

**Scheme for Registration Assessment framework – Visit 1 including Supervisor training review scores**

**Trainee name:**

This framework is to be completed by the trainee and a copy needs to be sent to the assessor prior to visit 1. To ensure that the assessor has all the relevant information required to prepare for the assessment, please complete the supervisor training review column on each page with your most recent score for that element of competence. For scoring key see appendix at the end of this document.

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| **Unit of competence 1. Communication –** The ability to communicate effectively with the patient and any other appropriate person involved in the care of the patient, with English being the primary language of communication. |
| **Elements of competence** | **Compulsory evidence type** | **Indicators** | **Patient encounter** | **Identifiers** | **Supervisor training review score** | **Assessor column** |
| 1.2.3 Discusses with the patient the **importance of systemic disease** and its **ocular impact**, its **treatmen**t and the possible **ocular side effects of medication**.**For side effects of medications, see comprehensive list of meds, indications and side effects.** | APR | Takes a **thorough history** from the patient to include: **medication, control, disease and duration**.Demonstrates **a thorough understanding of the disease process** in cases such as diabetes, inflammatory disease, etc.Provides a **layman’s explanation** of the **particular disease process**.**YOUR APR CHOSEN SHOULD HAVE A HEALTH CONDITION SUCH AS HYPERTENSION, HIGH CHOLESTEROL OR DIABETES.** **History taking notes should reflect:*** **Name of medication(s) for the health condition(s)**
* **Duration of being diagnosed**
* **When the last review was**
* **If diabetic, enquire when the last retinal screening was and how often they are being seen, any treatment done.**

**Diabetes**: elevated glucose levels in the blood due to the body’s inability to convert glucose into glycogen for storage. High sugar levels in the blood can lead to serious health problems like kidney issues, heart problems, nerve pain, eye problems. There are 2 types: Type 1 is the body’s inability to make insulin, which converts excess glucose and stores it. They require insulin daily. Type 2: the body is insulin resistance, that means it is ineffective at converting the glucose. This is due to lifestyle, risk factors being overweight, sedentary lifestyle. Other types of diabetes: gestational (during pregnancy)**Hypertension:** high blood pressure, the force of blood pushing against the vessels is consistently high. Untreated or uncontrolled hypertension can lead to serious heart problems, stroke, eye problems (CRVO, CRAO, ischaemic optic neuropathy). Risk factors: old age, genetics, sedentary lifestyle, overweight, high salt diet, excessive alcohol)**High cholesterol**: Cholesterol is fats which are required to build cells, but excessive amounts can clog up the arteries, narrowing the arteries and making it harder for blood to flow through. This increases the risk of heart disease and stroke. Can sometimes show up around eyes such as xanthelasma, arcus senilis, emboli in retina (cholesterol emboli also known as Hollenhorst plaque) | Patient taking **medication for systemic diseasee.g. cardiovascular disease, diabetes**. | APR \_\_\_\_\_\_\_ |   | Achieved □Not Achieved □Not Assessed □ |
| Assessor Notes*Tips: Pick an APR that allows you to discuss as many elements of competence as possible. Ensure your clinical records have covered the indicators above.**What is the health condition you have picked and how does it affect someone systematically and its ocular effects?* *E.g. A chronic poor controlled diabetic patient is at risk of proliferative diabetic retinopathy – which can result in reduced vision and long-term treatment (such as antiVEGF for macular oedema, laser photocoagulation, risks of haemorrhages severely affect vision, nerve palsy causing diplopia)* *Other ocular side effects to consider is fluctuating vision if sugar levels are unstable, more prone to dry eyes, reduced corneal sensation, slower healing time**Ensure regular monitoring on the diabetic eye screening, good control of sugar levels. Comanage with GP if necessary.**Be familiar with your local diabetic retinopathy grading schemes, how to record diabetic changes and management for different stages of diabetic retinopathy.* *Hypertension and high cholesterol: risk of hypertensive retinopathy, BRVO, CRVO, ischemic optic neuropathy, macula oedema, stroke which may result in visual field defects, nerve palsies* *Useful links:**Scottish Diabetic Retinopathy Scheme:* [*https://www.ndrs.scot.nhs.uk/wp-content/uploads/2013/04/Grading-Scheme-2007-v1.1.pdf*](https://www.ndrs.scot.nhs.uk/wp-content/uploads/2013/04/Grading-Scheme-2007-v1.1.pdf)*England Diabetic Retinopathy Scheme:* [*https://www.gov.uk/government/publications/diabetic-eye-screening-retinal-image-grading-criteria*](https://www.gov.uk/government/publications/diabetic-eye-screening-retinal-image-grading-criteria) *(click on the 2 documents)* |
| **Unit of competence 2. Professional conduct –** The ability to comply with the legal, ethical and professional aspects of practice. |
| **Elements of competence** | **Compulsory evidence type** | **Indicators** | **Patient encounter** | **Identifiers** | **Supervisor training review score** | **Assessor column** |
| 2.1.2 Maintains confidentiality in all aspects of patient care.TIPS:Logging out of computer when not in use Ensure no patient personal information is recognizable when using them for logbook, or leaving notes for colleagues (using customer number instead of full name and DOB) | APR | Demonstrates **knowledge of the Data Protection Act (1998)** and how these impacts on **security**, **access** and **confidentiality of patient records**. **Additional guidance**The 1998 act has been replaced by the Data Protection Act (2018). Trainee also demonstrates knowledge of UK GDPR.**Trainee must ask for and record verbal consent on all their records** and be aware of what to do if the patient refuses consent.TIPS: Permission to store patient’s personal details, if they deny, we cannot provide them a service because the clinical records will be held and stored. Ask for verbal consent and record (VCG) on all your records, even for referrals & dilation. Patients’ data are stored safely and not sold to third party agencies. The patient is entitled to 1. Know of the company’s contact details,
2. The purpose of processing their own personal data
3. Rights to access their personal data, rectify or ask for erasure of their data
4. Rights to lodge a complaint with the Commissioner and have contact details of Commissioner. When the patient makes a request for own personal data, the Controller must provide it in writing within 28 days

