="checkbox"/> We <input type="checkbox"/> Th <input type="checkbox"/> Fr <input type="checkbox"/>		
If your child attends another centre, please state _____		
Days child attends other centre (please tick all that apply): Mo <input type="checkbox"/> Tu <input type="checkbox"/> We <input type="checkbox"/> Th <input type="checkbox"/> Fr <input type="checkbox"/>		
Indigenous Status		
Is your child of Aboriginal or Torres Strait Islander origin?		
<input type="checkbox"/> Yes - Aboriginal <input type="checkbox"/> Yes - Torres Strait Islander <input type="checkbox"/> Yes - Both <input type="checkbox"/> Neither <input type="checkbox"/> Unknown		
Pre-Screening Questions – please answer all of the following questions:		
● Are you concerned about your child's vision?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, what are your concerns? _____		
● Is your child currently under care for their vision? Details _____		Yes <input type="checkbox"/> No <input type="checkbox"/>
● Does your child have a turned or lazy eye (squint or strabismus)?		Yes <input type="checkbox"/> No <input type="checkbox"/>
● Did anyone in the family have eye problems in childhood?		Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please provide details: _____		



Holias Punched as per AS2829.1: 2012
BINDING MARGIN - NO WRITING

18/02/2016 000116


SEStEPS CONSENT AND RESULT

NO WRITING

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 NSW Health	OFFICE USE ONLY	
	FAMILY NAME	MRN
	GIVEN NAME	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
	D.O.B. ____/____/____	M.O.
	ADDRESS	
	LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		
VISION SCREENER TO COMPLETE		
Location of Screening:		
Vision screening chart used: HOTV <input type="checkbox"/> Sheridan Gardiner <input type="checkbox"/> Vision screening distance: 6 metres <input type="checkbox"/> 3 metres <input type="checkbox"/> Vision was tested: Without glasses <input type="checkbox"/> With glasses <input type="checkbox"/>		
Visual acuity result: RVA _____ LVA _____		
COMMENTS / OBSERVATIONS		
_____ _____ _____ _____ _____ _____ _____ _____ _____ _____		
RESULT		
<input type="checkbox"/>Pass (vision within normal limits for age) <input type="checkbox"/>Borderline Pass (follow-up by parent/guardian in one year) <input type="checkbox"/>Referred for further assessment (for general referrals and not other referral types listed below) <input type="checkbox"/>Referred – High priority referral <input type="checkbox"/>Referred due to unable to screen/incomplete screen <input type="checkbox"/>Referred – vision within normal limits but requires referral for other finding <input type="checkbox"/>Absent on the day of screening <input type="checkbox"/>Currently under care for vision		
NOTIFICATION FORM COMPLETED? Yes <input type="checkbox"/> No <input type="checkbox"/> REFERRAL LETTER COMPLETED? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Screener's Name:	Signature:	Date:
Consent and Result Form to be forwarded to the StEPS Co-ordinator		
FOLLOW-UP BY LHD WITHIN 1 MONTH? Yes <input type="checkbox"/> No <input type="checkbox"/> Date of contact / /		
FOLLOW-UP BY LHD WITHIN 3 MONTHS? Yes <input type="checkbox"/> No <input type="checkbox"/> Date of contact / /		
OUTCOME:		
StEPS Co-ordinator:		Signature:

Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING



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APPENDIX B StEPS REFERRAL LETTER

StEPS Referral Letter

Date:

Dear

Re: _____ DOB: _____ MRN: _____ M / F

Centre:

Following the recent vision screening of your son or daughter by the StEPS program, it is recommended that you have his/her eyes fully tested by an eye health professional as your child may require glasses and/or treatment for reduced vision or an eye muscle imbalance.

You are advised to carry out this recommendation as soon as possible.

Vision screening chart used: HOTV Sheridan Gardiner
 Vision screening distance: 6 metres 3 metres
 Vision was tested: Without glasses With glasses

Vision screening result:	Right Eye _____	Left Eye _____	
Comment:			

Further information may be obtained by telephoning or writing to the address below.

Medicare rebates are available for children's vision assessments; however, costs may vary between eye health professionals and eye health services. Your eye health professional or eye health service will be able to provide further information on the costs of their service.

Please take this letter with you when you have your child's eyes fully tested.

A report from your eye health professional would be greatly appreciated, sent to the address below. Alternatively, please ask your eye health professional to complete the attached tear off slip and forward it to the address below.

