

The handover

Accuracy and good communication between professionals ensure high standards of care. **Shaunagh Aitken** emphasises the importance of the handover from optometrist to dispensing optician

The optometrist comes out of the refraction room with the patient, takes her to the waiting room and leaves her there. The optometrist tells the patient that someone will be with her soon, says goodbye and goes on to the next patient. Is this good practice?

What about this alternative scenario? How often does this happen in your practice? The optometrist comes out of the refraction room with the patient and takes them to the waiting room. The optometrist then introduces the patient to the dispensing optician by name and occupation. This tells the patient they are being seen by a qualified optical professional who knows what they are talking about.

The following points should be borne in mind at the handover to ensure our patients receive a professional standard of care.

● Introduction

The handover is one of the most important introductions that your patient should have. This enables dispensing opticians to be seen as professionals in their own right and not as just shop assistants, as a lot of patients seem to think they are. The dispensing optician is a highly qualified professional and it is important to establish this with the patient. The introduction should enhance the role that the dispensing optician plays in the care of the patient.

● Handover conversation

It is useful at the handover for any important advice that may have been given to the patient by the optometrist to be passed on to the dispensing optician also. This avoids any unnecessary duplication but also gives the dispensing optician a chance to confirm or otherwise that the best appliance has been recommended. It sometimes happens that further



The patient should feel confident she is being seen by a qualified dispensing optician

clinical information is offered during the dispense, such as for example a posture problem that may make progressive lens wear difficult. The dispensing optician is then in an excellent position to offer alternative solutions.

● No back vertex distance

If a prescription is over + or -5.00 DS, a back vertex distance must be written on the prescription. If this is lacking, the prescription should automatically be referred back to the optometrist. Without this information there would be a delay in ordering the spectacles and the patient would need to come back on another day to have the back vertex distance measured in the trial frame. This would not look professional to the patient.

● No patient name

The prescription is not legal and therefore invalid if the patient's name has not been written on it.

● No signature

The optometrist has failed to sign his name, print his name in block capitals and has failed to put down his supplementary list number (in the case of NHS prescriptions).

● No voucher

Always assume the patient is going to leave the practice and buy their spectacles elsewhere. In this way, all the forms will have been filled in and there will not be a delay in getting vouchers signed. If the patient is over 60 do not assume that they are not on benefits. Always double check, then the voucher will need to be written out and signed.

Vouchers seem to be a bug bear for many dispensing opticians. When a voucher has not been issued, the dispensing optician is left to chase it up with the optometrist. Has the prescription been put into the correct sphere cyl form to give the best voucher value? Transposition often

carries the patient into the category worth the higher value.

● No intermediate add

Only write down the intermediate add at a specific distance for the task if required. It is important in the eye examination to establish viewing distances for all tasks that the final appliance might be needed for. The appropriate add should then be stated on the prescription.

● Balance prescription

Where a lens power is stated followed by the word 'balance', this is wrong. Does the patient have useful vision in that particular eye? Both statements cannot be true. If there is no useful vision the optometrist should write balance. If there is, then state a power. The additional comments box can be used here; for example, 'patient has poor vision in the left eye'. True balance lenses should be the sphere plus half the cyl (ie the mean sphere) of the opposite lens power to give an equally weighted lens.

● Additional comments box

What needs to go in the additional comments box? It must be relevant. If there is a big change in the prescription this should be clarified and the possibility of adaptation problems highlighted in the box.

Two examples

● Rx: R: -1.50DS L:-2.00/-0.25x135
ADD R+L +1.50DS

A useful comment might be – 'Mrs X is a first-time presbyope. I have spoken to Mrs X; she does not mind taking her spectacles off to read'.

Another scenario might be – 'Mrs X is a first-time presbyope. Mrs X does not want to take her spectacles off to read. You will need to discuss her options regarding bifocals and progressive lenses.' In this instance, we cannot automatically assume that Mrs X will want a multifocal lens so there needs to be feedback from the optometrist.

● Rx: R: +6.75/-0.75X23 L: +5.75DS
ADD R+L+3.00DS

A vital piece of information here is 'Mrs Y has had a large change of prescription, and will require adaptation time.' ●

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Books go interactive

Bill Harvey looks at two recent publications, one of use for clinicians wishing to help patients, the other for them to help themselves



Compared to previous years where publishers appeared to be producing books related to optometry at a rate of almost one a week, things have been much slower this year. There have, however, still been some interesting books released recently.

Educate your patient

There is no doubt that a skilled clinician is not simply someone who grasps the undertaking and interprets the results of a bank of clinical tests. The ability to interact with the patient to gather as much subjective information as possible, and then the ability to communicate findings as effectively as possible, not only improves clinical accuracy, but can improve compliance as well as patient satisfaction. The latter has the knock-on effect of ensuring the patient returns and, in this uncertain climate, a stable patient base is in everybody's interest.

One of the well-trusted ways to ensure good communication is through visual cues. If explaining to a patient about their early cataract, it is invaluable to be able to use a clear and understandable illustration so the patient is better informed and, usually, less unnecessarily alarmed. On first qualifying I referred to a small booklet of barely legible line drawings. I soon took to drawing my own sketches and, more recently, have used some of the excellent illustrative images and diagrams on electronic display equipment, such as the City 2000 or some of the Optimed EyeMagination systems.

I was pleased, therefore, to see *The Optometrist's Practitioner-Patient Manual* by Anthony Phillips. It is a ring-bound hardback containing a myriad of laminated (and fingerprint-proof) cards enabling most aspects of optometry to be reasonably explained.

The handbook is split into five major sections, prefaced with a near acuity chart and an Amsler grid. The first section is titled 'The Eye' and includes schematics of the eye and the visual pathway, allowing the practitioner to explain something about most common illnesses and refractive errors. I particularly like the schematic explaining 'why do I see better in good light or if I screw up my eyes', something patients often ask when trying to put off the moment of their first correction. There are also some nice

photographic representations of how a bowl of variously coloured food will look to a protanope and a deuteranope – much better than a verbal explanation.

Section 2 is on ophthalmic lenses and includes the familiar graphics on lens design, often used when dispensing progressives for example. Section 3 is a fairly comprehensive series of high resolution images of a range of abnormal conditions, obviously concentrating on those most likely to be met in general practice. Sad to see the usual representation of sight through AMD as a central splodge surrounded by clear periphery. Who are these people with high acuity peripheral retinas? That aside, this has enough images to cover most lesions in need of explaining.

Section 4 is on contact lenses, though an anterior imaging system may be better to explain problems to an existing wearer as it personalises this. Good images of some complications of overwear and poor compliance though, which might provide the incentive to get a patient to change their behaviour. The last section illustrates strabismus and includes diagrams differentiating phorias and tropias, convergence insufficiency, and the extraocular muscles. I would like to try this in practice as up until now have tended to merely explain 'turns in the eye' in words.

Keep up-to-date yourself

The Test Yourself Atlas in Ophthalmology by Jack J Kanski has been a stalwart of revision for many years. I remember using the first edition myself so was pleased to see a third edition has just been published.

As ever, the quality of the images is excellent and the diseases covered diverse. Some sections should be easily answered by all eye care practitioners while there is plenty of obscure material here to tax the brain cells. One particularly disturbing series of questions shows eye disease resulting from previous inappropriate management.

But what is completely new here, so meriting this short review, is a code allowing access to a large online resource linked to the Kanski publications. At the time of the review this was not yet available but I look forward to scanning through the online images and questions soon. ●