The company (also known as the Controller who withhold personal data) should made aware to patients (1) purpose of storing data, (2) how long it will be held for Patient records are kept for 8 years after the last treatment. For the retention of clinical records in England, Wales & Northern Ireland it is 10 years after death, in Scotland for a patient’s lifetime and 3 years after death. 6 principles of data protection: 1. Processing be lawful and fair
2. Purpose of processing be specified, explicit and legitimate
3. Personal data is adequate, relevant and not excessive
4. Personal data is accurate and kept up to date
5. Personal data be kept no longer than necessary
6. Personal data be processed in a secure manner

Check out this pdf from British Medical Association about access to health records. It is very easy to read and has all the answers you need. <https://www.bma.org.uk/media/1868/bma-access-to-health-records-nov-19.pdf>Clinical records should be contemporaneous. If you make an edit, record the date of edit, who made the alteration Other useful links: <https://www.gov.uk/data-protection/print><https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted> | All sampled anonymised patient records | APR \_\_\_\_\_\_\_ |   | Achieved □Not Achieved □Not Assessed □ |
| 2.2.2 Is able to work within a multi-disciplinary team. | CS | Respects the **roles of other members of the practice team** and how **working together** gives the **patient the highest possible level of care**. In relation to shared care, is aware of:• local and national shared care schemes• the roles of practice staff within these schemes• the local scheme protocols **Additional guidance**Is able to explain how they fit into the practice team in terms of role and responsibilities.Demonstrates respect for other members of the team.**PRESENTED WITH CASE SCENARIO & DISCUSS WITH YOUR ASSESSOR**TIPSWorking in a team – D.O, optical assistants, receptionist, proper handover so that the patient’s journey is continuous. E.g. when handing over a patient who requires visual fields tests, ensure team members are aware of fixation loss, otherwise it can compromise the reliability of the test. Some dedicated members of staff are trained to triage and pass on the relevant information to the optometrists and advise appropriately when the patient needs to be seen. Know what is expected of you in the management of your local shared care scheme. E-referrals. Or managing certain eye conditions.e.g. a suspect glaucoma referral in Scotland requires full visual fields, DFE with volk, GAT before referral. In England this can vary. If you have a local CCG, familiarize yourself with that.  |   |  |   | Achieved □Not Achieved □Not Assessed □ |
| 2.2.3 Is able to work within the law and within the codes and guidelines set by the regulator and the profession. | CS | Demonstrates **knowledge of the advice and guidance set by the respective professional body** and standards set by their **local CCG**. Demonstrates knowledge of the **Standards of Practice** set down by the **General Optical Council**.Demonstrates a knowledge of the relevant law relating to their role, e.g. Opticians Act, GOS benefits, fees and charges, Medicines Act. Understands the implications for patient care in relation to the Mental Capacity Act 2005.**PRESENTED WITH CASE SCENARIO & DISCUSS WITH YOUR ASSESSOR****ROLES OF THE GOC**The Opticians Act 1989 created the GOC, which set rules to govern opticians, namely ensuring 1. The registrations of practitioners
2. Training and further qualifications (of institutions, and qualifying)
3. Disciplinary proceedings, fitness to practice.