Results Notification

Child's Name: _____ Date of birth: _____ MRN (if applicable): _____

Preschool: _____ Date of assessment: _____ Clinic/Provider: _____

Outcome: Please select all relevant categories:

Refractive error <input type="checkbox"/>	Anisometropia <input type="checkbox"/>	Emmetropia <input type="checkbox"/>
Amblyopia <input type="checkbox"/>	Strabismus <input type="checkbox"/>	Other (please specify) <input type="checkbox"/>
Monitor/review <input type="checkbox"/>	Discharge <input type="checkbox"/> (no treatment or review required)	

Diagnosis and treatment plan:

Send to: **StEPS Coordinator**
StEPS Department
 Sydney Children's Hospital
 High St, RANDWICK, NSW, 2031

Email: SCHN-SCH-STEPS@health.nsw.gov.au
 FAX: (02) 9382 0279
 PH: (02) 9382 0277



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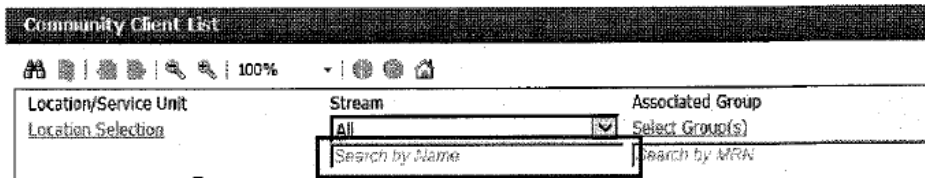
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APPENDIX C GUIDE TO COMPLETING 'StEPS Ax' FORM IN EMR


eMR Screener Guide

Logging On

1. Turn on laptop and enter username and password.
2. Open citix icon  and click on PowerChart icon .
3. Accept the NSW Health conditions of access and enter eMR username and password again.
4. The Community Client List will appear with all children registered for screening.
5. Search for child's surname in the 'search by name' search box.



6. Click on the child's name to open their medical record.

Name	Age	Location/Stream
<div style="border: 1px solid black; padding: 2px;"> MRN/Gender/DOB  </div>		STEPS CH SCH Child Youth and Family

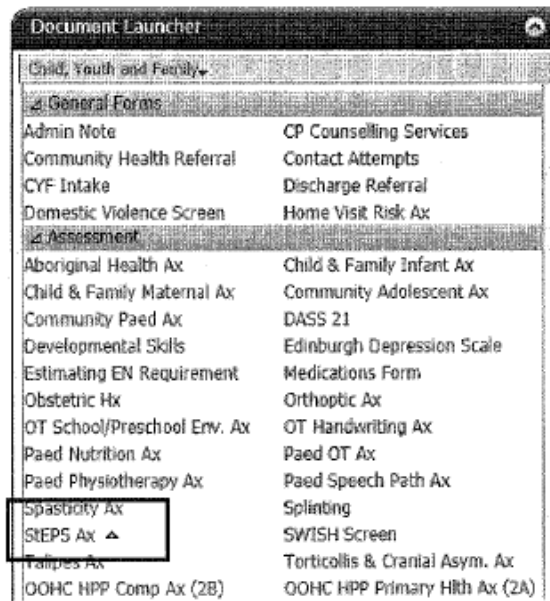
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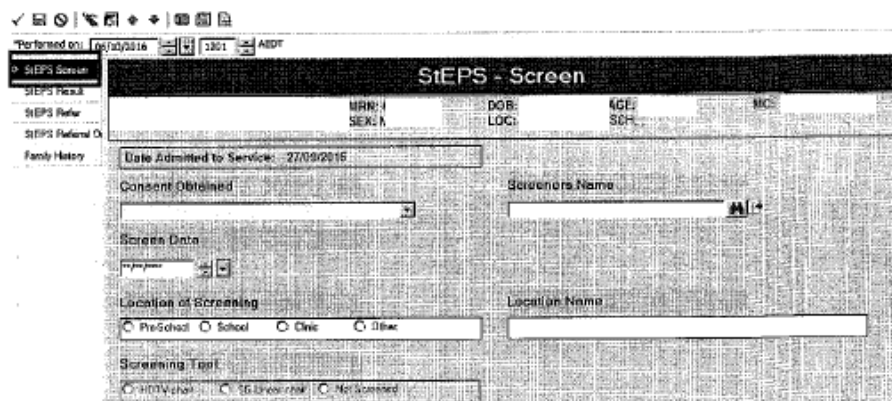
Completing the StEPS Assessment

- To commence the StEPS screen, click on "StEPS Ax" in the Document Launcher.



- The "StEPS – Screen" page automatically opens. Record as required

Tip: Yellow fields are mandatory.