**Know the STANDARDS OF PRACTICE FOR OPTOMETRISTS** (Page 5 GOC standards of practice, see link below)**GOS benefits** – who is entitled to free eye tests in England, Wales? Under 16, 17 and 18 in full time education, those on benefits (Universal credit, tax credit exemption, income support), diabetes, glaucoma, FOH glaucoma (direct family), registered partially sighted/ or sight impaired. Free NHS eye tests for all in Scotland, across all age groups. Different recall codes must be recorded if someone is not due an NHS eye test and reasons why an earlier recall is indicated.Mental Capacity Act 2005: what is meant by having mental capacity to make their own informed decisions. For those who are unable to, what can you do to support them. What do you do as a medical practitioner if you were to refer someone for treatment who has no capacity? (Discuss options with patients or carer/family members, what is in the best interest for the patient?) Useful links:GOC Standards of Practice: <https://optical.org/optomanddostandards/>Opticians Act <https://www.legislation.gov.uk/ukpga/1989/44/pdfs/ukpga_19890044_en.pdf>Mental Capacity Act 2005: <https://www.legislation.gov.uk/ukpga/2005/9/contents/enacted><https://assets.publishing.service.gov.uk/media/5a7d768340f0b64fe6c23dcb/making_decisions-opg601.pdf>**Additional guidance**CCGs no longer exist. Trainee demonstrates knowledge of standards set by authority responsible for commissioning health in their area. |   |  |   | Achieved □Not Achieved □Not Assessed □ |
| Assessor Notes |
| **Unit of competence 3. Methods of ocular examination –** The ability to perform an examination of the eye and related structures |
| **Elements of competence** | **Compulsory evidence type** | **Indicators** | **Patient encounter** | **Identifiers** | **Supervisor training review score** | **Assessor column** |
| 3.1.1 Uses instruments to **measure corneal curvature** and assess its **regularity**. | WT | Uses instruments to accurately measure, assess and record the corneal curvature and regularity.Correctly interprets the information gathered. **Additional guidance**Choice of instrumentation could include:• manual or automated keratometer• topographerAccurate results to within +/-0.10mm radius.TIPS Look up YouTube videos on how to use your keratometer.1 point or 2 point keratometer (Javal Schiotz)Mire clarity during keratometry can give valuable insights about tear film stability and corneal regularity. Keratometer measures the central 2-4mm of cornea which is sufficient for soft and RGP fit. Gives you an idea of whether astigmatism is corneal or lenticular. 2 types of corneal astigmatism: 1. Regular – the principal meridians are 90⁰ apart. (Most common type of astig)
2. Irregular – principal meridians are not perpendicular. May be due to corneal injury, surgery that causes corneal scarring, or due to keratoconus.