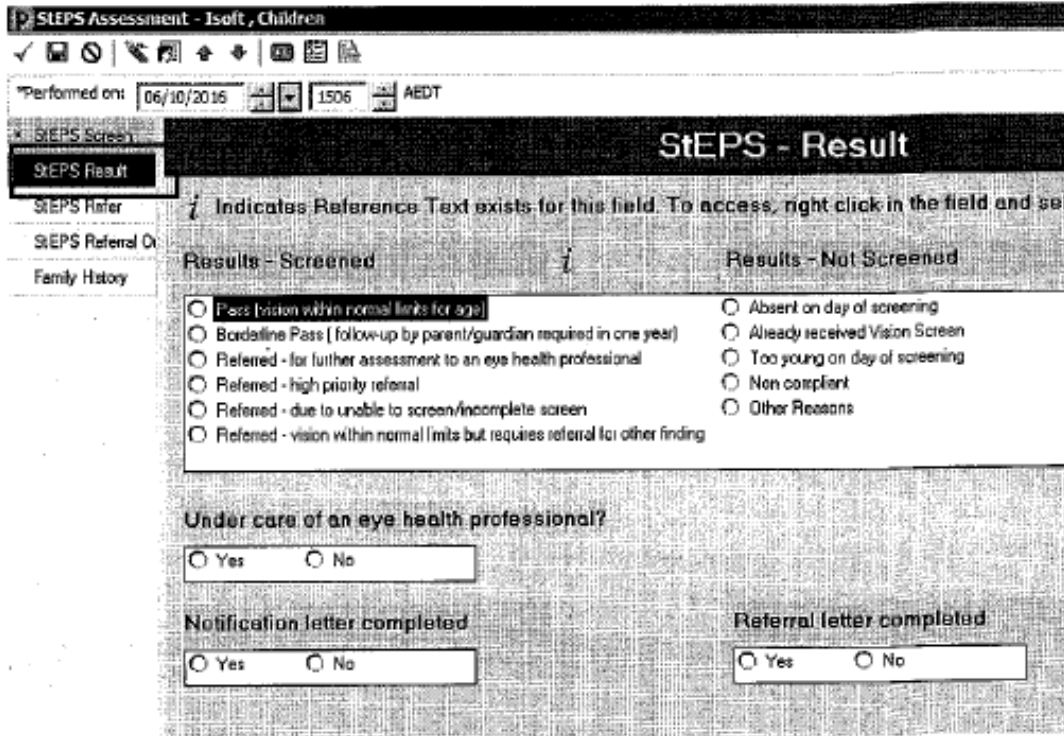
The screenshot shows the 'StEPS - Screen' form. It includes a toolbar at the top with icons for save, print, and other actions. The form is divided into several sections:

- Header:** Includes fields for MRRN, SEX, DOB, LOG, AGE, and SCH.
- Consent:** A section for 'Consent Obtained' with a dropdown menu and a 'Screeners Name' field.
- Screen Data:** A section for 'Screen Data' with a dropdown menu.
- Location of Screening:** Radio buttons for 'PreSchool', 'School', 'Clinic', and 'Other', followed by a 'Location Name' field.
- Screening Tool:** Radio buttons for 'HOTV Chart', 'SGLC Chart', and 'Not Assessed'.

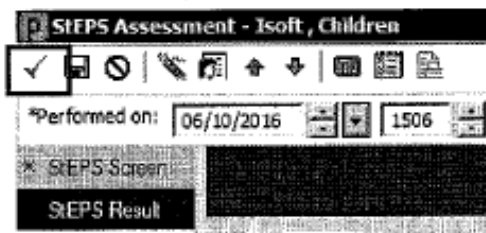
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- 9 After completing the child's screen and recording any observations in the "comments" box on the page, proceed to the "StEPS result" tab in the left hand corner to record the screening results.