Indications of keratometer: CL fitting; soft and RGP, Non-invasive tear break up timePractice, practice, practice! |   | WT |   | Achieved □Not Achieved □Not Assessed □ |
| Assessor Notes |
| **Unit of competence 4. Optical appliances –** The ability to dispense an appropriate optical appliance |
| **Elements of competence** | **Compulsory evidence type** | **Indicators** | **Patient encounter** | **Identifiers** | **Supervisor training review score** | **Assessor column** |
| 4.1.2 **Measures** and **verifies optical appliances** taking into account relevant standards where applicable. | WT | Measures and verifies that lenses have been produced to a **given prescription within BS tolerances**.Verifies that all aspects of the frame or mount have been correctly supplied.Measures and verifies that the lenses are correctly positioned in the spectacle frame/mount within BS tolerances.**Additional guidance**Choice of instrumentation could include:• manual or semi-automated focimeter (Fully automated focimeter e.g. Eye refract VX40 is not acceptable)Accurate results to within:• ± 0.25DS/DC for dioptric measurements• Axis appropriate to cylinder power o ≤ 0.50DC ± 9°o > 0.50DC ≤ 0.75DC ± 6 ° o > 0.75DC ≤ 1.50DC ± 4 ° o > 1.50DC ± 3 °• Centres – 1mm tolerance.Must demonstrate **a knowledge of actual tolerances.BS EN ISO 21987:2017**.TIPSKnow how to correct mark-ups of varifocals/bifs – dotting of varifocal markings, on HCL and how to focimeter them at the right spot. Focimeter on fitting cross for varifocals. Focimeter on HCL if there is prism on the varifocals. If you have a dispensing optician in practice, make friends with them and they’ll be happy to show you. If you have a semi-automated one, good for you. Otherwise, learn how to use the manual focimeter which you need to practice before the OSCES anyway. BS EN ISO 21987:2017:<https://cdn.standards.iteh.ai/samples/65161/eb339d4bf0374be8b87f375056f646f5/ISO-21987-2017.pdf> | K | WT |   | Achieved □Not Achieved □Not Assessed □ |
| 4.1.3 Matches the form, type and positioning of lenses to **meet all the patient’s needs** and requirements and **provides appropriate advice**. | APRCS | Provides all the necessary information for a pair of spectacles to be duplicated, to include:• prescription• lens type and form• centration and fitting positions • frame details• lens surface treatments.***You must provide a dispense APR and be prepared for questioning on a case scenario by your assessor.*** TIPS Lens type: CR39 (standard uncoated lens? Or with anti-reflective coating), 1.498, Aspheric lens, 1.60, 1.67, 1.74, glass lens etc. Single vision, occupational, varifocals, bifocals (D28, C28 etc)Centration and fitting: Mono PD or bino PD, heights from rim or horizontal centration line (HCL) for varis, bifs or even SV with a high RX. Or cyl. Frame details: name of frame/model number, colour, frame size + bridge size Coating of lens: A/R coating, standard uncoated lens, reactions, tints – grades and colour. If there is a change in the dispensed index lens to another, advised patient on adaptation.A new anisometropic prescription, or a big change in prescription also should be made aware of adaptation period. Someone with a high RX/Cyl, you should match the frame’s PD to the patient’s PD to avoid prism decentration.  | Patient dispensed where **information from the old spectacles was required** | APR\_\_\_\_\_\_\_ |   | Achieved □Not Achieved □Not Assessed □ |
| Assessor Notes |
| **Unit of competence 5. Contact lenses –** The ability to manage the fitting and aftercare of patients with contact lenses |
| **Elements of competence** | **Compulsory evidence type** | **Indicators** | **Patient encounter** | **Identifiers** | **Supervisor training review score** | **Assessor column** |
| 5.1.2 Instructs the patient in **soft lens handling** and how to wear and care for them. | RA | Instructs a patient in the techniques of soft lens insertion, removal and other relevant handling instructions.Instructs a patient on the principles of soft lens wear and care including use of soft lens care products.**Additional guidance** This must include:• sufficient detailed knowledge of own lens banks and solutions to advise appropriately and safely.• sufficient general knowledge of materials and care regimes to resolve problems.TIPSSoft lens wear – appropriate cleaning advice, how often, replacement regimen for monthly or biweekly lens. If using H202 how to correctly use it. How to clean CL case, when to replace it. The dos and don’ts of CL wear (advised against sleeping, swimming, extended wear, or reusing dailies, overwearing monthlies).Insertion: Wash hands. Check that the lens is the right way up and how to differentiate from the wrong way. Check that the lens is not torn. Ensure CL is the first to go in before doing any makeup or applying any facial products. This is because the fingers can get greasy from handling those and be transferred onto the lens. Removal: remove CL before removing makeup as the grease and debris from makeup removal can get transferred to CL. This is more crucial for monthlies. First time CL wearer – easier to fit a lens material that is higher in modulus to help with lens removal and insertion. Eg Total Dailies 1 and Precision are very comfortable dailies, very soft material and a bit slimy. Can be trickier to handle and teach I&R compared to Cooper vision clarity (umere) /My Day(linarial) – which are good lenses for beginner. Go to CL manufacturer’s page on lens materials and patient suitability. E.g. long hours wearer benefit from SiHy. Occasional social wear can get away with Hydrogel lens which may be more comfortable. What happens if someone develops an allergic reaction to CL solution? Signs and symptoms of allergic reaction such as burning, itching, clinical signs include diffuse SPK, conjunctival redness. Benzalkonium chloride is a common preservative that can cause allergic reactions. Consider changing solution or refitting with dailies. Cleaning/rubbing of reusable CL is essential to reduce risk of infection, improve comfort of lens wear especially during the 3rd or 4th week of wearing. YOUR REFLECTIVE ACCOUNT SHOULD INCLUDE:* Summarize the experience about the teach
* How you feel about it, and what have you learnt from this experience
* What actions you took and why you did it. (If you did not do it, why?)
* What do you think went well, and what did not go well for you?
* How can you improve on this (it could be the patient experience, your next actions, or your management)
* What actions will you take next time
 | Insertion and removal training to at least one soft lens patient. | RA\_\_\_\_\_\_\_ |   | Achieved □Not Achieved □Not Assessed □ |
| 5.1.4 Instructs the patient in **rigid contact lens handling** and **how to wear and care for them**. | RP | Instructs the patient in the techniques of RGP lens insertion, removal and other relevant handling instructions.Instructs a patient on the principles of RGP lens wear and care including the use of RGP lens care products.**Additional guidance**This must include:• **sufficient detailed knowledge of own lenses** and **solutions** to advise appropriately and safely.• sufficient **general knowledge of materials** and **care regimes to resolve problems**.**ROLE-PLAY A TEACH SESSION OF RGP WITH YOUR ASSESSOR**RGP Insertion & Removal: Hygiene – Always wash your hands with soap before touching your eyes and contact lens.RGP insertion: place lens at the tip of index finger (preferred dominant hand), look straight into the mirror, pop the lens in. Takes awhile to adapt having RGP in the eye, this is normal. May experience initial reflex tearing, which can take up to 20-30minutes to settle. (Looking down at the knee to reduce lid attachment and sensation helps)RGP removal: One index finger on the edge upper lid, one index finger on the lower lid. Simultaneously push the fingers towards each other and simultaneously blink at the same time to ‘prop’ the RGP lens out. Also able to use a suction pump if wants to but need to know how to remove RGP without any tool.RGP Indications: Irregular or high astigmatism, high RX that do not get good vision with SCL or glasses, e.g. keratoconus, corneal conditions. The tear lens corrects the irregularity of the cornea. Dry eyes patients Good for people who are planning to wear it on a regular basis but not for occasional wear. Avoid the use of RGP with hard contact sports or working in dusty environment as this can cause a lot of irritation. Lens material, design and suitability can be found on the manufacturer’s page. You need to look it up (depending on what you fit in your practice) Some materials are more prone to certain deposits than others (e.g proteins or lipid deposits). For someone who has MGD, this is something you need to take into consideration. Manage MGD and go for a lens material that is less prone to lipid depositions. Deposits on the lens surface can reduce patient’s comfort and vision, hence, consider additional cleaning products for the RGP (such as a lens cleaner and protein removal product to prolong the longevity of the RGP and improve patient’s comfort)If the above does not improve, can send the RGP back to the manufacturer to find out the type of deposits and change to a different lens material that is less prone to deposition.  |  |  |   |  Achieved □Not Achieved □Not Assessed □ |