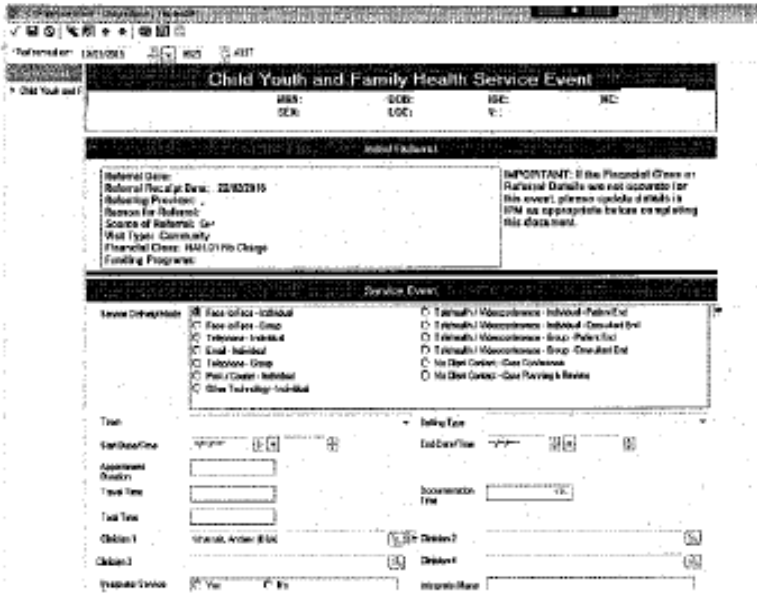
- 10 Sign the StEPS Assessment form by clicking on the green tick located in the top left corner of the screen and enter your password.




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11 Once the form is signed, a CYF Service event form will immediately open



IF a Service event is not required, cancel out of the form using . Otherwise complete the service event as per usual.

12 Follow the “Adding orders” guide if you wish to send a referral to StEPS for follow up.

13 Contact the StEPS Coordinator if you have any questions/issues on 0422 009 619.

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APPENDIX D GUIDE TO CREATING AN 'ORDER'/SENDING REFERRAL



PowerChart
eMR Quick Reference Guide

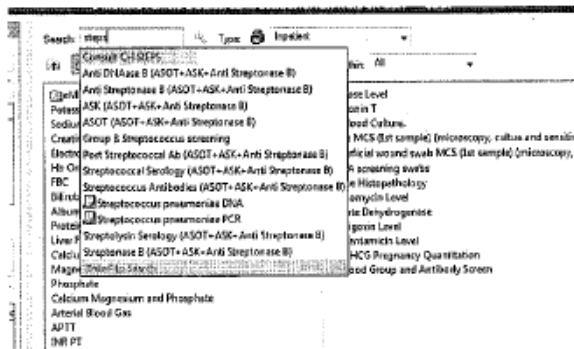
Adding an Order – Sending a referral directly to StEPS via EMR

To place an order for a patient:

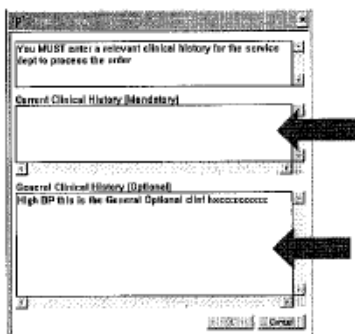
1. Open patient chart and from MPage click the blue cross to launch the order catalogue.



2. Or click on the orders tab in the menu and click **+ Add**
3. Search for "Steps" using the find function, and select "Consult CH StEPS". Left-click on order required to select



4. Complete the mandatory **Current Clinical History**, and click **OK**.
 - It is optional to enter **General Clinical History** and this will provide further relevant information for the department processing the request. It will also appear for anyone else ordering on the patient until it is removed.



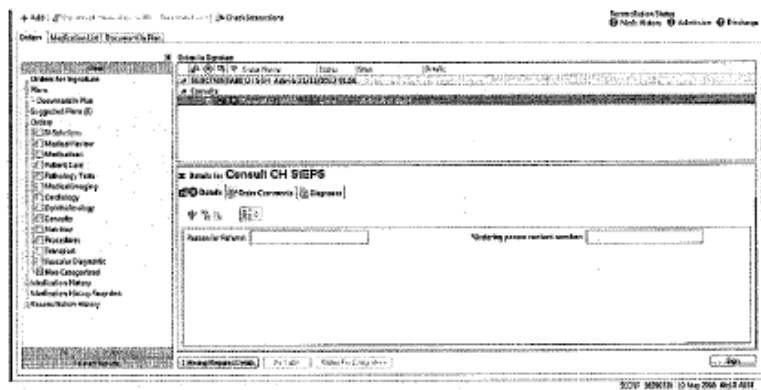
5. Click **Done** to complete your order selection. The order is now in the Order Scratch Pad.

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Adding an Order – Sending a referral directly to StEPS via EMR

- Complete all mandatory fields indicated by an asterisk and/or yellow box, that is reason for referral (e.g. "further assessment by eye health professional required") and referrers contact details.



- Click **Sign**. For security you need to enter your password. Click **OK**.



Consult orders go to the StEPS Practitioners Census Task list.