| Assessor Notes |
| **Unit of competence 6. Ocular disease –** The ability to identify and manage ocular abnormalities |
| **Elements of competence** | **Compulsory evidence type** | **Indicators** | **Patient encounter** | **Identifiers** | **Supervisor training review score** | **Assessor column** |
| 6.1.1. Understands **the risk factors for common ocular conditions**. | TCD | Understands the risk factors for developing common ocular conditions including:**Glaucoma, cataract, diabetic retinopathy and AMD.****Your chosen patient encounter should have the risk factors identified in the ocular condition.** **Glaucoma (POAG):** family risk factors, age, race (African, Asian, Hispanic), high intraocular pressure, thin central cornea, myopia, diabetes **Ocular hypertension:** Raised IOP (>24mmHg on GAT) but healthy optic nerve, no visual field defect, wide van herick, no signs of secondary causes of raised IOP (such as no pigment dispersion, rubeosis, pseudoexfoliation syndrome)Central corneal thickness (CCT) is commonly overlooked when measuring the IOP. Noncontact tonometry is more influenced by CCT than applanation (GAT). Most NCT assumes an average CCT of 520um. Thin corneas IOP can be underestimated, whereas thicker corneas IOP can be overestimated (higher than it is). Some studies have shown that there is a 0.71mmHg/10um deviation from an average CCT of 520um. **Angle closure glaucoma**: shallow anterior chamber, narrow van hericks (anatomy of the eye), more common in Asian population, age (due to progression of cataract which causes lens to thicken, further narrowing the anterior chamber angle), presence of moderate to high hyperope (smaller eye ball, coupled with moderate lens opacity, increases risk of angle closure), plateau iris (anterior rotation of the ciliary body, leads to peripheral bowing to the iris, resulting in pupillary block)**Normal tension glaucoma:** Japanese, hypertension, diabetes, vascular dysfunction and ischaemia Secondary glaucoma: Pseudo exfoliative syndrome is where exfoliative materials accumulate at the pupil and lens and clog up the trabecular meshwork, resulting in increase of IOP and hence pseudo exfoliative glaucoma. Seen in Scandinavian countries, age 50 and over. Not everyone with pseudo exfoliative syndrome will develop glaucoma but its 40-50%, hence those with PXS should be monitored regularly. Pigment dispersion syndrome: the pigment that rubs off the iris and when gets lodged in trabecular meshwork, can cause increase in IOP, optic nerve damage and pigmentary glaucoma. Usually seen in young Caucasian male (20s)Cataract: Age, lifestyle (Chronic UV exposure), medications such as steroids, diabetes,Diabetic retinopathy: poor control of diabetes, or being diabetic for a very long time (can be type 1 or 2)AMD: race (Caucasian), family history, age (>50 years old), smoking, high blood pressure, diabetes | Patient with a risk factor for an ocular condition | TCD\_\_\_\_\_\_ |   | Achieved □Not Achieved □Not Assessed □ |
| 6.1.11. Understands the **treatment of a range of common ocular conditions**. | CSQ | Demonstrates a **basic understanding** of the **treatment regimens of cataract**, **AMD, glaucoma**, **diabetic eye disease** and **minor anterior eye problems**.Can discuss the treatment options for two of the above conditions.**You will be given a case scenario by your assessor and discuss it**TIPSCataract: The referral guidelines and considerations such as reduced VA (worse than 6/12), glare, how it has impacted the patient’s quality of life (such as being unable to drive), reduced contrast sensitivity, struggling to see food packaging. Brief explanation of what to expect when a patient is referred for cataract surgery (pre-cataract assessments,AMD – wet and dry. To manage in practice or refer for Anti-VEGF? Recall period? Lifestyle modifications (stop smoking), supplements (studies have shown that those with moderate dry AMD in one eye or wet AMD in one eye benefits from supplements in slowing down progression, diet rich in antioxidants and dark leafy greens, good control of systemic conditions. Amsler to self-monitor for changes, how to use amsler correctly and what to look out for if a sudden change is noticed.Advanced AMD or those registered partially sighted – referral to low vision services for any help around the house and access to low vision aidsGlaucoma – anti-hypertensives eyedrops (and a brief understanding of the various types such as prostaglandin analogs, betablockers, CAI, alpha agonists)P.A.(Latanoprost, monoprost): usually first line of treatment, enhances uveoscleral outflow, reduces IOP by 25-33%. Usually well tolerated, used once a day in the evening. S/E: conjunctival redness, periocular pigmentation, increased eyelash growth. Contraindicated in uveitis/iritis as it can exacerbate inflammation.Beta blockers (timolol, betaxolol): Reduces aqueous production by blocking sympathetic pathways of ciliary epithelium, hence lowering the IOP (by 20-30%). Contraindicated (C/I) in asthma, chronic pulmonary conditions, myocardial infarctions, atrial fibrillation. CAI (brinzolamide, dorzolamide): inhibits carbonic anhydrase which is found in the ciliary epithelium. Blocking CA reduces formation of bicarbonate ions, reducing fluid transport and IOP. S/E: burns, bitter taste after instillation, allergic reactions of conjunctiva, superficial punctate keratopathy. (15-20% drop in IOP)Alpha agonist (brimonidine, apraclonidine): reduce aqueous secretion and improves uveoscleral outflow. Brimonidine can cause follicular conjunctivitis in 5-9%, apraclonidine in 30-48% (less prescribed due to increased incidence of ocular allergy)Peripheral iridotomy: laser a small hole in the iris to create an alternative drainage channel, used to treat or prevent angle closure. Selective trabeculoplasty (SLT): An argon laser is mounted on the slit lamp, with the use of a gonio lens to visualize the trabecular meshwork (TM), the laser creates a small hole in the TM, thereby improving aqueous drainage and reduces IOP. Argon laser is light pulses of low energy laser that only targets the melanin cells in the TM, leaving other structures of eyes unaffected. Laser induces a response from the body whereby the white blood cells are released to clear the affected cells and rebuild the meshwork, further reducing IOP.Used in POAG, reduces IOP by 30%. Almost as effective as prostaglandin analogs but without the side effects of eye drops. Indications: combination therapy with drops or an alternative when side effects or drops are not very effective, or when patient has difficulty with drops. Side effects post-op, mild blurry vision, post-op inflammation usually treated with NSAID drops and extra antihypertensives to prevent IOP spike. Success rate: 78% success in reducing IOP, may not work for some at all. Lasts between 1-5 years depending on the make-up of individual’s eyes and type of glaucoma.   Trabeculectomy: a flap is created in the sclera, removed a small piece of iris, flap is placed back, and conjunctiva sewn back in place. This creates a little small blister called the bleb underneath the conjunctiva for fluid to pass through, bypassing the normal drainage channel, thereby reducing the IOP. Indications: open and closed angle glaucoma, secondary glaucoma, moderate to advanced glaucoma not responding well to drops or previous laser. i-Stent: For POAG only, little stents implanted in the TM to drain fluid out from the anterior chamber into the Schlemm’s canal and out of the eye, reducing the IOP. Used to treat moderate to advanced glaucoma Diabetic eye disease – None for NPDR, regular monitoring under medical retina clinic or diabetic screening program. Co-manage with GP. Treatment for proliferative diabetic retinopathy (e.g. AntiVEGF for macular oedema, for small bleeds in the peripheral retina laser photocoagulation). For minor anterior eye problems, be familiar with the CMG for blepharitis, subconjunctival haemorrhage, episcleritis, bacterial/viral/allergic conjunctivitis.  |   |  |   | Achieved □Not Achieved □Not Assessed □ |
| Assessor Notes |
| **Unit of competence 7. Assessment of visual function –** The ability to assess visual function in all patients |
| **Elements of competence** | **Compulsory evidence type** | **Indicators** | **Patient encounter** | **Identifiers** | **Supervisor training review score** | **Assessor column** |
| 7.1.7. Understands **the special examination needs** of patients with **severe visual field defects**. | CS | Understands the **different types of severe visual field defects** and how to **adapt examination technique** to take them into account, in particular:• consideration of patient’s mobility• adaptation of routine.**You will be given a case scenario by your assessor and discuss it**Types of visual field defect: Tunnel vision: Due to retinitis pigmentosa (RP)/Advanced glaucomaHemianopia: following a stroke or compressive lesion.Stay within the patient’s visible field of view. Avoid having things laying on the ground, see if they need help with mobility or holding onto your arm. Have bright ambient lighting in the test room. Reduced peripheral vision: For proliferative diabetic retinopathy following PRP laser, retinal detachment – affected field of view will be the at the site of laser/previous injury.Paracentral, cecocentral, or central scotomas. – optic atrophy **Avoid using phoropter for people with severe visual fields defect. Always use a trial frame. When you ask is 1 or 2 clearer, BE VERY SLOW. For a new customer, consider performing retinoscopy on those with variable subjective response. Those with clear IOLs may get a very good reflex and refine with subjective refraction. Returning customers who have no new chief complaints can use spectacle or previous RX as a starting point.** **Always do refraction with good lighting! Dim illumination can cause pupils to dilate and increases spherical aberrations, making vision worse.** **Perform refraction first then slit lamp exam. People with low vision can have a longer light-dark adaptation period.** For paracentral scotomas such as advanced AMD, macular issues, you may want to encourage eccentric fixation during subjective refraction & record it. Larger bracketing may be required, e.g. +/-1.00DS or 2.00DS Be slow and patient, smaller bracketing can be used when finetuning VA. When refining the cyl, if the VA is too poor, instead of using the circles, isolate a large O or C that the patient can see and use that. Change cyl axis of about +/- 20degrees, +/-0.50DC or +/-1.00DC. start with cyl axis, then power.VA recording: LogMAR or the Thomson Test chart is more ideal than Snellen as the former have the same number of letters in each row and a uniform progression of letter sizes. If VA is worse than 6/60 or 1.0 logMAR, instead of recording CF/HM/LP, move the test chart or the patient! If VA is worse than 6/60 or 1.0 logMAR, test at 1-3 meters. If VA is between 6/24 – 6/30 (0.6 – 1.0 logMAR), test between 3-4 meters.VA better than 6/24, test at 6m. For logMAR, add 0.3 to each logMAR line when you half the working distance. If using a mirror to simulate 6m test room, get patient to sit opposite the test chart at the opposite end of the room, which will be 3m and record Snellen in 3/xxNVA – Test with good or if required extra illumination (daylight light is best, not too glaring but bright and comfortable enough for viewing), monocular and binocular VA should be recorded. Those with central scotoma and find it hard to follow words, some people may find it easier to shut the eye with worse vision, you can encourage that. Those with good binocularity, similar VA and a strong near add may benefit from base-in prism at near to facilitate comfortable fusion. For patients who spot-read, they may find it easier to move the chart across from right to left instead of reading across the page (steady eye strategy). As practitioners we try to encourage the smallest near visual acuity the patient can see but that is not always beneficial. Someone with low vision may be able to spot read N8 with difficulty but read more fluently at N10. So, to read comfortably, use N10 to calculate the amount of magnification required will give a more realistic outcome than using N8. I like to record: N8 Just, N10 Comfortable viewingA strong near add will magnify things but requires a closer working distance. Advise the patient of this and check if the reading they do is spot reading for food packaging instructions or fluent reading. In the latter, consider the practicality of using a magnifier for more fluent reading and a more sustainable comfortable reading position. Useful links on how to adapt your eye test for a low vision patient:<https://www.opticianonline.net/content/features/refracting-the-visually-impaired-patient/><https://www.rcophth.ac.uk/wp-content/uploads/2021/12/Low-Vision-Guide.pdf><https://docet.info/pluginfile.php/48543/mod_resource/content/4/conversion_table_for_logmar_to_snellen.pdf>  |   |  |   | Achieved □Not Achieved □Not Assessed □ |
| Assessor Notes |

**Supervisor training review scores**

**Key:**

**Level 0** – trainee has no experience in this area

**Level 1** – trainee demonstrates little understanding of the requirements for this area of practice and completes tasks only with detailed guidance from supervisor

**Level 2** – trainee demonstrates basic understanding of the requirements for this area of practice and is able to complete some tasks only without detailed guidance

**Level 3** – trainee demonstrates safe understanding and ability in this area of practice, occasionally checking with others if uncertain